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Empirical ethics and the special status of the practitioner's judgements

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Introduction

"Empirical ethics is a broad category, grasping different interpretations of combining or trying to integrate ethics and empirical research. … Although there are various ways of combining empirical research and ethical reflection (and of doing empirical ethics), they all have some basic assumptions in common: firstly, empirical ethics states that the study of people's actual beliefs, intuitions, behaviour and reasoning yields information that is meaningful for ethics *and should be the starting point of ethics* (italics awm)[…][1]."

This is a quotation from Pascal Borry, Paul Schotsman and Chris Dierickx' editorial to a special issue on empirical ethics of the journal *Medicine, Health Care and Philosophy* (Borry, Schotsman & Dierickx 2004). I can agree with their general description of empirical ethics and also with the first basic assumption, except for the sentence in italics. In a previous publication (Musschenga 2005) I distinguished two approaches in empirical ethics. Both aim to strengthen the context-sensitivity of ethics. The first approach is meta-ethically neutral, the second approach starts from the assumption that promoting the context-sensitivity of ethics requires the acceptance

[1] The other basic assumptions are: "secondly, empirical ethics acknowledges that the methodology of the social sciences (with quantitative and qualitative methods such as case studies, surveys, experiments, interviews, and participatory observation) is a way (and probably the best way) to map this reality; thirdly, empirical ethics states that the crucial distinction between descriptive and prescriptive ethics should be more flexible. Empirical ethics denies the structural incompatibility of empirical and normative approaches, and believes in their fundamental complementarity; fourthly, empirical ethics is a heuristic term which argues for an integration of empirical methodology or empirical research evidence in the process of ethical reflection … ; finally, empirical ethics cannot considered to be an anti-theorist approach, in which the context would dictate what is morally good or evil, because then it would cease to be ethics" (Borry, Schotsman & Dierickx 1004, p.1).

of a broad contextualist type of ethical theory.[2] It is the broad contextualist approach that finds that in practicing empirical ethics one has to start from the opinions and the conduct of those involved in a social practice. Since it is the task of sociology or anthropology to chart the opinions and the conduct of a group or community, empirical ethics[3] cannot do without them. In this approach the relation between empirical ethics and the social sciences is an intrinsic one. For medical ethics this approach implies that the starting point should be an examination of the beliefs and conduct of health professionals such as doctors and nurses.[1] Borry, Schotsman and Dierickx do not, at least not explicitly, say that ethics should start from the beliefs, intuitions, and conduct of *practitioners*. Ghislaine van Thiel and Hans van Delden are more explicit in stating that especially the intuitions of morally experienced people – people who 'work and live in a certain practice' – should be incorporated into a reflective equilibrium model of moral reasoning because they usually possess specific moral wisdom (Van Thiel & Van Delden 2009, p. **xx**.).[4] Neither Borry, Schotsman and Dierickx nor Van Thiel and Van Delden want to take the opinions and conduct of health professionals for granted, they want to take them seriously. For them Assigning these data a special status is a characteristic of empirical ethics.

If we want to map the professional morality of health professionals, it is obvious that we observe and interview members of the relevant professions. But the proponents of empirical medical ethics do not restrict themselves to the description of opinions and conduct of health professionals. They conceive empirical ethics as a special kind of normative ethics. Empirical medical ethics aims to be normatively valid not only for health professionals, but for all stakeholders in the medical enterprise, thus also for patients and the general public. The question whether they are justified in assigning a special status to the moral beliefs of health professionals still remains unanswered. In the next sections I discuss two possible defences of this

[2] The term 'broad contextualism' covers both Marc Timmons' normative and epistemic contextualism and coherentism. *Normative* contextualism holds that knowledge and justification are relative to the epistemic standards of one's group or community. It is analogous to ethical relativism, a normative ethical theory that relativises moral truth to the moral standards of a group. *Epistemic* contextualism is a thesis about the structure of justification intended as a response to the regress-of-justification problem. Epistemic contextualism argues that the regress of justification ends with beliefs that, in a context, are not in need of justification (Timmons, 1999, 182ff). These theories share a positive regard of people's actual beliefs and reasoning practices. (See also Musschenga 2005)

[3] Unless stated otherwise, I use the term 'empirical ethics' in the rest of this article to refer to broad contextualist empirical ethics.

[4] A similar position is taken by the contextualist political philosopher Joseph Carens who says that existing practices contain embedded wisdom that is absent in prevailing theories (Carens 2004, p. 121).

special status. The first defence is based on the special status of the moral beliefs health professional as an expert in medical ethics, and the second defence on the special status of the health professional's moral beliefs as a practitioner. The distinction between these two defences may seem artificial because practitioners are generally also seen as experts. Indeed, the same types of argument are used in both defences. The difference is that the first defence is build up around the opposition between experts and laypersons, while the second defence rests on the opposition between practitioners and experts.

