What Is a Clinical Ethicist?

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Let me address the “editorial” aspect of this editorial right away: I wholly agree with the principle that lies behind Mark Kuczewski’s admirable article. I take that principle to be that when clinical ethics issues affect undocumented patients, fostering efficient routine care in the setting of “new immigration-related stressors” is “to be resolved by finding creative means of instancing the values of care, efficiency, and public health.”

In Kuczewski’s article the clinical ethicist is a kind of mediator and moral conscience. His account of what he calls second-generation clinical ethics issues affecting undocumented patients caused me to think about a lively discussion in the late 1980s and 1990s: What is a clinical ethicist? Decades ago people wondered whether she was best defined as an applied philosopher, a moral witness, a “facilitator,” an educator, a secular priest or rabbi or imam, some combination of all of these, or something else entirely. Related questions were raised about the clinical ethicist’s moral authority, as well as problems like the ethicist’s role as potential whistleblower, her possibly conflicted position as an employee of the institution, and the nature and source of the moral consensus upon which she might rely.

This conversation was stimulated by the growing numbers of hospital ethics committees and consultants following the Karen Ann Quinlan case, when the New Jersey Supreme Court appeared to endorse “ethics committees” as an alternative to litigation about bioethics issues. In 1986 the Society for Bioethics Consultation (SBC), later merged into the new American Society for Bioethics and Humanites, was founded to study and support health care ethics consultation. Also in the late 1980s a debate erupted about credentialing for clinical ethicists. Should they be MDs or could those not doctorated in medicine qualify? The leading spirit behind the SBC, John Fletcher, was concerned that predicted demand for clinical ethicists called for opportunities for formal training. When he arrived at the University of Virginia in 1987 as director of its biomedical ethics center he established an intensive course focused specifically on continuing education for professionals. As his successor at UVA, I continued that program.

In the 1990s popular and elite media began to take an interest in clinical ethics as well. On the theory pronounced by Fletcher that every hospital would eventually have to have a clinical ethicist, at least one women’s magazine (I believe it was Cosmopolitan) listed it as a promising future career. In 1999 The Scientist, quoting a prominent bioethicist, called the field a “growth industry” but warned that the employment outlook was less clear. I never understood the assumptions behind these forecasts. It always seemed to me that there was little reason for health care organizations to hire people who were supposed to prevent or solve ethical problems for them but might create them as well. Still worse, even under the best of circumstances these same people weren’t paying for themselves. Where the ethicist is also a tenure-track professor in a medical school as compared to a hospital employee the protections are far greater but not absolute.

In 1997 The New Republic ran a provocative piece entitled “When We Were Philosopher-Kings.” The author was Ruth Shalit, a talented young writer who put the snark in snarky. Shalit reported on interviews with a number of bioethicists, highlighting what she viewed as their insufferable self-importance, not to mention self-appointment as moral authorities. (I was one of them, though I suspect that because of a personal connection in my family she wasn’t too hard on me. Six years later Shalit was dismissed on charges of plagiarism and inaccuracy.) She put the case against clinical ethics concisely:

Clinical ethics is not medicine, which is to say it is not science, which is to say it is to a very large degree whatever anyone wants it to be. In attempting to make a medical profession out of the study of what is morally right and wrong, the ethicists confuse the empirical and the theoretical. A surgeon who recommends amputation of a gangrenous limb as the right procedure means by right an action that will save the patient’s life. What a philosopher means by right is the action that is most moral. But these two rights are not equally absolute. The surgeon’s recommendation rests on an agreed-upon set of facts and criteria: there is no question that amputation is the appropriate action in extreme cases of gangrene.
The philosopher’s recommendation depends on a set of criteria that is not agreed upon, but varies from culture to culture and, more and more, from individual to individual. One man’s categorical imperative is another man’s heresy.

One could object to the cherry-picked example and observe that the clinical ethicist’s concerns rather have to do with consent and comprehension on the part of a patient with a clearly life-threatening condition, but the point about variability in moral norms isn’t easily dismissed. In this vein, Kuczewski writes that “clinical ethicists responding to issues regarding undocumented immigrants may be accused of being ‘political’ and exceeding their mission.” His response: The ethicist does not advocate breaking the law but is helping the institution live out its “mission and values.” In this respect, he argues, there is precedent in the far more familiar area of end-of-life decision making, “working to surface the values and principles” within medical and legal traditions. These passages echo some of the older discussions about the role of the ethicist as moral counselor and mediator who both relies upon and helps create a social consensus. Kuczewski is more confident that the end-of-life debates have issued settled principles that can withstand emerging problems like the status of those in minimally conscious states. I am reminded of the Jahi McMath case, in which matters of race and class arose in ways that caused discomfiting ripples in the consensus Kuczewski cites.

But of more interest to me in this context is, again, the role of the clinical ethicist. One California hospital has trained emergency-room workers in how to link arms to prevent immigration agents from entering. I wonder what the local ethicist would do if the institution reached a somewhat different conclusion about ICE agents’ access to the emergency room. Say the ethicist goes to higher authorities or the board itself but they hesitate overruling an administrator. The very idea that anyone would have reason to fear going to a hospital is abhorrent to me and presumably equally so for any reasonably competent hospital administrator, so such wavering is unlikely absent a valid legal order. Nonetheless, the possibility can’t be ruled out.

At least for the sake of argument, what such a horrid scenario indicates is that the values of the clinical ethicist and the “mission and values” of the institution should be aligned. Normally that will be clear to both parties at the outset so that any false assumptions would be avoided. Many, many years ago I was interviewed for a job as the ethicist for a Catholic health system. I would have been expected to function in accordance with their position on pregnancy termination. In another case as a consultant to a hospital founded by and serving many orthodox Jews it was made clear to me that I needed to keep my nose out of end-of-life matters. But what if it turns out that, despite a beautifully crafted mission statement, when push comes to shove the values of the ethicist and the institution are not aligned? As the philosopher William James said, citing a higher authority, “By their fruits shall ye know them.”

One option is civil disobedience, calling public attention to a moral violation. Some of our colleagues have done that in other instances. That would be an admirable and perhaps career-ending choice. There’s a good argument that all clinical ethicists should have some form of tenure.

As Kuczewski says, “The ethicist’s roles have always been somewhat fluid and evolving.” Let’s hope they flow and evolve in the right direction.