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The Place for Religious Content in Clinical Ethics Consultations: A Reply to Janet Malek

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Janet Malek (2019) argues that a "clinical ethics consultant's religious worldview has no place in developing ethical recommendations or communicating about them with patients, surrogates, and clinicians." She offers five types of arguments in support of this thesis: Arguments from (i) consensus, (ii) clarity, (iii) availability, (iv) consistency, and (v) autonomy. This essay shows that there are serious problems for each of Malek's arguments. None of them is sufficient to motivate her thesis (nor are they jointly sufficient). Thus, if it is true that the religious worldview of clinical ethics consultants (CECs) should play no role whatsoever in their work as consultants, this claim will need to be defended on some other ground.

Keywords: *Clinical ethics consult, religion, pluralism, spirituality, ethics expertise, ASBH*

INTRODUCTION

What is the role of a clinical ethic consultant's (CEC's) religious worldview in their consultative work? Janet Malek (2019) argues that a "clinical ethics consultant's religious worldview has no place in developing ethical recommendations or communicating about them with patients, surrogates, and clinicians" (2019, p. 92). She offers five types of arguments in support of this thesis: Arguments from (i) consensus, (ii) clarity, (iii) availability, (iv) consistency, and (v) autonomy. In this essay, we show that there are serious problems for each of Malek's arguments. None of them is sufficient to motivate her thesis (nor are they jointly sufficient). To demonstrate these claims, we proceed as follows. First, we sketch an outline of what a CEC's role is, as described by Malek. Next, we outline and respond to each of her five arguments, showing that each argument fails. Thus, defenders of the claim that "the religious worldview of a CEC should play no role whatsoever in her work as a consultant" must defend this claim on some other ground (Malek 2019, p. 91).

I. THE ROLE OF A CLINICAL ETHICS CONSULTANT

Malek falls squarely within one camp of the debate concerning the expertise and role of a clinical ethics consultant. We wish to note at onset that there is no one, authoritative understanding of the core competencies of the CEC, nor is there a single account of the role and purpose of the CEC generally. Rather, there is a literature of competing accounts. Indeed, a sampling of the literature

concerning the question of CEC expertise yields a number of answers.[1] Suffice it to say, Malek's understanding of the proper orientation of a CEC towards their consultative work should not be treated as if it were universally accepted.

In describing the role of CECs, Malek relies on Fletcher and Siegler's account, which states that CECs' primary goal is to "improve the process and outcomes of patients' care by helping to identify, analyze, and resolve ethical problems" (1996, p. 125).[2] To accomplish this goal, Malek argues, CECs "have (or should have) a fundamental set of knowledge and skills that enables them to carry out the goals of ethical analysis and conflict resolution" (2019, p. 95). The relevant knowledge and skills are gained via "formal or informal training in ethical theory, moral reasoning, values, elucidation, meeting facilitation, and communication skills" (2019, p. 96). Most importantly, learning to reason well, being trained in ethical theory, etc., in no way requires any sort of "expertise in religious tenets, application of a faith's beliefs, or analysis of sacred texts" (2019, p. 96). Put differently, the CEC is tasked with developing analyses and recommendations with respect to particular cases and providing ethical guidance to patients, family members, and clinicians. Religiously-based beliefs and values are entirely unnecessary for this task. Not only that, but such beliefs and values actually interfere with (or "corrupt") the process (2019, p. 95). Malek offers five types of arguments in defense of these claims. We now discuss and respond to each of them in turn.[3]

II. ARGUMENTS FROM CONSENSUS

To start, Malek argues that a CEC's "religious worldview should never influence her ethical analysis or development of a recommendation" because such views, beliefs, etc., fall outside of "areas of bioethical consensus" (2019, 4, p. 101). It is the duty of CECs to "analyze cases using bioethical methods" built on this consensus, not principles that fall outside of it (2019, p. 94). Even when dealing with ethical issues for which there is no clear consensus, CECs are still tasked with using "a methodology for thinking through the ethical problem in a clear and systematic way" and "coming to an independent conclusion using *accepted* moral principles" (2019, p. 95, emphasis added).

We might, therefore, put the argument from consensus like this. When a case raises an ethical issue for which there is a prescribed course of action—prescribed by the consensus—the CEC is tasked with recommending that course of action. When a case raises an ethical issue that is not directly addressed by the ethical consensus, the CEC must rely on "accepted moral principles" (principles that fall within the consensus) and derive a solution based upon those principles. Religiously-based beliefs and values fall outside of the consensus altogether. Thus, religiously-based beliefs and values have no role to play in *either* type of case. The consensus either provides a direct recommendation or provides the resources from which the CEC can derive

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[1] See, for example Iltis and Rasmussen (2016); Rasmussen (2016); Rasmussen (2011); Archard (2011); Tong (1991); Engelhardt (2017).

[2] Similar, albeit vague, language is used in the American Society for Bioethics and Humanities (2011). Indeed, they cite Fletcher and Siegler (1996) when they write that the "general goal of [Healthcare Ethics Committee] is to improve the quality of health care through the identification, analysis, and resolution of ethical questions or concerns" (2011, p. 3).

[3] Malek does not separate her arguments into five categories. Instead, she describes her project as presenting "numerous arguments" for her thesis (2018, p. 101). By organizing Malek's arguments as we do, however, we will gain a clearer picture of what she claims and why she claims it.

a recommendation. Malek concludes, therefore, that the consulting process (when done properly) "leaves little room for inclusion of a CEC's religious perspective" (2019, p. 95).

There are two responses to Malek's argument we will pursue here. First, a "bioethical consensus" does not exist.[4] Second, even if it did, there are still problems for Malek's arguments.

