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Diametros nr 22, 3-20

2009

Diametros № 22 (December 2009): 3 – 20

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The proliferation of ethics committees and ethics consultation services has engendered a discussion of the issue of the expertise of those who provide clinical ethics consultation services. In this paper, I discuss two aspects of this issue: the cognitive dimension or content knowledge that the clinical ethics consultant should possess and the practical dimension or set of dispositions, skills, and traits that are necessary for effective ethics consultation. I argue that the failure to differentiate and fully explicate these dimensions contributes to the confusion over the issue of expertise and fuels, at least partly, the controversies about expertise (or authority) in ethics and the legitimacy of the use of ethical knowledge in clinical ethics consultation.

The proliferation of hospital ethics committees and ethics consultation services in health care organizations has been influenced by two interrelated developments: first, the growing recognition that a mechanism to resolve conflicts and issues arising in medical care without recourse to courts of law was needed,[1] and, second, the Joint Commission for the Accreditation of Healthcare Organizations requirement for an "ethics mechanism,"[2] which was built on recommendations by other influential groups such as the President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research[3] and the American Medical Association.[4] These recommendations reflect the recognition that the basic need for some authoritative voice to address ethical conflicts and issues arising within patient care contexts. As Aulisio and Arnold recently expressed it,

> Much more significant, in our view, are the features of contemporary clinical care settings that give rise to the need for ethics committees (or something like them). These features include the complex value-laden nature of clinical decision making, the pluralistic context of contemporary society that is reflected to various degrees

[1] Cranford, Doudera [1984]; Dubler, Marcus [1994].

[2] JCAHO [1992].

[3] President's Commission [1983].

[4] JCAMA [1985].

> in clinical settings the world over, and, perhaps most importantly, a growing recognition of the rights of individuals and their implications for patient care.[5]

Because authority is an uneasy, political concept that naturally gives rise to concerns about oppression or the abuse of power vested in those with authority, it is no surprise that the development of ethics consultation services and ethics committees has been fraught with a good deal of controversy and concern.[6] The recognition of the need for some authority or expertise in addressing ethical problems has given rise to concerns over the power of anyone who addresses ethical problems, question, and conflicts in patient care. Given the diversity of cultural, ethnic, and religious beliefs of patients, families, and healthcare professionals that underlies the need for ethics consultation, it is not surprising that expertise in clinical ethics and ethics consultation has been a red-hot issue.

Historically, a number of questions have dominated the discussion of this topic: Who should provide ethics consultation services: ethics committees, teams, or individual consultants?[7] What kind of professional qualifications should the ethics consultant possess?[8] Should consultants be credentialed?[9] How does ethics consultation alter the distribution of power among families, physicians, patients, and nurses?[10] Should ethics consultants or advisors be tolerated in liberal, democratic societies?[11] These questions are critical for the field given that ethics consultation services and hospital ethics committees are ubiquitous features of contemporary health care. In 1983 only 1% of US hospitals had ethics committees, but, by 1989, the number had grown to more than 60%, and to more than 93% by 1999.[12] A recent study found that all US hospitals with more than 400 beds, federal hospitals, and those that are members of the Council of Teaching Hospitals have some

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[5] Aulisio, Arnold [2008] p. 418.

[6] Agich [1995].

[7] LaPuma, Toulmin [1989]; Ross [1990]; Gramelspacher [1991]; Cohen [1992]; Swenson, Miller [1992].

[8] Cranford [1989]; LaPuma, Schiedermayer [1990]; Grunfeld [1990]; Zaner [1984]; Ackerman [1987]; Morreim [1983]; Jonsen [1992]; LaPuma, Schiedermayer [1992]; Barnard [1992]; Thomasma [1991]; Marsh [1992].

[9] LaPuma, Priest [1992]; Fletcher, Hoffman [1994].

[10] Siegler [1986]; Lo [1987]; Siegler, Singer [1988]; Fleetwood et al. [1989]; Blake [1992].

