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Defending the Jurisdiction of the Clinical Ethicist

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Abstract:
In this essay I suggest that the bioethics profession's jurisdiction over health care ethics consultation is in need of reinforcement. I argue that as the profession becomes more successful competitors will challenge the profession to justify its ethical claims and ask whose ethics the profession represents. This challenge will come more quickly as the profession tries to influence the ethics of health care organizations. I propose a method of bolstering jurisdiction that will make the profession less vulnerable to challenge in the future.
Defending the Jurisdiction of the Clinical Ethicist

In this paper I examine an emerging threat to the bioethics profession in the area of health care ethics consultation (HCEC) and posit a solution. The threat is that as the bioethics profession becomes more influential, and its claims have an negative effect on others' interests, its competitors will challenge the profession to explain how its ethical claims are derived. Bioethicists are particularly challenged in justifying their claims, compared to other professions, because in the U.S. every individual is thought to legitimately have their own ethics. The challenge to the profession will be particularly acute if it tries to expand its jurisdiction into the ethics of health care organizations, as was recently supported by a committee of the American Society for Bioethics and Humanities (ASBH). I argue for a more transparent basis for ethical decision-making based on the ethics of the public the health system serves. This will bolster the profession's jurisdiction over health care ethics consultation and possibly give bioethicists some ground from which to challenge the ethics of health care organizations. I will call bioethicists who work in HCEC “clinical ethicists.”

This article is derived from the ideas put forward in my book The History and Future of Bioethics: A Sociological View.¹ In this article I focus particularly on applying these ideas to HCEC. Not wanting to reinvent the wheel, some of the ideas, as well as entire verbatim paragraphs, are taken (with permission) from that book.²
BIOETHICS AS A PROFESSION WITH JURISDICTIONS

To understand my argument we must begin with my claim that there is a distinct profession named "bioethics," whether it has been publicly declared or not, and this profession competes with other professions for jurisdiction over particular tasks. In his canonical text on the professions, Andrew Abbott conceptualizes the central phenomena of interest in the study of professions as "jurisdiction," the link professionals make between themselves and a series of tasks, or their "work." For example, physicians have established the jurisdictional link between themselves and the act of cutting into bodies with knives to heal diseases. A profession has jurisdiction if the audience for the jurisdictional evaluation thinks it should. In the case of physicians, the primary audience is public opinion—people are convinced that physicians should have jurisdiction over surgery, not some other profession (such as lawyers). Similarly, we do not look to a physicist to prepare our estate plan, but a lawyer. Who the jurisdiction-giver is is of critical importance for determining which profession has jurisdiction over a task.

More important, a profession obtains jurisdiction by having a "system of abstract knowledge" that legitimates its claim over certain tasks. Medicine, for example, has the system of abstract knowledge called medical science, which contains much knowledge about the reaction of the body to being cut by knives, as well as the definitions of and methods for curing disease. It is the legitimacy of using the system of abstract knowledge for the task in the eyes of the jurisdiction-givers that confers jurisdiction over that task. Physicians have increasing jurisdiction over reducing the weight of an obese person because the public as jurisdiction-giver thinks its system of abstract knowledge—medical science—is better for this task than a competing system
of abstract knowledge, like that proposed by dieticians.

Professions do not simply take over and "professionalize" a task, but rather are in constant competition with each other for jurisdiction over the same tasks. Medicine has been in competition with chiropractic care over the task of relieving back pain, and has faced recent challenges on other tasks, from acupuncture and aroma therapy. Of course, medicine has been one of the most successful professions, competing for and winning jurisdiction over all sorts of tasks formerly under the jurisdiction of other professions, such as alcoholism, mental illness, and obesity. It is so successful that there is a special term for its voracious additions of jurisdiction – medicalization.

Finally, other ecological metaphors can be helpful. For example, professions can concentrate their energy on one task to protect themselves, or spread themselves thinly in the interest of jurisdictional expansion. They can also spread themselves too thinly through expansion and threaten their jurisdiction in their once-secure jurisdictional homeland. To anticipate what I write below, in expanding their jurisdiction to cover organizational ethics, bioethicists face the threat of spending their system of abstract knowledge too thinly, and thus losing jurisdiction in their jurisdictional homeland.

Some professions have absolutely rock-solid jurisdictions over some tasks and face no credible threat. Medicine's core jurisdiction over healing disease in human bodies really faces no challengers, and it is so institutionalized that if a person not certified by the profession tries to engage in the task they will be thrown in jail by the government.