There are factual and in-principle problems with Malek's claim of an existent bioethical consensus. For the sake of space, we focus only on the factual problems, though the literature concerning the in-principle problems is vast.[5] There is no bioethical consensus concerning the right, the good, or the virtuous.[6] There are dominant, politically successful paradigms that convey authority as a result of their popularity amongst select circles of society, but this is not as a result of their ability to establish a canonical account of medical morality. Indeed, Malek's claims concerning the centrality of bioethical consensus as the content of the canonical morality that CECs have special, expert access to are puzzling considering the immense disagreement characteristic of most, if not all, major issues in the bioethical literature. Even more strange is the claim of a *secular* consensus that characterizes a field that is populated by diverse philosophical traditions, some of which are explicitly religious in nature.[7] Even amongst organizations like the American Society for Bioethics and Humanities, there are deep disagreements between members concerning foundational topics like the permissibility of abortion,[8] private ownership of one's body and organs,[9] or issues centered on when informed consent is required for including subjects in research[10] (just to name a few).

In sum, the problem is that the consensus Malek appeals to is supposed to be the timeless result of "secular reasoning" (2019, p. 100). It is supposed to include principles that everyone agrees upon; principles that can be discovered (or derived) via ethical inquiry (at least once we have bracketed all religiously-based beliefs and values from the discussion).[11] Malek must,

[4] At the very least, asserting the existence of such a consensus raises questions like: What is included in the consensus? Where did it come from and how was it formed? Who are the consenters and why does their view matter? How much disagreement must exist between bioethicists before a consensus is undermined? Why think the present consensus is correct? Why think that gathering a consensus on an ethical issue is a reliable way of resolving the issue? And so forth.

[5] See, as a sampling of criticism concerning the view that bioethical consensus is preferable to other arguments for moral authority or even possible, Trotter (2006); Veach (1991); Cherry (2010).

[6] Indeed, the American Society for Bioethics and Humanities (2011) is upfront about the competition of values that exists in clinical ethics currently. Early (page 2) in the book, the Task Force notes that "value uncertainty or conflict often arises because of competing values from these different domains (e.g., judgements about 'best treatment' often differ depending on whether medical values or individual patient values are being considered" (2011, Footnote 2, 2).

[7] Christopher Tollefsen, Frank Beckwith, Melissa Moschella, and Christopher Eberle are just a few of the well published and well-established bioethicists with an explicitly natural law orientation working in the field of bioethics currently.

[8] See, for example, the diverse perspectives of Steinbock (2019); Lane (2006); Boyle (2004); Saenz (2014).

[9] For example, on arguments central to the organ donation debate see Pilkington (2018); Saunders (2012); Cherry (2017).

[10] See Rebers et al. (2016) for a discussion of possible exceptions to requiring informed consent for inclusion in research.

[11] Of course, if the consensus itself contains principles or values that have been influenced by some religious ideals, that could be a point of embarrassment for Malek's view. In that case, a CEC might respond that religiously-based beliefs and values can have an influence on the CEC's work if they are causally upstream from the consensus itself (i.e. if they contributed in some way to the content of the consensus). This, Malek could argue, is still different than allowing the CEC's *own* religious worldview to influence her work. But in response, we need only imagine cases in which the religious worldview that contributed to the content of the consensus is the *same* religious worldview that

therefore, explain why there has been *tremendous* diversity within discussions of secular, moral theory.

Perhaps Malek would argue that many secular moral theorists have gotten moral principles wrong (or made errors in their reasoning). Differences within the secular sphere, therefore, are just the result of mistakes in authors' reasoning. The consensus, on the other hand, is correct. It is the result of proper ethical reasoning. That view seems fairly presumptuous, but it is a story Malek could tell.[12] Even assuming it is correct, however, a major problem with Malek's account remains: Not only must CECs abide by (and apply) a particular set of ethical principles, they must also accept a very particular story about the consensus (including its formation and its secular nature) *and* they must carry out all of their work by the power of secular reasoning alone.

For the sake of argument, let us set all of these questions aside and simply grant Malek's assumption that the relevant kind of consensus exists. Concerns arise for her argument nonetheless. To see why, suppose the consensus includes (or entails) the principle *do not amputate a patient's limbs unnecessarily*. Next, imagine that we have two CECs—Smith and Jones—facing comparable cases in which healthy patients are requesting to have their arms and legs amputated. Smith applies the principle *do not amputate a patient's limbs unnecessarily*, and so recommends against the surgery. Jones applies the principle *do not amputate a patient's limbs unnecessarily*, and so recommends against the surgery as well. Have both CECs acted appropriately? If Malek is right, then, oddly enough, the answer is "we cannot be sure."

To expand on Malek's answer, suppose we do some digging and discover that Smith derived the relevant principle—i.e., *do not amputate a patient's limbs unnecessarily*—from the process of "ethical reasoning" based entirely in her "training in ethical theory" (Malek 2019, p. 95-96). Jones, on the other hand, derived the relevant principle from his own religious worldview, which includes a more general belief that mutilating human beings is morally impermissible. In this case, Smith has acted as a CEC should. Jones has not. This follows even though their respective assessments and recommendations relied on the very same principle. Why think Jones did something wrong?

According to Malek, what is wrong with Jones's work (as a CEC) is that he has risked "an imposition of [his] own religiously-based beliefs and values" upon the patient, whereas Smith has done no such thing (2019, p. 98). It does not matter that Jones's religiously-based beliefs and values happen to align with the consensus. In cases where such an alignment occurs, Malek states that "although preferences and commitments that derive from religious worldviews may lead to good outcomes or be *consistent with morally praiseworthy actions*, the goodness or

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the CEC holds. In those cases, Malek's response would entail the claim that it is permissible for the CEC's religious worldview to influence her work as a consultant. That is enough to undermine Malek's main thesis.

