

Fiduciary Knowledge and Moral Consensus in Bioethics

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Having fiduciary knowledge in the required sense involves precisely "knowing the reasons for which a person deserves respect as a theorist or scholar." This means that interpersonal relations in [ethics] committees must come in for scrutiny in a new and perhaps unwelcome way.

--Peter Caws¹

A former colleague in a department of philosophy once observed that only a few of us have the ability to open a line of inquiry through a single pithy remark. Peter Caws has that ability, as exemplified in the above text. Although he is in a better position than I to articulate the philosophical context for his original statement – part of his long standing interest in the “knowing subject” – I can speak to its importance for a line of inquiry I undertook around the time Peter wrote those words. In fact, they appeared in an article I invited Peter to write for a special issue of the Journal of Medicine and Philosophy, an issue I co-edited with Robert Veatch in 1991.²

Peter’s statement captured a concern that was growing among bioethicists at that time. The field of bioethics (I consider it an inter-disciplinary field rather than a discipline), had entered its third decade as a self-conscious pursuit, related to but distinct from moral philosophy, theology and health law. Replete with academic positions, independent and university-based centers, a growing list of journals, competing volumes on bioethical theory by recognized scholars, several professional organizations and growing publicity, bioethics was clearly around for the long haul by 1991.

But bioethics was and is more than an academic field. Bioethics also manifests itself in clinical and public policy roles. Due to widespread uncertainty about the ethics of certain medical and behavioral procedures and the vicissitudes of legal liability, ethics committees and clinical ethicists had become a part of the social landscape, especially in the decade of the 1980s. As well, for these reasons and political advantage, government advisory commissions on bioethics had appeared since the mid-1970s on both federal and state levels.

In one sense, then, bioethicists were coming to look much like the philosophical equivalent of clinical psychologists, applying their conceptual schemes to actual problematic cases. Crucially, like the clinical psychologists, the clinical bioethicists could draw on a theoretical framework of principles (autonomy, beneficence, non-maleficence, and justice). Unlike the psychologists, the bioethicists had no “data” to demonstrate the success of their work, nor even much agreement about what

“success” means in this context. Moreover, the field was by no means settled about the primacy of the principles, with several competing approaches advanced by important thinkers.

In another sense, bioethicists who served on or staffed governmental or professional commissions were coming to look much like economists or experts in public administration, moral policy wonks, as it were. But here again the lack of data, of agreement about what counts as effective public policy in bioethics, and of a settled theoretical framework, set public bioethics apart from other policy areas, and continues to do so.

In both cases the problem that began to concern some in bioethics, as well as a few critical journalists who sensed a good story, could be phrased in terms of the credibility of “ethicists” to function in a fiduciary capacity for others with respect to the resolution of ethical problems. The concern applied as well to individuals acting as ethics consultants as to groups serving ethics committees: Who do these people think they are, anyway?

It should perhaps be emphasized that these connected problems concerning the legitimacy of certain individuals as moral fiduciaries might not apply in a faith tradition, as within an institution like a hospital in which certain values are presumed, or in a theocratic public domain. They arise specifically in societies that are secular and pluralistic, and among people who do not necessarily identify with a clerical authority, or at least do not wholly submit to such authority.

There was, therefore, good reason for bioethicists to feel insecure about what they were up to in these non-traditional roles, even as they were embracing the professional opportunities they created. Moreover, the momentum on behalf of putting them in these positions was only growing. In the late 1980s there was speculation that eventually every hospital was going to need a clinical ethicist on staff, and even that these services would be reimbursable (by Medicare, perhaps), in which case people were going to need training and certification. An organization (the Society for Bioethics Consultation, which later merged into the American Society for Bioethics and Humanities), was founded in 1986 with this understanding.

Any possibility that clinical ethics would be a widespread and financially supported profession withered with the explosion of managed care in the mid-1990s. Managed care organizations, like other commercial entities, are not in the business of hiring internal critics. But that was not at all clear in 1991. As to governmental and organizational ethics commissions, while clinical ethics took a beating as the 1990s unfolded, bioethics advisory groups became familiar furniture in the federal government. There several in the Department of Health and Human Services and two

were authorized directly by the White House, and within several of the most aggressive new companies attempting to exploit the results of the human genome project (Celera and Geron, to name two companies with bioethics advisory groups).