[11] Agich, Spielman [1997]; Avorn [1982]; Beauchamp [1982]; Delgado, McAllen [1982]; Noble [1982a, b]; Singer [1982, 1988]; Wikler [1982]; McAllen, Delgado [1984]; Baker [1989]; Pellegrino, Sharpe [1989]; Scofield [1993, 1994]; Sharpe, Pellegrino [1997]; Wildes [1997]; Spielman, Agich [1999].

[12] Youngner et al. [1983]; Fleetwood et al. [1989].

form of ethics consultation available.[13] Hospital ethics committees are at least as prevalent in Canada as they are in the United States, and their presence is growing elsewhere around the world as documented by a well-developed literature.[14]

The Dimension of Knowledge

Is there special or appropriate training or education that an ethics consultant should possess as a prerequisite for doing ethics consultation?[15] In other words, what knowledge would qualify an individual to provide ethics consultation services? This has been an extremely contentious question in the development of ethics consultation and hospital ethics committees. There is a huge literature documenting the debate over a number of different ways of formulating this question. For example, there has been debate over whether physicians or philosophers are qualified to provide ethics consultation,[16] whether providing consultation services to patients, families, and health professionals is a legitimate function for bioethicists, or whether knowledge of ethics, medicine, or health care practices is essential for providing ethics consultation.[17] It should be noted that debates of this sort are common in other fields that are transitioning from academic subjects of study, research, and teaching into more practical pursuits such as consultation or the provision of professional services other than teaching and research. Therefore, the occurrence of debate is not surprising, but the rapid proliferation of hospital ethics committees and ethics consultation services suggests that the worries of academics within the field of bioethics about the legitimacy of clinical ethics and ethics consultation are not impeding others from providing these services. The literature and published surveys show that the majority of hospital ethics committees and ethics consultation services are composed of health professionals of various types, most of whom do not have formal ethics education; thus, the question

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[13] McGee et al. [2001].

[14] Schlaudraff [1992]; Graf, Cole [1995]; Thornton, Lilford [1995]; Slowther, Underwood [1998]; Robles [1999]; Mino [2000]; Melley [2001]; Parker [2002]; Reiter-Theil [2001a, b]; Richter [2001]; Slowther et al. [2001]; Slowther et al. [2001]; Sass [2002]; Wray [2002] Steinkamp [2003]; Lebeer [2005]; Meulenbergs et al. [2005]; Guerrier [2006]; Akabayashi et al. [2007]; Hurst et al. [2007]; Hurst et al. [2007]; Forde et al. [2008]; Reiter-Theil, Agich [2008]; Sorta-Bilajac et al. [2008].

[15] Agich [2005].

[16] Jonsen [1980]; Zaner [1984]; Ackerman [1987]; Cranford [1989]; Grunfeld [1990]; LaPuma, Schiedermayer [1990]; Thomasma [1991]; Barnard [1992]; LaPuma, Priest [1992]; Marsh [1992]; Fletcher, Hoffman [1994]; TFSBC [1998].

[17] Morreim [1983]; Zaner [1984]; Ackerman [1987]; Cranford [1989]; Grunfeld [1990]; LaPuma, Schiedermayer [1990, 1992]; Thomasma [1991]; Barnard [1992]; Marsh [1992].

of expertise is implicitly coupled with the issue of the relevance of education in ethics for clinical ethics.

Regarded philosophically, the question is whether the knowledge of philosophical ethics provides the requisite cognitive framework for ethics consultation. For philosophers, it should be evident that framing the question in this fashion conceals a number of background issues that might shape how the question is understood, much less answered. For those who see ethics as a primarily theoretical activity, with a range of associated activities that are principally academic such as engaging in ethics research, publication, lecturing, and teaching, ethics consultation will appear problematic for a number of understandable reasons.