[12] As one reviewer helpfully points out, Malek is free to argue that where there is disagreement between secular moral theorists, there is no consensus. This route does not seem promising, however, given how deep the disagreement runs. Engelhardt (1996), for example, provides an overview of the plurality of ways principles of justice and autonomy have been understood by secular moral theorists (56-8). If disagreement on a matter (between secular moral theorists) means there is no consensus on that matter, then not even principles of justice and autonomy—which are taken by authors like Beauchamp and Childress (2012) to be foundational to bioethical deliberation—can be thought of as part of the consensus. In short, if disagreement undermines consensus, then given the wide variety of (incompatible) ways in which principles—even foundational ones—have been defined and understood, it seems unlikely the consensus will contain much (if any) substantive content at all. And if there is no consensus (or virtually no consensus), Malek's project fails.

praiseworthiness of those choices can be described using secular ethical concepts as well" (Malek 2019, p. 95, emphasis added). In other words, Jones could have—and *should* have—arrived at the very same conclusion as Smith without referring to any of his own religiously-based beliefs or values.[13] Even if Jones's reliance on religiously-based beliefs and values was "implicit," it nonetheless "corrupts the consultative process" (Malek 2019, 95). Jones's actions, therefore, are impermissible even if he never explicitly mentions his own religious worldview to the patient.

These cases make it clear that—on Malek's account—it is not good enough that CECs apply the right principles to their cases. CECs must also apply the right principles for very specific reasons (namely, that these principles are part of the consensus or derivable from it).[14] Furthermore, on Malek's account, CECs are required to accept that virtually *all* ethical principles that should guide their work are discoverable via (or entailed by) "secular reasoning" and reflection on "secular ethical concepts" (Malek 2019, p. 95, p. 101).

In other words, not only are we told that there is a bioethical consensus, but there is a *purely secular* bioethical consensus—not influenced by any religiously-based beliefs or values whatsoever—that can be discovered by anyone willing to reason carefully about moral issues. Responsible CECs know this and act accordingly. These claims are *much* stronger than simply asserting that there exists a bioethical consensus of some kind. Thus, if there is reason to be concerned about the latter claim, there is far more reason to be concerned about the former set of claims.

What about CECs that do not buy Malek's story?[15] Is there no place for them within the profession? Malek's arguments seem to entail an affirmative answer. Alternatively, maybe those who do not buy into Malek's story about morality must simply pretend that it is true. Still, this is asking far too much of the CEC. The goals of a CEC are (for Malek) to help identify, analyze, and resolve ethical problems. But to argue that it is necessary for the completion of these goals that all CECs must personally accept an extremely particular, highly controversial view of moral principles goes too far. The above discussion reveals that Malek is making at least two major

[13] Malek might be able to argue that Jones's happening to arrive at the right conclusion is coincidental, in the same way that an agent coincidentally forms justified true beliefs in Gettier cases. In Gettier cases, coincidentally arriving at justified true belief is usually taken to be insufficient for knowledge. So in the Smith/Jones case, Malek may argue that Jones's coincidentally arriving at the right principle is insufficient grounds to say he acted responsibly. This response will not work, however, in cases where Jones willingly abides by the consensus whether or not doing so conflicts with his own religious views. For cases like this, see Levin and Birnbaum (2000). Furthermore, see Gettier (1963) as well as Ichikawa and Steup (2018, Section 3) for an overview of Gettier cases.

[14] This seems to go against at least one recommendation by the American Society for Bioethics and Humanities concerning what they see as the "Core Competencies" of the CEC. We think it important to include this particular approach to what Core Competencies might be because Malek herself cites it in her own paper. The Task Force writes, "For consultations involving an active patient case, the consultants should remember that the 'right' substantive decision is ultimately the responsibility of the ethically appropriate decision maker(s) (generally the patient, the surrogate, the healthcare professional, the institution, or, at times, some combination of these) and not the consultant. The consultant's role is to help these parties think more clearly about the ethical implications of their actions to optimize decision making" (American Society for Bioethics and Humanities, 2011, p. 9).

[15] They might, for example, doubt the existence of a secular moral consensus, that the principles within the consensus can be discovered via secular reasoning, that there is a distinction between secular reasoning and non-secular reasoning, that religiously-based ideals and values have not influenced the consensus at all, etc.

assumptions that are quite dubious: (a) this very particular story about morality is *correct* and (b) all CECs must subscribe to this story to do their job properly.[16]

In sum, there are several serious problems with Malek's argument from consensus. First, her view relies on the questionable assumption that there exists a purely secular moral consensus that will be accepted by literally anyone who reasons carefully about moral issues. If there is no such consensus, then Malek's argument falls apart. The diversity of thought among secular moral theorists is fairly damning evidence against the existence of such a consensus.[17] Additionally (and independently), Malek requires that CECs not only act according to principles contained within the consensus, but that they themselves subscribe to an extremely particular view of morality. These requirements certainly leave no room for religiously-based beliefs and values. But Malek's requirements also leave virtually no room for *any* philosophical disagreement about the nature of morality, how we can discover normative principles, and how to apply those principles.[18]

III. ARGUMENTS FROM CLARITY

Another argument Malek gives in support of her thesis stems from practical concerns over clarity.[19] Imagine a case where a patient tells a CEC that he is Jewish. The CEC also identifies as Jewish, and so allows her own faith to influence her discussion with the patient. In this kind of case, Malek raises the following concern (which we will refer to as the "Clarity Problem"): "A presumption that sharing a label for one's worldview implies that two individuals share beliefs is likely an overgeneralization in many cases" (2019, p. 99). In other words, simply because the CEC and the patient both identify as Jewish, it does not follow that they believe the same things, maintain the same values, and so forth. That is, sharing a label does not imply that the two parties share the same understanding of their religious tradition. By bringing her faith to bear on the situation, the CEC is (unduly) allowing her own understanding of Judaism to influence the patient's decision.