By the early 1990s disquiet about the way they had been swept along this tide of extra-academic legitimacy (even while their academic colleagues were skeptical of the entire enterprise), led some bioethicists to engage in both informal and more formal conversations on the matter. One literature focused on the meaning of moral or ethical “expertise.” What is required to be an ethics expert? Any particular credentials, skills or experience? This conversation continues to this day, capped with a report on the training of ethics consultants by the American Society for Bioethics and Humanities, but without the edge of concern in the early days when ethics consultants were expected to litter the health care landscape.

In the late 1980s, several papers in bioethics opened up the subject of the “ethics committee,” focusing on what struck some as an awkward conjunction of ideas in this phrase. For me and for (a very few) others the underlying issue was not the legitimacy of the ethics committee itself but rather that of the sort of interactions that characterized moral discourse in groups. In fact the consensus issue got more traction in Germany, where philosophers and bioethicists were stimulated not only by their own ethics committee movement, but also by the influence of Habermas among German philosophers and bioethicists.³ Habermas had for years been working on the incorporation of communications theory into his social philosophy and epistemology. Another reason for the interest of German scholars might well be the problems their modern history causes for a consensus-based moral theory. (American philosophers like Alan Gibbard who work on decision theory were writing on similar topics but had little if any influence on bioethics.)

Around 1990 I started talking to Peter Caws about moral consensus and ethics committees, eventuating in that special issue of the Journal of Medicine and Philosophy on “Consensus Decision-Making in Panels and Committees.” I had in mind a book that concentrated on ethics committees, portions of which I submitted to Oxford University Press in 1992. Reviewers for the press liked the first chapters but encouraged me to think about the role of consensus in bioethics more broadly than just the ethics committee setting. I had already considered that the ultimate target of a work on moral consensus should be broader but appreciated this would be a much bigger job. Thanks to my discerning colleagues I had no choice but to face up to it. Two years later, I completed my manuscript for a book I called Deciding Together.⁴

The problematic I set out in Deciding Together attempted to capture the oddity of philosophers (and other Western-style humanists) doing bioethics: trained to strike a

skeptical posture toward matters of mere social agreement, we nonetheless find ourselves working in all sorts of panels with precisely that as a goal. That skepticism runs deep in the Western intellectual tradition and also in Western culture itself. As the existentialists noticed, the great moral heroes and heroines define themselves precisely in opposition to herd opinion. Thus in the book I was obliged to train that skeptical light on my own activities as a bioethicist, activities that ranged far beyond the traditional classroom setting in which taking a morally heroic posture does not exact a very heavy price. These activities partly entail taking the role of ethics expert. In Caws' terms, to be a bioethicist involves being a possessor of fiduciary moral knowledge. How then do these experts achieve and sustain their status as moral fiduciaries in institutional processes while at the same time facilitating valid moral consensus concerning controversial matters?

My own writings on ethical expertise and that of others did achieve something of a consensus on the question of what characteristics were required of the ethics expert. For example, a reasonable list would include access to the knowledge base of bioethics (philosophy, medicine, history, law, religious principles etc.), analytic ability (discernment, ability to analogize, abduction), a certain temperament (interpersonal skills, willingness to take unpopular positions), and probably a particular institutional status (tenure). The latter is especially important as experts are not normally expected to be martyrs but might take positions that are not appreciated by their employers. Absent from any such list is a particular disciplinary background. What seems required is rather a certain temperament.

Some progress has been made, as well, on the idea of moral consensus. One problem has been simply unpacking the idea. In [Deciding Together](#) I suggested a series of categories and distinctions that at least one reviewer found as exhausting as it was exhaustive, but I found that no gains in understanding moral consensus could be made with much clarification. Not much analysis on the idea of consensus in bioethics had been done, save for a provocative observation by Stephen Toulmin about his experience as a staff member of the National Commission for the Protection of Human Subjects in the 1970s, the first national ethics commission.⁵

In his essay, Toulmin reported his observation that the commissioners often surprised him with their ability to agree on the response to a problematic case or policy issue. When he approached them individually and asked them to reconstruct their reasoning, he found they had often reached the same conclusion from different premises. In my terms, their superficial consensus was not necessarily derived from a "deep consensus." Toulmin draws the conclusion that it is often easier to agree about a solution to an ethical problem than it is to agree on a moral framework, a point he and Al Jonsen later put to work in their reintroduction of casuistry as a method of moral reasoning. Another conclusion one might draw is that, contrary to the intuition

that a group of moral deliberators should examine their ethical presuppositions, it might be better for the members to remain naive concerning the others' deeply held values, lest they become skeptical of one another's intentions. Their differences are likely to come out gradually anyway, but little good seems to be accomplished by dwelling on them -- an attitude that some psychotherapists might prescribe for marriage as well!