First, the setting of ethics consultation is dramatically different from that of academic philosophy within which ethics has traditionally functioned.[18] Ethics consultants operate within health care institutions that are involved primarily in patient care. Even if these healthcare institutions are teaching hospitals and the philosopher is involved because of an academic appointment to teach bioethics, the role of the clinical ethics consultant is one that does not mesh well with the standard expectations associated with the academic role. I have argued that the ethics consultation role is actually a sub-role of clinical ethics, which itself is removed from, but related to, the academic role of teacher and researcher.[19] Thus, it is not surprising that there have been expressions of skepticism about philosophers providing clinical ethics consultation services. Some of this skepticism is driven by professional conflicts as is evident in the debate over whether philosophers or physicians are best qualified to provide the services in question. These disputes unfortunately miss the deeper issue which is not about which profession should be allowed to provide ethics consultation services, but what, if any, specific knowledge is requisite for providing ethics consultation services. If there is no distinctive knowledge base that underlies ethics consultation, then no matter who provides it, they will do so with a distinctively non-cognitive claim to expertise.

Non-cognitive claims to expertise are not illegitimate, in my view, because there are types of experts whose expertise consists in the possession of practical skills and experiences, competences of various sorts, which gives them qualifications over others in many spheres of life. For example, accomplished musicians or craftsmen who lack formal training or education – indeed some may be illiterate – can surely be said to possess expertise in their field of performance, but their ex-

[18] For the purposes of this paper, I confine my discussion to philosophy and ignore religious ethics or ethics grounded in theology rather than philosophy.

[19] Agich [1990].

pertise might not be based on knowledge theoretically understood. They may have idiosyncratic ways of speaking about their skills and performances that not only fail to correspond to standard ways of understanding their requisite fields, but also represent inconsistencies or confusions in how they "think" about what they nonetheless "do" successfully as practitioners. Such individuals can be acknowledged as experts, but a socially accepted field of knowledge might not undergird their expertise.[20] The field of knowledge might exist, but the particular individuals could function as experts without possessing the knowledge. For example, an unschooled musician might be unable to read music or understand musical theory, but might provide expert advice and direction to a novice musician about correct technique in playing a piece of music.

An important anchor for the question of expertise in ethics was provided in a paper by Stephen Toulmin entitled "How Medicine Saved the Life of Ethics."[21] In the 1960s and 1970s, bioethics developed as part of a broadly based applied turn in ethics and philosophy. This academic turn occurred in a time of social criticism and protest when conventional or traditional ways of thinking and doing things were widely subject to critical examination. The practical turn was auspicious, because it breathed new life into philosophical ethics.[22] In Toulmin's view, philosophical ethics had become trapped in a positivistic universe in which facts and values were separated; the legitimate domain of philosophical inquiry and professional activity for philosophers was rigidly restricted to theoretical and conceptual concerns with little regard for ethical problems of everyday life. As Timothy Williamson in his presidential address to the Aristotelian Society recently put the point, "If anything can be pursued in an armchair, philosophy can."[23] In this universe, philosophical ethics can be committed to approaches that abstract from concrete problems and can be dealt with comfortably from the chair of theory. Armchair ethics not only focused on the meaning of ethical concepts and their

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[20] The issue of what qualifies one to be an expert has arisen in the context of so-called "expert testimony" in courts of law. See, Agich, Spielman [1997]; Delgado, McAllen [1982]; Fletcher [1997]; Kipnis [1997]; Mishkin [1997]; Pellegrino, Sharpe [1989]; Scofield [1994]; Spielman, Agich [1999].

[21] Toulmin [1982].

[22] This involvement of philosophers in patient care is not without its critics. David Rothman [1991], for example, regarded the presence of lawyers and philosophers at the bedside, and generally within healthcare settings, as intrusive and destructive of traditional physician-patient relationships and physician authority. This reading, however, overlooks the important point that the many of those he termed "strangers at the bedside" were invited by physicians and healthcare institutions, because physicians and health care institutions *wanted* outside assistance in addressing complex ethical problems arising in contemporary healthcare.