In place of his religious worldview, Malek tells us, the CEC ought to speak from the framework of secular morality. But, why think that the terms, concepts, and ideas associated with secular morality are automatically immune to the Clarity Problem? Malek gives no reason. She just asserts that there *is* a "common language" that is "available and relevant to any individual" (2019, p. 100). To test Malek's claim, consider justice. Is it the case that discussions of the nature of justice will become perfectly clear—parties will speak about justice without speaking past one another—once we eliminate all religious worldviews from the debate? No. Additionally, is it the case that concepts of autonomy, harm, benefit, quality of life, and so on, are all understood in exactly one way (again, once we bracket religious beliefs and values)? It would be absurd to

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[16] To be clear, given our argument that there is no bioethical consensus, we think that assumption (a) is problematic by itself. But requiring CECs to perform their duties in accordance with a strict set of principles—a "consensus"—is more defensible than requiring CECs to perform their duties in accordance with a strict set of principles *while believing a very particular story* about the foundation and nature of those principles. After all, the latter view (which seems to be what Malek advocates) faces all the same problems as the former, plus more.

[17] And again, if the presence of disagreement destroys consensus, then (as noted above), it is not clear what will be left of the consensus once we consider the widespread disagreement that exists between secular moral theorists over even the most "foundational" principles of bioethics.

[18] So, again, even if there is a consensus on some moral principle, CECs must accept that principle for a very particular reason. Suppose, for instance, that there is a consensus—across all worldviews—on the principle "do good and avoid evil." Religious CECs that accept this principle—even at the most general level—for religious reasons have done something inappropriate (on Malek's view). After all, to accept a principle for religious reasons is to allow one's religious perspective to affect one's ethical analysis of a case (and this is exactly what Malek says is impermissible).

[19] Malek does not use the term "clarity," but it captures a concept that is central to her argument.

suggest so. Unless Malek is ready to argue that secular morality exists in exactly one form or that its concepts, terms, etc., are always understood univocally by properly reasoning human beings, then there is little reason to conclude that parties identifying themselves as subscribing to secular morality are automatically immune to the Clarity Problem.[20]

For Malek's argument to work, it would seem that the secular CEC must be less likely to misunderstand and misrepresent the patient's religious worldview than religious CECs. But, Malek is on shaky ground here. To see why, consider an analogy. Suppose we have a patient that speaks a dialect of British English and two CECs. One CEC speaks only American English, the other speaks only Mandarin. Which CEC would we expect to be more capable of communicating effectively with the patient? Obviously the former, despite differences in the CEC and patient's respective dialects. Similarly, CECs' familiarity with a patient's religious worldview (whether they share this *exact* worldview or not) seems like it would often be an asset rather than a liability in helping to identify and resolve ethical issues. On the other hand, CECs that have no familiarity with a patient's religious background (and have only secular moral theory to rely upon) may often be less well-equipped to accurately identify and resolve ethical issues (within the context of the patient's worldview). The concepts and moral principles associated with the patient's worldview may be so foreign to secularly-minded CECs that they fail to accomplish their primary goals as CECs. In fact, these CECs seem to be at great risk of imposing on the patient ethical principles that are foreign to the patient (i.e. those grounded in secular morality as opposed to those that are rooted in the patient's own worldview).[21]

In response to a concern like this one, Malek seems to suggest that religiously-based beliefs and values are entirely individualistic (2019, p. 100). She explicitly states that "religious beliefs may appropriately be used to guide an individual's decision-making" but "cannot be drawn on in conversations with others" (2019, p. 100). Taken literally, this assumption is obviously false. People can draw from their religious beliefs when having conversations with others (that is, it is possible for them to do so). Perhaps by "cannot" Malek means "should not." On this reading, individuals' own religious beliefs may guide their own decision-making, but they *ought not* apply those beliefs in conversations with any other people (regarding how they should live their lives, at least). If this is what Malek means, then she is committed to an incredibly narrow view of religion which undermines the communal aspect of many religious traditions. It seems to imply that members of religious communities are always doing something wrong when they provide

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[20] Another problem for Malek's argument from clarity is this. Her concern is that people who identify themselves as belonging to the same religion are at risk for talking past one another (or, worse, projecting their own understanding of the religion on one another). There is great potential for miscommunication between people who claim to be members of the same faith. In response, we might wonder: What about an alternative scenario, where a CEC knows nothing of a patient's religion? The CEC may be well-trained in secular moral principles and secular reasoning, but given their ignorance concerning the patient's religion, is their secular training enough to ensure that they will be able to understand the patient's concerns and wishes? Or, is there still a risk that the CEC will project her own (secular) values onto the patient? More importantly, which risk is greater: The risk that a CEC who accepts the same label as the patient will misunderstand the patient's religious perspective or the risk that a CEC completely unacquainted with a patient's religious worldview will misunderstand the patient's perspective?

[21] Malek may argue that no such risk exists because secular moral principles are "available and relevant to any individual" (2019, p. 100). That is, if everyone—no matter their worldview—subscribes to a particular moral principle, then it is not possible to impose that principle on a patient, since that principle is automatically consistent with the patient's worldview. We will address this argument at length in the next section.

suggestions—based on their own understanding of religious teachings—regarding how fellow members should act.

Lastly, when Malek asserts that religious beliefs "cannot be drawn on in conversations with others" maybe she just means this: Individuals' own religious beliefs can guide their decision-making in life, but they ought not apply those beliefs in conversations with others (about how they should live their lives) when those others do not share their religious worldview. This reading is not obviously false, nor does it threaten the communal aspect of various religions. But it will not help Malek's thesis either. On this reading of "cannot," the door would open for the CEC to apply their own religious worldview to their work in cases where patients share their worldview. That is the very practice Malek is trying to resist.

In any case, if Malek wishes to argue that CECs will never be in a good position to know that they truly share the same religious worldview with their patients, then she must explain why the same concern—the Clarity Problem—does not apply to all ethical discussions. In other words, if CECs are incapable of judging whether or not they share a worldview with patients, this seems to be a universal problem, not one specifically linked to religious worldviews. Thus, Malek's appeal to the "individualistic" nature of religious belief commits her to a blatant falsehood, to a wildly implausible account of religion, or (in principle) she must allow CECs to apply their own religious worldviews to their work. All of these results are bad news for Malek's thesis.