The task of making ethical claims about scientific and medical technologies and practices has been a much less institutionalized area, with many professions fighting for jurisdiction over
the past few decades. No profession has approached the level of institutionalized jurisdiction that medicine has over healing disease, but the bioethics profession has had the most success.

Many readers will object to the idea that there is a profession of bioethics. I recognize that a debate continues, particularly in clinical ethics, about professionalization projects like licencing and having a distinct educational degree. Moreover, the vast majority of people practicing clinical ethics have other primary occupations, like medicine, nursing or social work. However, in the sociological approach to the professions, professions are not defined by having an association, an academic degree or by the practitioners working full time, but by having a distinct system of abstract knowledge. The bioethics profession has a distinct system in comparison to its competitors.

The bioethics profession's system of abstract knowledge is centered on the idea that ethical recommendations are not based on an ethicist's own personal values or the values of a particular group in society, but based on the values of either the individuals involved with an ethical decision or the values of the entire public. A professional is not a bioethicist if they make recommendations based upon their own values or the values of a subgroup of the public. In political theorist Mark Brown's division of bioethicists into liberals, communitarians, and republicans I am therefore defining all bioethicists as "liberals." And, as liberals, their central concept is that they do not want to impose their values on others: "Liberal bioethics thus models itself on a rationalist and decisionist view of expertise, according to which experts provide value-neutral knowledge that allows non-experts to effectively pursue their subjective preferences" writes Brown.

I recognize that I am defining some self-identified bioethicists out of the profession.
However, my definition of the system of abstract knowledge of the bioethics profession is consistent with the understanding of most self-identified bioethicists. The bioethicists' system of abstract knowledge is evident in bioethicists' work in hospitals, where they primarily help families and doctors clarify their own values so that families and doctors can make a decision that is right for them. This system of abstract knowledge is evident in bioethicists' work in protecting the human subjects of research when they apply ethical principles that are purportedly taken from the "common morality," not from their own morality or the morality of a subgroup of the population. It is evident in government ethics commissions that try to foster consensus among diverse commissioners, because they argue that this consensus means the ethical recommendations will represent the public's values.  

**THE JURISDICTIONAL CLAIMS OF THE BIOETHICS PROFESSION**

The profession of bioethics seeks or defends four jurisdictions over four related tasks. The first is HCEC.  

HCEC is "a set of services provided by an individual or a group in response to questions from patients, families, surrogates, health-care professionals, or other involved parties who seek to resolve uncertainty or conflict regarding value-laden concerns that emerge in health-care."  

This task is done by a committee, a team, or an individual. A typical question here would be whether life support should be ended for a patient when doctors and family members disagree.  

The task of HCEC itself is quite institutionalized. One study found that by the year 2000, 92% of hospitals with 100–199 beds had HCEC, as did 100% of hospitals with more than 400
Moreover, the government regulator that accredits hospitals requires that hospitals have a process to handle ethical issues that arise, and a process is "legally mandated under specific circumstances in several states." Another entity that establishes certification requirements for medical schools requires all medical schools to teach bioethics to their students. The authors of one study conclude that health-care ethics consultation "has become a routine part of U.S. healthcare."  

The system of abstract knowledge these largely part-time bioethicists are using is that of the bioethics profession. According to the report on core competencies for HCEC published by the ASBH, bioethicists are not to impose their own values, but rather to facilitate an ethical decision between the interested parties, constrained by what are called "established ethical standards." While the phrase "established ethical standards" would not preclude using the ethics of some subset of the population, the practice is to use values portrayed as representing universal public morality. It is the threat to this jurisdiction that I focus upon in this paper. However, to understand the challenge, and the solution, we must examine the other three jurisdictions.

The second jurisdiction of the bioethics profession is research bioethics, where the task is to propose ethical constraints on the behavior of individual scientists and physicians in scientific and medical research on humans. This task is even more institutionalized than HCEC in that every entity that receives government research money must have an institutional review board to review the ethics of research conducted with federal funds. Like HCEC most of the bioethicists conducting this task are part-time and have other professional identities besides "bioethicist." The jurisdiction over research bioethics is even more secure than over HCEC because the federal
government enforces the use of the bioethicists' system of abstract knowledge through public regulation. In this jurisdiction, the "other people's values" that are being used are the general public's values, as the federal government requires the use of a particular method – common morality principlism – that claims to be using the public's universally held values.