[23] Williamson [2004].

theoretical justification; it did so with a sense that this focus defined the legitimate scope of philosophical ethics. But it is one thing to include practical or applied concerns within the academic subject of ethics and quite another to step outside the academic settings and venture into settings and institutions that primarily provide patient care rather than education or research.

To appreciate the significance of the transition from the university to the medical center, it is important to recall that the development of applied ethics in the 1960s and 1970s, and the subsequent emergence of the interdisciplinary field of bioethics in the 1980s, propelled some philosophers into clinical settings. They came first as academics, as teachers of medical ethics, but subsequently gained membership on hospital ethics committees, and stepped into the role of the ethics consultant. Although these developments set the stage for the debate over expertise, most of the work in bioethicists – and not just philosophers working in the field – was done within the academic world, so clinical ethics and ethics consultation proportionally represents an applied turn that is still relatively unusual for bioethicists. It is no wonder, then, that clinical ethics challenges those who cling to an academic vision of the field. Saying this, of course, does not show that concerns about the relevance of knowledge of ethics for ethics consultation are spurious or a matter of "turf" or "professional identity" concerns, but it does suggest that arguments to show either that formal education in ethics is *not* relevant for clinical ethics or that philosophers should not participate in ethics consultation might be framed by background concerns about professional status. While the (ir)relevance of knowledge of ethics for ethics consultation is often asserted or alleged, most of the debates do not contribute much to resolving the conundrum over the epistemic contribution of knowledge of ethics to ethics consultation.

For those who do not hold a rigid academic conception of ethics as a primarily theoretical enterprise, ethics as a body of knowledge is not so much applied – as in "take a theory and analytically rely on it to reach a conclusion in a problematic ethical situation" – as it is a set of concepts, principles, and theories that inform reflection on ethically problematic situations or issues and that provides guidance for action. In this sense, then, ethics is more than a body of knowledge; it is a process of reflection that involves ethical knowledge to be sure, but the knowledge is not static or academic in any pedantic sense. Rather, the knowledge is intrinsically connected with reflection on the moral life, and it is dynamically a component in thinking about human actions and institutions *in a certain way*.

Viewed in these terms, it would be very odd to say that competence in ethics as a field of knowledge would turn out to be irrelevant for ethics consultation or that individuals who possess such knowledge – philosophers trained in ethics,

for example – should not engage in ethics consultation, and it would be equally odd if just possessing knowledge of concepts, theories or principles of ethics were enough for effectively reflecting on the practical problems of ethics posed by medicine, patient care, and the life sciences. Those who would insist that philosophers or others who possess such knowledge should be excluded from providing ethics consultation services will have a formidable task of mounting compelling arguments to support this claim. At the same time, those who would insist that knowledge about ethics is sufficient for clinical ethics work would also face the formidable challenge of showing that such knowledge *in itself* is sufficient.

Knowledge of ethical concepts, principles, and theories provides the necessary background for addressing the complex and often novel ethical problems that arise in contemporary biomedical science and research. There is really little disagreement about this point. What is at issue, however, is whether such knowledge is also central to the more mundane problems of ethics that arise in the everyday care of patients. These questions, issues, and conflicts over patient care decisions make up the bulk of ethical questions that hospital ethics committees and ethics consultation services address. Many of these conflicts, issues, and questions have been addressed in institutional policies, professional guidelines, and laws which provide a framework for thinking about everyday clinical ethics issues. It is important to note that the ethical concepts, principles, and theories that make up the formal subject matter of ethics are embedded in these institutional policies, professional guidelines, and laws. Knowledge of these intermediary policies, guidelines, and laws thus introduces the relevant ethical concepts into clinical ethics, which is why, perhaps, the vast majority of hospital ethics committees and clinical ethics consultation services function successfully even though they may be said to lack an enriched knowledge ethics as such.