In something of the manner of an automobile engine badly in need of repair, just about everything I touched in my exploration of the idea of moral consensus led to another problem. As the philosopher's tool kit consists mainly of distinctions, I wielded as many as I found. Thus I also urged a distinction between consensus as a process (which is what consensus is in spite of the way English grammar objectifies it), as against consensus as a mere goal (unintelligible without a series of consensus-based propositions to "prop up" succeeding steps). I also distinguished procedural consensus (about rules) and substantive consensus (about conclusions), a distinction well recognized by our legal system.

I also insisted on distinguishing between consensus and compromise. Compromise entails preserving one's principles while achieving a *modus operandi*, while consensus does not necessarily involve any compromise of principle because the protagonists may not even be clear what principles are at stake in the matter. In a consensus situation, ideally speaking, the participants enter the room without even being sure how to approach the matter beyond some generalities. Confronted with a moral controversy, as open-minded democratic deliberators they engage in a process of give-and-take, respectful of minority and other unpopular points of view, and together arrive at an arrangement they find provisionally acceptable.

Although at least one reviewer took me to task for what seemed to him an excessively idealized view of consensus formation, with openness and transparency more rare than my account of moral consensus seemed to allow. Yet my own experience with many ethics committees, as both a member and a consultant, suggests that to a surprising extent efforts are made to approximate this ideal. Similar reports have been made concerning the seriousness with which juries take their role. My guess is that ethics committee members tend to have an implicit understanding that they are in fact moral fiduciaries for those whom they "represent" (with the sense of representation being very loose here), and that their colleagues, patients and other stakeholders largely expect them to engage in a sincere effort at moral inquiry.

Much more complicated is the role of the commissioner on a governmental or organizational ethics panel. Examples are the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1974-78), the President's Commission on Ethics in Medicine and Biomedical and Behavioral Research (1979-

82), the Advisory Committee on Human Experimentation (1994-95), the National Bioethics Advisory Commission (1998-), and the National Human Research Protections Advisory Committee (2000-). How are we to conceptualize the role of such an individual as a moral fiduciary? The function of the democratically elected representative is complex enough, has been hotly debated and is somewhat instructive. Shall we agree that the ethics commissioner is to reach conclusions that reflect the consensus views of the American people, or of his or her constituency? Or should we rather view the ethics commissioner as an open-minded inquirer whose views must satisfy his or her own powers of reasoning and the limits of conscience?

My own inclination is to view the governmental ethics panel in a democratic and secular society as an intensified version of the society as a whole, working through the moral uncertainties and dilemmas on behalf of their fellows. On such a model the members should not entirely leave behind intuitions of their fellow citizens, but owing to the limits of those intuitions they cannot be bound by them. Often an ethics commission needs to exercise leadership, preserving the underlying values that allow the general public to identify with their deliberations but elaborating upon those values in a way that might not be available to those without the opportunity to engage in careful reflection. Clearly the initial selection of commission members is of great importance. They should be possessed of an open and self-critical attitude as well as the capacity to assimilate a great deal of information, drawn probably from several disciplines.

While this formulation of a model of the governmental ethics commissioner as moral fiduciary is undoubtedly inadequate, it is at least a start. But does it, or my account of ethics consultation, satisfy the Caws requirement for the fiduciary role: “knowing the reasons for which a person deserves respect as a theorist or scholar”? I think it does not, for while Caws’ requirement is sensible as an intellectual requirement for representative moral deliberation, “knowing the reasons for which a person deserves respect as a theorist or scholar” is not a sufficient condition for the institutionalized ethics processes I have described to succeed. Rather, I submit that what is also required is confidence in the character and judgment of the ethics consultant, or committee or commission member. The implications of this assertion are important in an understanding of the difference between the moral philosophy of medicine and bioethics.

In [Deciding Together](#) I argued that bioethics is not reducible to the moral philosophy of medicine, that it is a set of social practices that extend beyond the seminar room, and that these practices are transformative of the activity of moral deliberation about the life sciences. Thus, although the scholarly standing of the “ethicist” is surely an important consideration, in fact, a variety of skills must be brought to bear in what is essentially and in the classic sense a political activity. Bioethics is moral deliberation

in public, the results of which could affect the lives of many, often in concrete and irreversible ways. In such a context theoretical mastery and scholarly attainment are insufficient conditions for success, which must be measured partly in the extent to which a consensus can emerge.