The third task space is public policy bioethics. The task being competed over is to propose ethical courses of action for scientists and physicians that can be incorporated into general policies that will be applied to all citizens. For example, the chair of one government ethics commission said the commission was created because "senior NIH administrators felt they needed guidelines to instruct members of Institutional Review Boards . . . charged with approving human subject and fetal tissue research." Another example is a government ethics commission that proposes an ethical policy on human reproductive cloning. The most common location of this task is government policy settings such as the government ethics commission. However, proposing ethics for non-governmental institutions that affect all citizens is also part of this jurisdiction. Therefore the ethics of healthcare organizations that serve the general public are part of this jurisdiction.

The fourth task space I will call "cultural bioethics," which consists of trying to convince the ordinary citizens of the proper ethical course of action concerning a medical or scientific technology or practice. An example of this task would include being interviewed for a newspaper article and saying that reproductive cloning is wrong because it destroys the individuality of the clone. Another would be writing an article that concludes it is acceptable for scientists to destroy embryos to make stem cell lines because it is a moral imperative to heal disease. Communicating with the media, teaching, writing tracts intended for the public, and communicating through
social-movement organizations are all tasks that professionals in this task space engage in. Most purely academic ethical writing that does not address policy would also fit into this category.

**DETERMINING THE ETHICS OF OTHERS**

The system of abstract knowledge of the profession is based on the idea of using the ethics of others. But, how is this done? To generalize, in HCEC the ethics of others is obtained by directly asking the others, who are typically patients, doctors and family members. However, in Public Policy Bioethics, there is no one individual to ask, so other methods have been created by the profession, such as the notion that consensus among a demographically diverse group results in a position that is universally held by the general public. However, the dominant method for obtaining the ethics of the general public in the research bioethics and public policy bioethics jurisdictions is common morality principlism.

The principles approach, most famously and influentially articulated by Beauchamp and Childress, holds that there are a limited number of mid-level principles that need to be weighed and balanced when considering an ethical decision. Most critically, the principles of bioethics are considered to be universally held by all people and apply to all problems in medicine and science. The principles of biomedical ethics are autonomy, beneficence, non-maleficence, and justice.

Principlism fits as a method in the system of abstract knowledge of the bioethics profession because principlism assumes that the principles represent "the common morality." According to Beauchamp and Childress, the "common morality" comprises all and only those
norms that all morally serious persons accept as authoritative." 18 They also argue that it is "an institutional fact about morality, not merely our view of it, that it contains fundamental precepts" that function above the particularity of subcultures. 19 Many observers have noted the dominance of the principlist system in bioethical arguments. Hoffmaster calls Beauchamp's and Childress's textbook "the Bible of academic medical ethics."20 Similarly, Dubose claims that this one book has more than anything else "shaped the teaching and practice of biomedical ethics in this country. . . . [becoming] a standard text in courses and a virtual bible to some practitioners." The ethical framework provided by the book "shapes much of the discussion and debate about particular bioethical issues and policy, whether in the academy, the literature, the public forum or the clinic." 21 The institutionalization of this form of argumentation for human experimentation and increasingly for other problems was so strong that one set of critics begin their essay with the mocking claim that "throughout the land, arising from the throngs of converts to bioethics awareness, there can be heard a mantra ‘. . . beneficence . . . autonomy . . . justice. . . .'" 22 Fox and Swazey have recently claimed that the approach in the book "has been so widely disseminated across national boundaries that it has become a kind of bioethical lingua franca." 23 Others have recently shown how it is being imported wholesale into non-Western countries. 24

Bioethicists often object to the empirical claims of social scientists that principlism is the dominant method in the system of abstract knowledge in the bioethics profession. However, this objection is voiced by the bioethical theoreticians, who do not recognize that their perspective is different from that of the professional masses. Every profession has its theoreticians, and their role is to debate what the proper system of abstract knowledge of the profession should be. At this elite level, there is a debate between people who want the profession to adopt different
systems of abstract knowledge based on pragmatism, principlism, feminist bioethics, casuistry, and other theories. To give but one example, an article debating whether pragmatism should be the new system of abstract knowledge of the bioethics profession begins by claiming that the profession was "[d]ominated in the 1980s by so-called ‘principlism' and utilitarian/deontological ethics," but "bioethics has turned to other perspectives" such as "narrative ethics, casuistry, and the ethics of care." "Like these other ‘new’ approaches, much has been made of late concerning the insurgence of pragmatism into both the clinical and theoretical aspects of the bioethics discipline" the author concludes.