What added value, then, does advanced knowledge of ethics provide for ethics consultation? To answer this question it is essential that we enlarge the framework by shifting our attention from the knowledge that an individual possesses to the developed capacities of an individual who is knowledgeable. In other words, it is important to distinguish knowledge of ethics as a subject matter from the competent capacity to reflect ethically and to use the concepts, principles, and theories of ethics in addressing ethical problems, questions, or issues. Knowledge of ethical theories and principles, analytical, conceptual, interpretative, and argumentative skills are often bundled into claims about the relevance of ethical knowledge in clinical ethics. However, they need to be distinguished, because individuals may in an academic sense have a sophisticated knowledge of ethical

principles, and theories, but lack the ability to think ethically *in concrete and challenging situations.*

With this distinction in mind, I would argue that the cognitive, communicative, deliberative, and interpretive skills that individuals acquire in the course of study of ethical concepts, principles, and theories, what might comprehensively be termed *ethical knowledge*, are essential ingredients for doing ethics and, by extension, for functioning effectively in the field of clinical ethics. Such skills may be acquired, to some extent, independently of formal study of ethics, but it is undeniable that such skills need to be anchored in concrete ethical knowledge. The following example can illustrate this point.

Some individuals have deep knowledge of topography. They know how to read maps and understand the relationships among topographical features. Other individuals have an *on the ground* knowledge of the land. They know the terrain intimately because they have worked, hiked, or hunted on the land. They know the features of the terrain in person and not abstractly. However, it is seldom the case that such individuals have a full grasp of the landscape in question. Their actual experience of the land might be confined to known trails and so their awareness and understanding of off-trail features will be limited, if not absent. However, individuals who possess accurate maps and are able to read topographical maps will have a *fuller* but more abstract understanding of the land, including features remote from trails, for example. They will have an overview or more complete picture of the land, but will lack the intimacy of detail that individuals with on-the-spot experience have. It would be a mistake to deny that individuals who *only* have in person experience of the land lack knowledge needed to make sound judgments about the land – unless, of course, one stipulates that knowledge is simply topographical map knowledge. In a parallel fashion, it is also true that both kinds of individuals have incomplete knowledge to some degree.

Thus, expertise in ethics should be understood in at least two parallel and somewhat complementary senses. First, the ethics expertise requisite for clinical ethics consultation involves formal knowledge of ethical concepts, principles, theories as well as the cognitive, analytical, and other skills essential for the use of such knowledge. And second, the ethics expertise requisite for clinical ethics involves some degree of *on the ground* experience of healthcare institutions and patient care as well as knowledge of the concrete values and ethical concepts, principles, and theories that are embedded in patient care practices and that are articulated in institutional ethics policies, professional ethics guidelines, and laws.

The Dimension of Practice

In discussing ethics as knowledge, I noted that cognitive, communicative, deliberative, and interpretive skills that individuals acquire in the course of their study of ethical concepts, principles, and theories make up what is commonly meant by the term *ethical knowledge*, which is acquired in philosophical education. Such skills are primarily academic and are essential ingredients for doing academic work in ethics. They point to the second dimension of the issue of expertise in clinical ethics consultation, namely the dimension of practice.

Toulmin's claims about the importance of the applied turn for the field of ethics is not just a claim that ethics turned away from attention to purely theoretical, abstract, or academic subjects and towards more practical, concrete, or engaged subjects, but a claim that the mode of inquiry and discourse itself shifted as philosophers became engaged with medicine and more practical matters.[24] Not only did the content of ethics change as a subject matter, but the *orientation* of ethics became more practical than theoretical. The issue of expertise in ethics thus has to be framed in terms of the dimension of practice as well as the dimension of knowledge.[25] This is challenging since many treatments of the issue of expertise fail to appreciate that clinical ethics is a practice.[26]