To summarize, Malek either overestimates the risk of CECs imposing their own religious worldviews on patients (when patients claim to subscribe to the same religion as the CEC) or she underestimates the risk of CECs imposing secular moral principles on patients. Either way, it is plausible that responsible CECs should minimize these risks. That is, they should take stock of their own worldviews (whether their own beliefs and values are religiously-based or not) and work to avoid imposing these beliefs and values on the patient. Sometimes allowing their religious worldview to shape their assessments and recommendations will not constitute an imposition. Sometimes allowing secular moral principles to shape their assessments and recommendations *will* constitute an imposition. Thus, CECs should be mindful of their own worldviews (religious or otherwise) and the impact that their worldviews may have on their work. This is quite a different conclusion from Malek's thesis.

IV. ARGUMENTS FROM AVAILABILITY

Next, according to Malek, one important difference between religiously-based moral principles and secular moral principles is that the former are "only available and relevant to those who subscribe to that religious tradition" while the latter are "available and relevant to any individual" (2019, p. 100). As we consider what is meant by "available and relevant," however, problems arise. First, for Malek, "available" means something like "logically consistent with." Secular moral principles, she tells us, are "available to all people regardless of their religious affiliation" (2019, p. 97). If "available" means something like "logically consistent with," then take a given secular moral principle and you will find that it does not conflict with any religious worldview.

On this reading of "availability" Malek's claim—that secular moral principles are logically consistent with all religious worldviews—is plainly false. To illustrate, suppose the principle *it is morally permissible to consume pork* is a secular moral principle. This is obviously not "available" to every member of every religion. The same story can be told for principles of beneficence,

nonmaleficence, autonomy, and justice.[22] In short, an attempt to find universal moral principles that are compatible with literally *every* religious worldview is doomed from the start.

Malek may object that the principles in the consensus are supposed to be very general. Thus, it is unsurprising that more particular principles (e.g., "it is permissible to consume pork") are not part of the consensus.[23] In response, suppose the principles within the consensus are very general (e.g., "do no harm," "equals ought to be treated equally," etc.). Very general principles like this have a better chance of being "logically consistent with" a wide range of worldviews (perhaps even all of them).

The problem, as Beauchamp and Childress (2009) point out, is that general principles—like "equals ought to be treated equally"—are devoid of substance (and are fairly useless when it comes to guiding action) (242). That is, the principle "equals ought to be treated equally" gives no guidance to CECs' actions without their having a more substantive view of who counts as an equal and why (among other things). So, if the consensus is nothing but very general principles, the consensus provides no real guidance for action (by itself).

Malek may object again: The consensus by itself does not guide action, sure, but the consensus plus secular reasoning does.[24] In response, whatever is entailed by the principles of the consensus must be treated as part of the consensus. To illustrate, let the consensus (of very general principles) be *A*. By secular reasoning, suppose we discover that *A* entails some particular principle *B*. Those who reject *B* reject *A*. Or, put differently, if CECs accept *A*, they *must* accept *B* (on pain of irrationality). So, if secular reasoning allows CECs to discover more particular principles (when they are entailed by the consensus), then they must accept those principles just as much as they accept the consensus itself (on pain of irrationality). Since these particular principles should be treated as part of the consensus, it follows (for Malek) that these particular principles will also be logically consistent with all worldviews. But as we saw above, as principles become more particular, it becomes increasingly less plausible that they will be consistent with all worldviews.

Worse still, filling out the details of general principles often requires an appeal to substantial philosophical commitments. As mentioned above, "equals ought to be treated equally" requires answering questions about who counts as equal and why. But there are many (incompatible) responses to those kinds of questions. For example, should CECs consider fetuses to be "equal" to newborns? They cannot, because the claim that fetuses are equal to newborns is not part of the consensus.[25] For the exact same reason, however, they cannot assert that fetuses are *not* equal to newborns. That claim is no more a part of the consensus than its counterpart. Thus, CECs will be rendered unable to provide any guidance in cases that involve these sorts of issues—

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[22] See Engelhardt (1996) for a brief overview of how principles of autonomy and justice have been developed in various, incompatible ways (pp. 56-8). Additionally, the four principles we list above are commonly associated with principlism as developed by Beauchamp and Childress (2012). Malek (2018) only hints that "respect for autonomy" may belong within the consensus (she does not provide explicit examples of principles in the consensus) (p. 10). Given her emphasis on respect for autonomy, therefore, we believe it is reasonable to suppose she thinks it is included in the consensus, and that the other principles developed by Beauchamp and Childress may be included in the consensus as well.

[23] We are grateful to an anonymous reviewer for raising this concern.

[24] Here, we set aside questions about what "secular reason" is, whether or not it is compatible with all worldviews, etc.

[25] Cf. Malek (2018, p. 95).

issues over which there is no consensus—unless they are permitted to import *some* substantial philosophical content. This is especially concerning if our discussion in Section 2 is correct and there is little consensus, if any, regarding most issues in bioethics. That would mean that CECs relying on just the consensus and secular reasoning would be rendered unable to provide guidance in most (if not all) cases. If we allow CECs to invoke substantial philosophical commitments, it may be that these commitments are not logically consistent with all worldviews, but at least CECs will be allowed to perform their duties.

In sum, so far, if the principles in the consensus are particular (and, therefore, capable of guiding action), then claiming that these principles are logically consistent with all worldviews looks implausible. If the principles are very general, they fail to guide action. Secular reasoning is not enough to imbue general principles with action-guiding power either. Rather, CECs need to invoke substantial philosophical commitments—accounts of personhood, equality, fairness, etc.—to provide guidance for action. But those commitments will not be consistent with all worldviews. This leaves us with a dilemma: The principles in the consensus are either too particular to be logically consistent with all worldviews or they are too general to guide action without introducing further, controversial commitments.