However, in the next paragraph the author acknowledges that, for pragmatism, one of these new systems of knowledge that is supposedly on par with principlism in the field, "there have been no standard textbooks in medical ethics that have included articles written from explicitly pragmatic perspectives." This suggests that, while all professions have theoreticians who argue over the proper system of abstract knowledge, the ordinary writers and practitioners of the bioethics profession are not followers of any of these challengers.

Even if the empirical claims of sociologists are not true and principlism is not the dominant form of argumentation in bioethics, my claim is that for the good of the bioethics profession, principlism should be. It will be difficult enough to make principlism legitimate in the eyes of jurisdiction-givers, let alone methods like casuistry where any connection with the ethics of those represented – the public – is even more difficult to make.

In HCEC, bioethics professionals claim two methods for determining the ethics of others. The first is to simply ask those involved with the ethical decision, such as the patient and the physician. The second, rarely acknowledged as such, is the use of the ethics of the general public
in the decision by the bed-side by invoking common morality principlism. The use of this
second method is clear from HCEC textbooks. The influential textbook Clinical Ethics: A
Practical Approach to Ethical Decisions in Clinical Medicine, now in its sixth edition, states that
"there is general agreement that modern medical ethics depends on a small group of moral
principles: respect for the autonomy of patients, beneficence, non-maleficence, and justice." 31
These principles are so undebatable that the book has a four-fold table with the principles as
headings in each box, listing questions the consulting ethicist should ask at the bedside. 32 A
copy of this table on card stock is included at the end of the book so that it can be torn out and
put in a pocket when walking around the hospital. Similarly, The Handbook for Health Care
Ethics Committees, designed to train members of hospital ethics committees, writes that the
"core ethical principles that support the therapeutic relationship and give rise to clinical
obligations include respecting patient autonomy . . . beneficence . . . nonmaleficence . . . [and]
distributive justice." For more details the authors suggest consulting the dominant description of
common-morality principlism written by Beauchamp and Childress. 33

THE POTENTIAL THREAT TO BIOETHICISTS' JURISDICTION OVER HCEC

There are two potential threats to the bioethicists' jurisdiction over HCEC. The first is the
result of a tension between the two methods used in HCEC. The ASBH has written that HCEC
should mediate between the values and ethics of the various parties to a medical decision, such as
family members, doctors, and the hospital administration, but only allowing options that are
"ethically justifiable and consistent with prevailing ethical and legal standards." 34 There is no
discussion about how those involved with HCEC are supposed to determine what the "prevailing ethics" are, besides an examination of the bioethical literature, statements of bioethics commissions, and so forth. Textbooks used to teach HCEC imply that principlism is the source of "prevailing ethics."

At least wealthy, highly-educated patients are increasingly empowered through the easy access to medical information. Medicine is being increasingly portrayed as a service and medical professionals as service providers. Autonomy is increasing in strength. It is simply a matter of time before a patient concludes that their ability to make their own ethical decisions about their own health care was thwarted by a bioethicist laying claim to a prevailing ethical standard. The profession needs to have a way of explaining where its prevailing ethical standards come from. Physicians can point to medical research studies to justify their medical decisions, but I suspect that few if any clinical ethicists in HCEC can explain where the prevailing principles used in HCEC came from. The first question is going to be: "whose ethics are represented in the principles?" The second will be: "how was it determined that those are the principles of the group whose ethics are represented?"

The answers to these questions are, if you dig deeply into the history of principlism going back before the Belmont report, through the making of the Belmont report and subsequent modifications by scholars like Beauchamp and Childress, that the principles were determined through reflection by academics about what the values of the public are, as demonstrated by historical controversies, existing professional codes of ethics and the like. (On the details of the creation of the Belmont Report, which was part of the creation of the principles, see the competing accounts of Jonsen and Beauchamp. If someone begins to challenge this, it will
certainly come up that the commission that approved the Belmont report was an extremely unusual demographic slice of the country in that, for example, almost everyone had a Ph.D. or equivalent and religious perspectives – which have a huge influence on views of bioethical issues – were limited to religious liberals. It would be impossible to say that the ethical diversity in the U.S. was represented in the room.

The second and far more serious threat is that the bioethics profession is in the midst of trying to expand its jurisdiction. It is increasingly claiming that it is not only the ethics "by the bedside" that is under its jurisdiction, but the ethics of the hospital as an organization. The ASBH report on core competencies for health-care ethics consultation "endorses the trend toward integrating ethics across all subspecialties in an organization," which includes business, professional, and organizational ethics.