Practices have a number of distinctive features. For present purposes, I summarily discuss the features most important for the issues of expertise and draw from an earlier paper to do so.[27] In a practice, rules exist in their enactment and primarily are experienced in the process of enactment. The rules of a practice are thus like the grammar of a living language; they are embedded in the myriad acts of speech that comprise the language in use. In this sense, a rule is quite unlike a formal code, principle, or theory. A rule in a practice expresses the normative features that *operatively* guide practitioners in the actions that make up the practice in question. For example, a carpenter who uses a hammer and chisel to cut a mortise does so by following rules that are embodied in the way he has learned to hold the chisel (firmly, but not too tightly), the way the chisel is angled to the wood (acutely for a slicing cut), and the degree of force with which the hammer strikes the chisel to make the intended cut (strongly to cut across the grain, less forcefully to cut with the grain). In this case, the rules are embedded in the very skills of the carpenter in using the particular tools for particular purposes.

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[24] Toulmin [1981].

[25] Agich [2001, 2009a, b].

[26] Agich [2009a].

[27] Agich [2001] pp. 32-33.

Reflection on the actions that make up a practice can yield statements about rules including guidelines, principles, processes, or procedures that describe or explain the main activities of the practice. Just as formal rules of grammar can be constructed for a language, formal statements of the rules of a practice are possible. These formal statements of rules make up not only the cognitive stock of knowledge *about* the practice, but are often used by participants *in* the practice, for example, to provide guidance to novices. In learning to engage in a practice, these rules often take the form of injunctions that might say "hold the hammer this way" or "hit the chisel easy to cut with the grain" accompanied by the master carpenter showing or demonstrating the technique to use. But to learn the practice, the novice carpenter must put the rule into practice by doing it. It is no wonder that such skills are both learned and carried out by practice.

The "rules" can be articulated in various ways. The concepts and linguistic statements that express rules are abstracted from the lived experience of the practice and are ultimately dependent upon the experience. Statements of rules in a practice serve at least two important functions. First, they permit individuals without direct or relevant experience of the practice to engage in discussion about it. In this sense, many educated citizens have knowledge of acquaintance with various points of law and legal principles. Although this knowledge is universally seen as inadequate for the practice of law, it allows citizens to understand in a general way what legal processes and procedures involve and the social purposes that they serve. Second, the generalized concepts or statements of rules provide more than a linguistic framework within which participants can reflect on the practice; they also contribute to the conscious shaping of its development. This is more evident in mature practices like law that have a strong intellectual component in the sense that the prominent actions in the practice involve thought and judgment. In practices that involve high levels of analysis, cognition, and judgment, the framework of rules can include not only complex levels and domains of practical knowledge and experience and can utilize specialized scientific or technical disciplines or domains of knowledge, but they can also be expressed in terms of "higher" principles. Medicine is a good example of such a complex practice. An emergent practice like clinical ethics consultation, however, exhibits a less elaborate structure in comparison.

The concept of a rule in a practice is thus Janus-faced. On the one side there are constructed rules about the practice. They involve abstract concepts and judgments about the practice and contain a strong normative component. They also include ethical judgments and concepts that are often expressed summarily in terms of ethical principles or other theoretical statements. On the other side there

are the rules that are embedded in the actions of the participants in the practice. These rules are furtively formative of the actions or processes that actually constitute the practice in question. As such, these rules are part and parcel *of* the practice rather than simply *about* the practice.

Of these two aspects of rules in a practice, the constructed rules can be discussed apart from the actual on-going experiences of and the doings that make up the practice. This explains why academic bioethicists can and do address clinical ethics issues and problems. Enacted rules, however, are constitutive of the particular doings that make up the practice. They are inextricably enmeshed in it. They are evident in the actions and judgments of skilled participants in the practice, but have no separate existence apart from the various doings that they guide. This double-sided aspect of rules in a practice suggests that the question of expertise in clinical ethics consultation should involve a more complex approach than that provided by a purely knowledge-focused understanding of formal statements or analyses of constructed rules alone. It also suggests that the question of expertise is incompletely framed in terms of rules that are expressible and exist only as abstracted from the practice, because these rules omit the other rules that guide the actions of those who actually perform clinical ethics consultations in a competent fashion.