It is unclear which option Malek would seek to defend. The level of generality (or particularity) that Malek attributes to principles in the consensus is unclear, given that she does not mention any examples of principles in the consensus (but instead focuses on what is *not* within the consensus, namely, principles associated with religious perspectives). Additionally, as discussed in the previous section, even if individuals from every religious worldview did use the same terms (e.g., imagine all people agree with the statement "we ought to promote justice"), it does not follow that they are using these terms univocally. The Clarity Problem looms large here.

In light of these concerns, we could adjust Malek's account of "available." Instead of "consistent with," perhaps "available" means something like this: Anyone who brackets their religious worldview and relies entirely upon secular moral reasoning will come to the same conclusions. That is, from the secular perspective, all proper, careful moral inquiry will lead to the same end. Everyone is free to adopt a secular perspective (i.e. to bracket their own religious worldviews). Thus, everyone has access to the same set of moral principles (i.e. principles derived from moral reasoning within the framework of a secular perspective).

The problem with this version of Malek's account is that it renders her claim—that the relevant moral principles are "available" to everyone—entirely trivial. On this reading, every set of moral principles is available to everyone. To access a given set of principles, one need only to adopt a particular framework. Christian principles are available to an atheist, for example, supposing the atheist takes on a Christian perspective. The major problem for Malek is that her argument relies upon the claim that "availability to all" is what *distinguishes* secular moral principles from religiously-based ones (2019, p. 97). But, the present reading collapses that distinction. So, this interpretation will not help Malek defend her thesis.

Now, Malek may object that the secular framework is not just one framework among others. Rather, the secular perspective is just whatever perspective is left over once we bracket all religious worldviews, beliefs, and values. But even if true, this response does not make a difference. It is still true that any set of moral principles is "available" to a given agent (in the relevant sense) if they change their worldview. They might bracket their own religious worldview

to take on another, adopt a religious worldview where previously they had none (i.e. move from a secular perspective to a perspective within the framework of a religious tradition), and so on. Thus, "availability" (in the relevant sense) is not enough to distinguish secular moral principles from religious ones. Trivially, all moral principles are "available" to agents with enough revision to their worldviews.

V. ARGUMENTS FROM CONSISTENCY

The penultimate argument we shall consider here involves "consistency" in CECs' work. As Malek puts it, "Although no two ethics consults will be exactly the same, a uniform set of practices should be used by all consultants that conforms with existing professional standards. This practice is vital to ensure *consistency* and high quality in the 'product' offered by a consultation service" (2019, p. 96, emphasis added). More importantly, she adds, by "eliminating individual religious perspectives from ethical reasoning" we "would reduce variation and make consistency more likely" (2019, p. 96).

In response, we should ask two questions: What is consistency (in this context) and why does it matter? On one hand, we might read consistency as applying to the *substance* of a CECs' work.[26] If all CECs operate consistently with respect to substance, then they apply the same moral principles derived from the same source (i.e. the consensus) in the same way, insofar as is possible. Why does this type of consistency matter? We are told that it "is vital to ensure…high quality in the 'product' offered by a consultation service" (2019, p. 96). But, there is good reason to doubt this claim.

Recall that the primary goal of a CEC's work is in dispute. For Malek, the goal is to "improve the process and outcomes of patients' care by helping to identify, analyze, and resolve ethical problems" (Fletcher and Siegler 1996, p. 125). In section 1, we pointed out a wide range of alternatives. Consistency will be threatened to the extent that there is disagreement over what the goals of a CEC even are. To work towards promoting consistency in CECs' "product" before there is agreement in what we take the goals of a CEC to be would be to put the cart before the horse.

But, suppose everyone does come to an agreement over the primary goals of a CEC's work. In fact, let them be exactly what Malek claims. Malek's main claim is that consistency in substance will result in CECs accomplishing these goals more often (and to a greater degree) than if we allow their religious worldviews to impact their practices. In other words, a one-size-fits-all approach to consulting (rooted entirely in secular morality) will be more effective than alternatives. To show that this is false, we need only argue that alternative approaches—approaches that do allow CECs' own worldviews to play some role in their consultative work—will be just as effective (or better) at accomplishing the relevant goals.

To this end, it is obvious that patients have a wide variety of religious and non-religious worldviews. There is little doubt that ethical analyses and recommendations from a purely secular perspective (i.e. the one-size-fits-all) will sometimes help identify and resolve ethical issues to the patient's satisfaction, but sometimes they will not. Many patients, for example, will be staunchly opposed to the moral principles contained within the consensus, especially when those principles are defended or described in purely secular terms. As such, a one-size-fits-all approach will

[26] This does seem to be the sense in which Malek is talking about consistency. As evidence, she writes, "if variation in the substance (rather than style) among consultants should be minimized, there is little room to accommodate variation in consultation practices based on an individual consultant's religious worldview" (2019, p. 96).

accomplish the CEC's primary goal sometimes, while failing to accomplish it in others. In some cases, this approach may even make things worse for patients.

What might be more effective at accomplishing the CEC's primary goal would be allowing CECs to use a wider range of tools than those afforded to them by secular morality alone.[27] That is, if CECs were well-versed in a variety of different worldviews (religious and non-religious alike), they would be more apt to recognize the important features of patients' diverse worldviews. Familiarity with a variety of perspectives might better enable CECs to identify and resolve ethical issues to the patient's satisfaction.[28] Furthermore, if CECs are given a robust education regarding a variety of viewpoints (and allowed to bring this insight to bear in their cases), then it makes no real difference whether they subscribe to the worldview that is being applied or not. What matters is whether the terms, concepts, etc., of a relevant worldview are being applied at the right time and in the right way, all for the sake of the patient. Assessing these particulars is something that we can leave to the judgment of the CEC herself.