In the early statements on this issue, the motivation for jurisdictional expansion was quite clear and, like most professions that see themselves as serving others, the purpose of expansion is to advance the good that the profession represents. For example, back in 1996 clinical ethicist Robert Potter wrote that "clinical ethics should be expanded into health care organizational ethics. This movement is the next logical and practical step toward achieving the patient-oriented goals of clinical ethics [. . .] Passionate bioethics reformers who are not satisfied with partial success have been looking for the next ‘edge to push on.’ The growing edge is the new frontier of organizational ethics."  

For bioethicists the transparently obvious reason for this expansion of jurisdiction is that individual ethics consultation takes place in a context of sociological constraint from the organization that the health care situation is embedded within. To take but one of the many
possible examples, patients only have choices if they can afford the choices, and "administrators at the institution may build facilities for affluent patients while neglecting the poor in the neighborhood that surrounds it." 40

One way to expand into organizational ethics would be to use the bioethics method of asking those involved with a decision about their ethics, and then clarifying or adjudicating these different ethical positions. Bioethicists would then have to ask the organization about its ethics. For example, Potter defines organizational ethics as "the intentional use of values to guide the decisions of a system. The intentional use of values implies that members of a cooperative group have articulated and reflected on a set of values and have accepted them as normative for the culture of that organization." 41

However, with this analogy to by-the-bedside ethics in place, what would happen if the ethics of the organization is "to make as much money as possible?" In by the bedside ethics, the public's ethics, represented by principlism, acts as a limit upon people's ethical stances. This is analogous to the patient who claims that their ethics require them to be harmed or that they just want to hand over all decision-making to their favorite nurse. Similarly, I think that as bioethics professionals try to expand their jurisdiction into organizational ethics, they will try to use the existing principles they use by the bedside as the limits of the ethical stances of the actors in organizational ethics by proclaiming that some organizational decision violates "generally accepted principles."

Reiser, for example, sees the primary problem with the expansion to the ethics of health care organizations as "ethical bifurcation," where clinical ethics is well developed but organizational ethics are not. The situation can be resolved by "reference to the knowledge of
professional and medical ethics developed particularly in the last thirty years."  Ells and MacDonald write that "bioethics stands to make several important contributions to organizational ethics." The second is that "bioethics can contribute a well-developed range of tools with which ethical dilemmas can be identified, assessed and resolved. These include, for example, theories, decision frameworks and professional codes of ethical conduct. Third, bioethics contributes a familiarity with the extensive and diverse values associated with healthcare (beginning with priority to the interest and well-being of patients). Within bioethics, much work has been done to articulate the values at stake and how they interact. Addressing matters of organizational ethics within the healthcare context requires that we begin with a firm understanding of these values."  

It appears that early forays by bioethicists into organizational ethics have included the use of the existing principles. Silva and colleagues report that some of the respondents to an empirical study of ethicists who are trying to expand into organizational ethics "expressed concerns about the adequacy of clinical ethics tools and frameworks in addressing ethical issues on an organisational level." As one respondent noted, "are the tools of autonomy, beneficence, justice, etc. – ya know, the bread and butter of bioethics – are those the right tools to use?"

This attempt to use the existing system of abstract knowledge is not surprising because this is how professions expand jurisdiction. To expand, a profession does not claim that it has invented a new system of abstract knowledge for the new issue. Rather, it claims that its already institutionalized system is applicable to a new area. For example, physicians now claim that the medical system of abstract knowledge is the solution for issues formerly under the jurisdiction of other professions such as obesity, child misbehavior, emotional troubles, childbirth and so on. They did not invent a distinct system of abstract knowledge to deal with obesity.
The Eventual Challenge

I think that there are people with decision-making authority in health care organizations who are not solely motivated by patient well-being. For example, owners of health care organizations have financial interests, and these owners typically have power. The bioethics profession has been tolerated by people with actual power because it largely has not affected them. Yes, medical researchers had to start getting permission from their research subjects, but that was in the end not too much of an imposition. Physicians were not happy with losing sole jurisdiction over HCEC, but they have adjusted with minimal damage to their core jurisdiction. However, when a bioethicist or a bioethics committee tries to make the claim that based on "accepted ethical principles" that the hospital should stop catering to wealthy people's interests, or pay nurses more, they will encounter someone who asks: by what authority do you make that claim?