Thus, the dimension of practice highlights what we might term a set of practical *skills* essential for ethics consultation. These include skills that are analogous to, but not wholly congruent with, the skills of reflection and deliberation that are a much neglected part of the dimension of knowledge. This set of practical skills includes cognitive, communicative, deliberative, and interpretive skills that are *skills in clinical ethics consultation* and not just general academic skills of thought or cognition. They also include a more specific set of skills that are particular to the engagement in clinical ethics consultation. For example, in addition to general communicative skills associated with ethical knowledge such as ethical concept analysis and articulation, it is essential to have skill in communication with patients, families, health care professional in the face of confusions about or conflicts over information or decision making, and dealing with emotions that play out in patient care settings. Corollary skills involve conflict resolution or negotiation. It is beyond the scope of this paper to elaborate this list any further. The important point for present purposes is that the dimension of practice frames the issue of expertise in terms of the possession of certain skills that are particular to doing clinical ethics.[28] Forgetting this point distorts the understanding of expertise in clinical ethics.

[28] Agich [2005].

Sometimes it is said that besides knowledge of ethics, one needs a set of clinically-relevant skills to do clinical ethics consultation. The requirement for two sets of knowledge/skills, i.e., ethics on the one hand and clinical practice skills on the other, undergirds much of the advocacy for a team approach to ethics consultation. The ethics consultation team is ideally composed of individuals who bring a balance of the knowledge and skills requisite for effectively providing ethics consultation services. Although it is an open and empirical question whether such skills and knowledge are best delivered by teams or individual ethics consultants, it is certainly evident that both formats are thriving in a wide variety of healthcare settings. However, it would be unjustified to conclude from the fact that interdisciplinary teams are effective that the practical skills involved are precisely the clinical skills that only healthcare professionals possess and that these general clinical skills are requisite for effective clinical ethics consultation. Although the "clinical" skills necessary for being a health professional may be analogous to the skills necessary for effective clinical ethics consultation, it would be wrong to view them as identical. If they were, then why don't health professionals, using their clinical skills, resolve ethical problems, issues, or conflicts without the need for ethics consultation? Clearly, clinical skills are not enough. The skills used in ethics consultation, although analogous to the general skills that a competent health professional needs to possess, are something different in the context of clinical ethics. The difference cannot simply be because knowledge of ethics is additionally involved in clinical ethics consultation whereas knowledge of medicine or nursing is involved in providing medical or nursing services. If that were the case, the ethically educated health professionals would have both the knowledge and skills needed, but that has not been the history of the development of clinical ethics. The better educated physicians and health professional are in ethics, the more they seek clinical ethics consultation services to help them address the problems emergent in their health care practice. The difference has to do with the skills in addressing the ethical problems and issues involved in the particular patient care settings. I would admit, however, that the skills have not been fully identified. Perhaps, because so much attention to the issue of expertise has been heretofore focused on the dimension of knowledge to the exclusion of the dimension of practice, the practical ethics skills that are essential for doing clinical ethics appear so elusive. This need not be the case, but there is currently little consensus about clinical ethics as a practice upon which to resolve the issue of expertise.

Conclusion

I have argued that the issue of expertise in clinical ethics consultation is complicated by the failure to differentiate the dimension of knowledge and the dimension of practice in assessing expertise. The failure to differentiate these two dimensions is understandably tied to intraprofessional and interprofessional issues associated with status and power in the socially important field of bioethics. Given the history of the development of clinical ethics and the controversies associated over who or what discipline is competent to provide consultation services in ethics, it is easy to see why expertise has been treated in an incomplete fashion. A full treatment of expertise in clinical ethics thus requires an account both of the dimension of knowledge and the dimension of practice which is possible only if one separates, for the purpose of analysis, this question from the more political issues regarding status of those who provide clinical ethics services.

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