Now, Malek may insist that in cases where a CEC maintains a religious worldview, those influences are not active for every CEC. As such, religious CECs will approach their job with a different set of tools than non-religious CECs. In response, in section 4 we saw that secular moral principles are not available to everyone either. Or, if secular moral principles are available to everyone, then the components of religious worldviews are available to everyone in exactly the same way. So, if Malek wishes to maintain that secular moral principles are available to everyone, she has no reason to deny the claim that diverse sets of ethical concepts, terms, etc., are available to all CECs as well (whether those CECs are religious or not).

In sum, consistency with respect the "product" offered by a consultation service should matter only in terms of how well CECs accomplish their primary goals. That is the proper measure of "quality." If we ignore the disagreement over what a CEC's goals are (and just assume that Malek's view on the matter is universally accepted), then what should be consistent is that CECs are consistently doing their job well: Identifying, analyzing and resolving ethical problems, particularly to the satisfaction of the patient. Malek's one-size-fits-all suggestion (with respect to substance) does not seem to promote this kind of consistency as effectively as available alternatives which make use of a wide range of worldviews (and, in fact, *do* allow the CECs' religious worldview to influence their work in some cases, at least).

VI. ARGUMENTS FROM AUTONOMY

Finally, Malek argues that CECs' religious worldviews cannot influence their analysis or recommendations given that such an influence may undermine patients' autonomy (2019, p. 97). A commitment to autonomy "requires that a patient (or surrogate on his behalf) be empowered to make decisions based on his own worldview without manipulation or undue influence from others" (2019, p. 97). The problem, Malek tells us, for the CEC with a religious worldview is that by allowing "her own religious perspective to shape her ethical analysis or recommendations" the

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[27] Here, we will ignore the problems raised for "principles of secular morality" that we advanced above. Let us just suppose (for the sake of argument) that all secular moral reasoning leads careful thinkers to the same conclusions, as Malek seems to assume.

[28] No doubt, Malek would object that training CECs in this way runs the risk of their misunderstanding or misinterpreting patients' religious beliefs and values. But this is the same argument—involving the Clarity Problem—discussed (and addressed) in section 3 of this essay.

CEC "risks imposing her own beliefs and values on the patient, particularly if the CEC represent[s] those recommendations as deriving from bioethical consensus" (2019, p. 97).[29]

But why think that making recommendations on the basis of the consensus never undermines patients' autonomy (i.e., their power to make decisions based on their own worldviews)? Is it because everyone in the world agrees with principles within (and derived from) the consensus? Obviously not. Malek does seem to suggest that the principles associated with consensus are "available and relevant" to everyone whatsoever. But the discussion in section 4 showed that this claim is problematic. As such, to advance recommendations on the basis of secular morality (or the consensus) poses *just as much* a threat to patient autonomy as does advancing recommendations on the basis of other forms of morality. If the patient, for example, holds to a set of moral principles that conflict with the consensus, to push the consensus view is to threaten the patient's autonomy.[30]

These problems with Malek's arguments from autonomy suggest a common criticism given with regard to the idea that clinical ethicists retain an expertise in what the right thing to do is. Indeed, we earlier commented that Malek retains a clear position in the ethics expertise debate. In the interest of space, we point to two major camps within this debate: (a) Those, who like Malek, understand CECs ideally to fulfill the role of ethics experts, people who retain a set of ethical insights that allows them authoritatively to recommend clinical courses of action and (b) those who disagree, arguing that CECs are not ethical experts, but may retain competencies in other areas.

We follow Ana Iltis and Mark Sheehan in arguing that two things are required to delineate who is an expert. What matters is that there is some defined domain or knowledge of skills that constitutes the content of the expertise and that there is some standard by which to judge experts versus non-experts.[31] According to Malek and proponents of the CEC as ethics expert view, CECs retain both a domain and knowledge of skills that constitutes the content of their expertise and a standard by which to judge experts and non-experts. Specifically, for Malek, this domain concerns competency with a secular bioethical consensus, apparently found in the relevant literature, as well as a competency in medico-legal policy. The standard by which we judge expert from non-expert presumably concerns the CEC's command over this literature and ability consistently to prescribe recommendations that fulfill the goal of uniformity with the profession. The major similarity

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[29] The American Bioethics and Humanities Core Competencies Task force agrees with Malek insofar as they write that "Ethics consultants need to be sensitive to their personal moral values and should take care not to impose their won values on other parties" (2011, p. 9). However, contra Malek, who recommends eliminating personal ethical and religious commitments from the consultation in most cases, the Task Force recommends that CEC's be able clearly to "articulate their own views and develop self-awareness regarding how their views affect consultation" (p. 9). This approach differs substantially from Malek's. It is an entirely different thing for a clinical ethicist to be clear about their own moral or religious stance and then make recommendations versus being forced to make recommendations based strictly on an industry-standard.

[30] As one reviewer reminded us, a good example is the Orthodox Jewish rejection of brain death. Consider an Orthodox Jewish man who is pronounced dead according to brain death criteria. His wife, also devoutly Orthodox, rejects brain death for religious reasons. The family decides to pursue treatment to sustain the biological function of the body despite their secular CEC's recommendation to terminate said support. On Malek's view, the CEC has undermined the Orthodox family's autonomy by imposing his view death on the Orthodox Jewish family.

[31] Specifically, Iltis and Sheehan write, "… the possibility of there being experts in any domain rests on there being a standard according to which we judge individuals to distinguish experts from nonexperts" (Iltis and Sheehan 2016, p. 418).

between views like Malek's concerns the authority and expertise that ethics experts, be that moral philosophers or secular bioethicists, retain as a result of their skills: their competencies give them an authoritative view into a certain view of what counts as canonical morality.

There are problems that we have already hinted at with this view, however. For example, Iltis and Sheehan argue that describing clinical ethicists as experts in what ought to be done brings the discipline in conflict with meta-ethics. Entrenched meta-ethical disputes pose major problems in the search for those who authoritatively know what ought to be done (as we argued in the sections 3 and 4). For one thing, this is because it is not easy to specify the domain of knowledge or ability because "in meta-ethics both the nature of ethics and the existence of standards in ethics are contested" (Iltis and Sheehan 2016, p. 421). The lack of agreement concerning which account of morality should reign marks dubious claims of expert insight into one specific understanding of what morality prescribes.