Before Bioethicists start claiming that "ethics" demands an action that is contrary to the interests of people with actual power, they should become clearer on the basis of their authority. I agree with Gary Belkin, who claims that "bioethicists have not generally included in their work questions such as ‘How is it that I am in a position to address these particular kinds of questions in the forms and approaches I do, and to the audience and with the authority and sponsor I have?’" 46

Note that there are very few possible claims to authority for the bioethics profession. Many professional jurisdictions are made through claims to Truth justified by science. Engineers have jurisdiction over designing hospital buildings that will not fall over in an earthquake because they use methods that have been almost universally accepted as producing truth (e.g.
physics). Doctors claim jurisdiction over heart surgery because it is "true" that cutting this way instead of that leads to higher survival. Lawyers claim jurisdiction over certain tasks in the hospital because the government has essentially granted them jurisdiction through public law. But, by whose authority does the bioethicist assert their truth? The problem, in the U.S. in particular, is that "ethics" are not thought to be "true," but rather relative to the citizen. No one is entitled to their own view of scientific facts, but everyone is entitled to their own view of ethics. Bioethics has thus always had a very weak claim of authority.

To recap: it has never been clear how the bioethics profession justifies using "accepted ethical principles" in HCEC when they are supposed to be clarifying the ethics of others. This is a weakness and may lead to challenge. More critically, before bioethicists move too strongly into organizational ethics, where they will encounter people with true power, they should derive an answer to the question of "whose ethics do you represent" and "how do you know what their ethics are." Two answers that will not work in a pluralistic liberal representative democracy are: "I represent my own ethics," and "I represent the ethics of the collective wisdom of a particular academic tradition." So, what can be done?

**RECOMMENDATIONS**

**Using the Public's Ethics**

If the owner of the health care organization challenges by asking "whose ethics do you represent," I think the proper answer should be "the public's." To further specify the system of abstract knowledge of the profession, it represents the public's values either one member of the
public at a time (HCEC) or collectively (through common morality principles in the HCEC and other jurisdictions). Yes, bioethicists mediate with the ethics of those with power, such as physicians, but the original impulse of the profession was to protect the (weak) public at the hands of the (strong) profession. The public's ethics will not always prevail in organizational ethics decisions, and they will have to be compromised, but I think the public needs to be represented – and the bioethics profession is the only group situated to do so. I do not think that bioethics should be the profession that represents the values of a health care organization – that is, the entity with power.

Another way to look at this is that organizational ethics is actually part of the public policy bioethics jurisdiction, so technically the expansion of jurisdiction is not from HCEC to organizational ethics, but rather it is trying to solidify the bioethics jurisdiction over public policy bioethics by incorporating the new area of organizational ethics. The reason is that health care organizations are effectively public entities. They are all regulated by the government to make sure that they fulfill the needs of the community. The non-profit ones receive tax exemptions. Like any public organization, they view their constituency as "the community" or "the public." They make general rules and policies (akin to laws) that apply to everyone.

**How to Legitimately Represent the Public's Ethics**

How then can the collective patient – the public – be legitimately represented in organizational ethics in a way that is less vulnerable to challenge? Before getting to my answer, I should say that this has long been the Achilles heel of the bioethics profession. It claims to be representing the "other," but has no explanation for how it does so. In HCEC it has had one
plausible mechanism based on the idea that they are directly told the ethics of the other by the other themselves, and then communicate directly with them. Our everyday understanding of conversational techniques at least allow us to imagine how that works. However, in the public policy bioethics jurisdiction, and in the "prevailing ethical standards" also used in HCEC, there is no explanation for how the public's ethics or value are known and thus represented.

I do think the first bioethicists had the right idea in claiming that through advancing the common morality they represented all the citizens, because such a claim, if legitimate, would be a powerful argument for jurisdiction. Bioethics needs to retain the claim of representing the common morality, but using methods that are convincing enough that they can loudly say that their ethical recommendations are better than their competitors' because they are representing the public. I think that principlism remains the best answer. As I show elsewhere, principlism fits with the way that bureaucracies work. It is somewhat simple and can be easily explained to others who do not have Ph.D.s in philosophy. It is semi-transparent and calculable. Most critically, to paraphrase Winston Churchill's statements about democracy, it is the worst form of ethics except all of the others that have been tried. Reliance upon the ethicists' reflection of ethical traditions (such as virtues) are difficult to portray as representing the public. How casuistic reasoning works, and how the paradigmatic case being built upon reflects the public's values, remains unclear.