The obvious objection at this stage of the argument is that such consensus can too easily focus more on the sophistic craft of the ethics expert than on the reasons she deserves respect as a theorist or a scholar. The objection is warranted if no other requirements are applied to public moral deliberation. These other requirements attend to the process of the deliberation as well as to the quality of those who in effect represent us in that process. For example: Are we sure about the “data base” that constitutes or informs our assumptions? Are all the stakeholders represented? Are unpopular positions given an opportunity for a full and fair airing? These are among the qualities we expect of a democratic deliberative process. The ethics expert should be one who is evidently committed to the satisfaction of these procedural values, and who is skilled in guiding the proceedings in accord with these criteria.

Thus in bioethics, as against the moral philosophy of medicine, respect on intellectual or scholarly grounds is not enough. Those granted the fiduciary role in this public and policy-driven context must be possessed of skills not ordinarily required of the intellectual or scholar. Considering the range of abilities involved, from the academic to the interpersonal and political, psychoanalysis might well take a back seat to bioethics as “the impossible profession.”

In this paper as in the rest of my work on moral consensus in bioethics I have been concerned with the way moral consensus works in particular cases. I contend that in the vast majority of cases consensus about particular moral issues is typically regarded as possible and successful. All this having been said, I also view my work on the nature of consensus in bioethics as a continuing challenge to the field, as a burr in the bioethicist’s saddle, as it were, lest we become too comfortable. For the most devastating critique of moral consensus, and one that can never wholly be refuted, is that it is fated always to be merely the embodiment of that position that most advantages those in power. “The ruling ideas,” wrote Marx and Engels, “are nothing more than the ideal expression of the dominant material relationships, the dominant material relationships grasped as ideas; hence of the relationships which make the one class the ruling one, therefore the ideas of its dominance.”⁶

As intuitively appealing as this notion might be, like so much of the rest of Marxian critical theory of “hegemonic materialism,” it is too strong. Just as the observation of the world-transforming power of capitalism is so strong that it undermines attempts to explain how the proletarian revolution is possible, so the critical analysis of consensus

as simply the will of the stronger imposed through non-violent means fails to explain how moral controversy is possible.

Yet the argument does capture an element of consensus development and fiduciary moral knowledge in bioethics that has impressed me more in recent years than when I first began work on the topic. Informed by personal experience as senior staff for two presidential commissions and as a member of several other governmental and professional advisory bodies, I now think we must take more seriously a conservative strain in effective consensus building, one that surely does tend to reinforce the interests of dominant power centers. The best statement of the inherently conservative streak in consensus building appears in Aristotle's Rhetoric, when it is observed that enthymemes help command interlocutor's assent when there are no deductively conclusive arguments. Building arguments out of endoxa helps because these are views that "are accepted by our audience or *by those whose authority they recognize*" (emphasis added) – in other words, those possessed of fiduciary knowledge.

Yet we should take care not to over-emphasize as without escape the conceptual box in which we are thus placed. Leaps in moral perception are possible. They are the ethical analogue to what Charles Peirce called abductive inference in science. Though we cannot as yet fully explain how they occur, those well-equipped to seek and articulate them are the best moral fiduciaries we can have.

Notes

1 Peter Caws, "." In "Consensus Decision-Making in Panels and Committees." Journal of Medicine and Philosophy, 16(4), 1991.

2 "Consensus Decision-Making in Panels and Committees." Journal of Medicine and Philosophy, 16(4), 1991.

3 See K. Bayertz (ed.), Dordrecht, the Netherlands: Kluwer Academic Publishers, 1994; (ed.), Frankfurt am Main: Suhrkamp, 1996.

4 Jonathan D. Moreno, Deciding Together: Bioethics and Moral Consensus. New York: Oxford University Press, 1995.

5 Stephen Toulmin, "How Medicine Saved the Life of Ethics," in New Directions in Ethics, ed. J. P. DeMarco and R. M. Fox (New York: Routledge and Kegan Paul, 1986), pp. 265-81.

6 Marx K. and Engels F. [The German Ideology](#). New York: International Publishers, 1967, p. 39.