Furthermore, it is not clear that if we found an ethics expert, they would automatically deserve the authority to tell us what to do concerning our medical decisions. Usually, we think of experts as possessing some kind of authority behind their recommendations. As Iltis and Sheehan bluntly put it, "Giving such authority to others over our ethical decisions can be distressing….[and] seems to undermine our moral status" (Iltis and Sheehan 2016, p. 421). That is, there are questions concerning the need for an expert in ethics altogether if one is persuaded by the idea that patients are in the best epistemic position to know what they ought to do given that they are immersed in the relevant context, a tension demonstrated by the problems cited with Malek's autonomy argument. There are further epistemological worries given the context-dependence of ethical issues. The context of the patient at the center of medical-ethical decisions is of great importance to the decision that must be made. An ethics expert in clinical situations would need to have direct access to that context in order to qualify as an ethics expert. It might be the case that "someone outside of the context may be able to provide useful or helpful suggestions, but the decision about what ought to be done would rest with those in the context, and any standard or comparison would be limited in that respect" (Iltis and Sheehan 2016, p. 422). Furthermore, if we appreciate medical-ethical decision making as deeply personal, then it is hard rationally to imagine a canonical standard by which to judge experts from non-experts. That is, it would be difficult to conceive of a standard by which a class of experts would be said to be more knowledgeable or skillful in understanding the personal ethical decisions of patients.

Note that these worries do not preclude the CEC from retaining an expertise in conflict adjudication or the important skill of being able to explain the moral complexity of a given situation. These worries only suggest that CECs should not be categorized as ethics experts because it is not at all clear that CECs are better suited than anyone else at knowing what to do. CECs might, however, be very well suited at knowing how best to mitigate a conflict between clinician and patient.

VII. A BETTER WAY AND CONCLUSION

One approach that is friendlier to a pluralistic discipline like clinical ethics (friendlier than Malek's strict consensus view, that is) is found in Engelhardt (2017). Engelhardt argues that clinical ethicists retain the particular expertise of acting as 'quasi-lawyer' and conflict-resolution specialists, persons whose main job is to ameliorate tense legal situations and help patients understand the conceptual geography of their particular ethical case. Within this understanding of their expertise, ethicists are free to advance recommendations motivated by a plurality of

background beliefs as long as they retain their competence in dispute resolution and medical law.[32] In the American context, this does not mean that CECs merely interpret the state law because the United States does not set the norms of the medical profession by law. Rather, "American medical ethicists….can at best lay out disparate codes for the practice of medicine and particular specialties, as well as how they constrain members of particular associations of physicians (Engelhardt 2017, p. 284). Further, clinical ethicists can function successfully by identifying and characterizing "grey zones and then make suggestions about how to act with the least moral (read legal and public policy) risk" (Engelhardt 2017, p. 285). Indeed, Iltis and Sheehan make a similar recommendation when they characterize the competencies of the clinical ethicist as laying primarily in conflict resolution, noting that

> Again, here we see these skills and abilities instantiated to varying degrees among the types of expertise associated today with the CEC. But that is because they are relevant and useful to the task at hand-resolving conflicts, advising about reasoning, outlining regulation, etc.- not because they are the elements of ethics expertise (Iltis and Sheehan 2016, p. 430).

It is key to categorize the expertise of the clinical ethicist as one of conflict resolution and quasi-lawyer, where knowing what the right thing is to do or the content of morality is not necessarily required to avoid the inherent difficulties associated with identifying who the ethical expert is.

Furthermore, the development of competing codes of medical professionalism and medical ethics as opposed to falsely claiming that there exists one bioethical consensus allows more honesty about the nature of the bioethical project. Competing ethical codes will advance conflicting claims about what is permissible and impermissible for clinicians and patients to do. As Engelhardt writes,

> The result of [the recasting of the clinical ethicist as quasi-lawyer] is that there is not just an American bioethics and a European clinical bioethics, but also a German clinical bioethics, an Italian clinical bioethics, a Chinese clinical bioethics, a Japanese clinical bioethics, a Texan clinical bioethics, and a Californian clinical bioethics…(2017, p. 285).

Our suggestion is that religious CEC's should recognize the political potential of advancing their clinical policy recommendations similarly. Here, the Catholic, Jew, Muslim, or Orthodox Christian clinical ethicist may work, for example, as legal advocate for policy adaptations in their specific clinical context that allow for the freedom of patients and doctors alike to object to participating in (what they take to be) offensive clinical practices. Working to advance religiously friendly policy recommendations while at the same time remaining skilled in the ability to adjudicate uncertainties and recognize legal and policy risk to the hospital is consistent with remaining a professionally adept clinical ethicist when the role of a CEC is understood as a quasi-lawyer and not as an ethical expert.

Finally, we mention that the quasi-lawyer view of clinical ethics creates a certifiable competency through which potential CECs can be vetted as properly trained or not. One is certifiably competent as a CEC when they know the relevant public policy and law pertaining to clinical issues on this view.[33] Given the importance of certification in the literature (Kodish, et al. 2013), we see this as a boon for the view. But, setting these suggestions to the side, we have

[32] Engelhardt writes "clinical experts are not experts as to which professional norms or ethics should be followed apart from that which is established at law and in public policy" (Engelhardt 2017, p. 284).

[33] We thank an anonymous reviewer for pointing out the importance of the certification debate.

demonstrated that Janet Malek (2019) has failed to provide a compelling argument for her thesis that a CEC's religious worldview should never influence her ethical analysis or development of a recommendation. Of course, doing so does not establish that CECs' religious worldviews should play an important role in their work (though we have outlined some ways in which they might). Either way, if Malek (and those who agree with her) wish to defend the importance of a divorce between religiously-based ideas and values and the work of CECs everywhere, their work is cut out for them.

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