However, principlism needs some modifications if it is to be used to claim that the principles represent the ethics of the public, because the connection to the public's values is unclear. The first problem with principlism that makes its connection to the actual common morality of the public unclear is that is that the principles themselves are vague. Critics have
pointed out that this vagueness means that one can reach any ethical conclusion with the same principles. As Leigh Turner notes, "[a]greement at the level of general norms has no inherent practical significance since it is possible to derive markedly divergent policies and practices from the 'same' principle, maxim, or moral intuition." For example, "[o]ne person can use the principles to make the case for the legalization of physician-assisted suicide, while another individual can argue that physician-assisted suicide should never be legalized." This then means that for "the principles to have meaning and weight, they require interpretation," which then "requires some substantive commitments."  

Much of the ethical action happens in the specification of principles, and this specification is done with reference to the particular value community of the analyst, not of the public. This makes the application of principles appear to not be based on universal values at all. Therefore, we need principles that are less vague, recognizing that a degree of vagueness is inevitable in this approach.

The first step toward creating principles that are less vague, and therefore more closely reflect the public's values, is to redefine the term common in common morality. Bioethicists mean by this the few values that are "common to everyone," as in "universal." But of course this is rhetorical. For example, not everyone in the United States holds autonomy as a principle. We could imagine that 99% believe in beneficence and non-maleficence, 80% in autonomy, and 75% in justice. Rejecting the rhetorical claim to universality, the profession should explicitly state a level of acceptance of a principle before it is considered "universal enough" to represent the common morality. Skipping how this would be determined for a moment, let us just set 80% as a placeholder. Therefore, a principle is held in a high degree of consensus in American society if
80% of the people adhere to it. So, step one is to acknowledge that there are no universal principles in the United States, but to explicitly say that principles with a high degree of consensus will be used to recommend ethical policy for the public on issues like HCEC and the ethics of health care organizations.

Bioethicists are also going to have to abandon the idea that the same principles are universal across all issues. Both the claim that the principles are universally shared by all people and the claim that the principles are universal across all issues are the result of the bioethics profession's ignoring who actually confers jurisdiction. In the 1970s bioethics was a new enterprise whose academic status was shaky at best. It needed to have academic credibility in order to be a part of the modern university, given that its proponents worked in universities, not for the state. Both the cross-person and the cross-issue universalism would have served to bolster the legitimacy of principlism in the eyes of academic philosophy. Moreover, many of the early bioethicists were trained as analytic philosophers.

Analytic philosophy, perhaps ultimately because of Enlightenment commitments, but not necessarily for my argument, has a commitment to universal theories. As Howard Brody summarizes, analytic philosophy argues that "any true ethical statement ought to take the form of a universal proposition that holds for all cultures and all historical periods," and " Anglo-American analytical philosophy, for much of the twentieth century, treated universality as a sine qua non of ethics." Believing in universal moral principles is then a minimum for principlists to create a system that was unified enough to pass muster with the philosophical community. However, this concern of philosophers is not relevant to operating as a profession in the public sphere, as the American Philosophical Association does not provide jurisdiction.
So, the bioethics profession would give up both universal claims—that four principles are universally applicable to all medical and scientific issues, and that these principles or values are universally held by all persons. These changes result in the following: If we think in terms of principles, there may be a common morality about by the bedside health-care issues that is represented in principles A, B, C, and D, which are held by 80% of the population. With issues in public policy bioethics, the values of the public regarding human genetic engineering might be represented by A, C, E, F, and H. With reproductive cloning, the public's values may be represented by A, E, and J. And, critically, the principles for the social organization of health care provision might be A, B, K and L.

How then are the ethical principles of the public for the specific issue of the social organization of health care determined? The previous method, reflection by a group of academics, is not going to be considered legitimate. The most obvious objection is that this group has different beliefs and values than the general public, for example on religion. The solution is for social scientists to determine the principles that the public holds for an issue like human reproductive cloning and the social organization of health care delivery.

Empirical Measurement of the Public's Principles

The first step is to determine the ethical principles of the public. This is standard fare in the social sciences. For example, I have conducted a study of the discourses that religious Americans use to discuss reproductive genetic technologies. Typical of the social sciences, I began with an in-depth qualitative study that examined a not-exactly-representative group of religious Americans. This inductive analysis provided an initial window into how citizens think
about an issue, and initial conclusions were made. I also used a nationally representative survey that was representative of the people in the country. This could easily be repeated for the public at large. Similarly, Bellah and his colleagues in Habits of the Heart, one of the most influential sociology books of all time, found four moral languages in use in the United States. Moreover, it is a premise of the emerging field of empirical bioethics that it is possible to evaluate the public's views on bioethical issues.

In fact, bioethicists already extensively use social science research in their work, such as studies to see if normative problems exist. For example, the President's Commission of the early 1980s conducted an empirical study of hospital ethics committees. Bioethics commissions have even commissioned social science research on the attitudes or values of the public, although they have not been clear how such data inform their ethical recommendations. The first bioethics commission conducted an empirical study of people's views of the implications of advances in biomedical and behavioral research, and the President's Commission of the early 1980s conducted a survey of the general public's views of informed consent in the doctor–patient interaction. With regard to the empirical measurement of principles, Beauchamp and Childress have themselves acknowledged that their four principles should be empirically verifiable with social science.

Objections

People could object that the results will be fuzzy. The values or ethics that the citizens want to advance through scientific and medical technology will be difficult to describe, and they will to some extent be contradictory. This complaint can be dismissed by the adage about the
drunk looking for his lost keys under the lamppost because that is where the light is. You cannot only ask the easy ethical questions. Instead, the standard of evaluation should be: Is this a better way of determining the principles held by the public than what we currently have? The current method is academic reflection on what the analyst thinks the public morality is. My proposed method would have to be better, if for no other reason than that there is more of a record of how the analysts came to their conclusions.

Would this method of empirically determining the public's principles be seen as legitimate? The question is really: would it be seen as legitimate by those who grant jurisdiction to the profession. For by the bedside ethics, I think that this empirical method is going to strengthen jurisdiction. I suspect that if an empirical study was conducted, it would result in re-discovering the existing principles. That is, I think that the academic reflection in the process that led to the Belmont report had it about right in HCEC. However, it would be good to justify this with an actual study, because there would then be a clear way to show the actual basis of the bioethicists' authority as representing the public's values.

I think that if you conducted a study of the public's ethics regarding human reproductive cloning you would not end up with the current principles, but something else. It is the extension of the principles of human experimentation and HCEC into the public policy bioethics realm that stretched the bioethicists' system of abstract knowledge beyond credibility. I also think that if you did an empirical study of the public's ethical principles in the organization of health care you would end up with a slightly different set of ethical principles than are currently used. But, what is more important is that the profession would have a basis to claim that it derives its authority from the public.
A challenge will be that the public is not very familiar with how social science could determine which principles are used for an issue. For example, the public does not necessarily understand how a random selection can be used to determine a representative sample of a larger entity. Political philosophers Dryzek and Niemeyer have a number of solutions to this problem, in a slightly different context, such as making sure that the social science itself is conducted as democratically and transparently as possible. The social science could involve citizens themselves, with social scientists as consultants, and all of the data could be available for public viewing. Of course, some residual distrust would remain, but it would certainly be more accurate and transparent than the method of determining the public's principles currently used by bioethicists.

CONCLUSION

I have suggested that the bioethics profession shore up its jurisdiction over HCEC before it tries to expand its jurisdiction into the ethics of health care organizations. To do so the profession needs to clarify whose ethics it speaks for and how it knows what these ethics are. I have proposed that the profession retain its reliance on common morality principlism to represent the public’s ethics, but to determine the principles of the public empirically through representative samples, so as to avoid the accusation that the principles that are purportedly of the public are simply those of the scientists, bioethics professionals, or people with Ph.D.’s in general. Such modifications of the system of abstract knowledge of the bioethics profession are not actually very disruptive in that the form of work would not really change, but the profession
would presumably be on stronger ground in the future, particularly as it tries to expand into organizational ethics.

ENDNOTES


2. Specifically, most of the paragraphs in first two sections, and half of the paragraphs in the final section, are taken directly from that book.


17. While "principlism" generally refers to this four-principle system popularized by Beauchamp and Childress, there are many less influential but similar and competing systems in bioethics that share the same logic. For example, Robert Veatch identifies single-principle theories, like utilitarianism and libertarianism, that maximize the values of beneficence and autonomy, respectively. Two-principle theories include the "geometric method" of comparing benefits and harms, and Engelhardt's approach, which uses the principles of permission and beneficence. Other systems have five principles (Baruch Brody), six principles (W.D. Ross), seven principles (Veatch's own system) and ten principles (Bernard Gert) (Veatch 2007). For my purposes I will call these all "principlism" because they are based on fixed principles that can be used for any bioethical issue. This obviously glosses over some differences in order to generalize. I will generally make reference to Beauchamp's and Childress's specific ethical system because it is far and away the most influential. Note, however, that not all of these alternative systems explicitly presume a common morality.


42. Reiser, "The Ethical Life of Health Care Organizations," 29.


44. Silva et al., "Clinical Ethicists' Perspectives on Organisational Ethics in Healthcare Organisations," 323.