The health professional as an expert in medical ethics

Assume that you have an advanced stage of lung cancer. Your oncologist says that you meet all the inclusion criteria for an experimental study of a new combination of drugs and invites you to participate in this study. He provides you with a patient information sheet that contains, he says, all the information you need about the risks and benefits of participation in the trial. Since your oncologist is the principal investigator of this study, you also want the advice of a more impartial doctor, your general practitioner. Suppose your best friend asks why you go to your general practitioner and not to, say, your neighbour who is equally impartial. I guess you would be highly amazed by such a stupid question. Your general practitioner knows the ins and outs of medical experiments and may be expected not only to understand the information sheet, but also to be able to read between the lines. Consulting your general practitioner is the obvious thing to do. However, is it also obvious to consult your general practitioner or another doctor on morally controversial questions?

'Doctors' Moral Views Influence Their Advice to Patients,' is the heading of an article in the *Washington Post* of February 7, 2007. The first sentence of the article reads: "Your physician's moral outlook may play a larger role in your medical care than you realize, according to the first-ever survey of doctors' views on controversial procedures." These procedures included administering terminal sedation for dying patients, providing abortion for failed contraception and prescribing birth control to adolescents without parental approval. The article is based on the publication of the results of a survey in *The New England Journal of Medicine.* In their conclusion the researchers state that many physicians, especially religious ones, do not consider themselves obligated to disclose information about - or refer patients for legal, but morally controversial, medical procedures. Patients who want information may need

to inquire it proactively to determine whether their physicians would accommodate such requests (Curlin, Lawrence, Chin et al. 2007, p. 593). The appropriate answer to the question on consulting one's general practitioner in morally controversial issues seems to be that it is *not* obvious to consult your general practitioner on, say, administering terminal sedation to your dying grandfather, if this doctor does not share your moral views. Of course, asking moral advice is not the same as doing empirical ethics, but this answer does raise questions on the justification of the assumption of contextual empirical ethics that the moral judgements of practitioners should have a special status. However, assuming that I have good reasons to ask my general practitioner for advice on my participation in the medical trial, why don't these reasons also apply to seeking advice in the case of administering terminal sedation to my grandfather? The simple answer is that my general practitioner is a medical, but not a moral expert. Of course, my general practitioner is not a moral expert in, say, marriage ethics or economic ethics, but it is not evident that he cannot be considered as an expert in medical ethics. Note my formulation above: I said that it is not obvious to consult your general practitioner *if he doesn't share your moral views*. Suppose that you are rather critical of the paradigm of the established medical science. If you needed medical advice, you would probably prefer to go to a doctor who shares your views. Even if I don't share the 'moral paradigm' of my general practitioner, I may still consider him as an expert in a certain tradition of medical ethics.

What does it mean to be an expert? The most general definition of an expert is: Someone who performs outstandingly in a certain domain for a collection of standardised tasks. According to Darcia Narvaez, experts and novices differ from one another in three basic ways (Narvaez 2006). First, experts in a particular domain have more and better organized knowledge than novices. However, the skills and knowledge that experts have are specific and context-bound and have little application to other domains (Chi, Glaser, & Farr 1988; Sternberg 1998). Expert knowledge interacts in performance in different ways, for example, declarative (what), procedural (how), conditional (when and how much). Second, experts perceive and react to the world differently, noticing details and opportunities that novices miss. Third, experts behave differently. Where novices use conscious, effortful methods to solve problems, expert skills are highly automatic and effortless (Ericsson & Charness 1994).

Most people are definitely not medical experts. In the domain of morality it is not so easy to make a distinction between experts and laymen. According to Hubert and Stuart Dreyfus (1991), all people who have had a normal moral education, are moral experts. Thus, all ordinary, morally competent person are moral experts. If we want to prove that health professionals not only have medical expertise, but also expertise in medical ethics, we must be able to show that there are specialised tasks in medical ethics in which they perform better, not better than moral laymen, but better than non-specialised, general moral experts.

Do health professionals have specialised moral expertise?

For the moment, I will concentrate on the skills that moral experts are supposed to have. The Dreyfus brothers explicate moral competence in terms of the mastery of skills, but they don't specify what kinds of skill morally competent people possess. Based on a follow up of James Rest's (1983) review of social development research, Narvaez has identified the characteristic skills of persons with good character (Narvaez & Lapsey 2005). These skills extend Rest's four psychologically distinct processes (ethical sensitivity, ethical judgement, ethical motivation, and ethical action) by outlining a set of social, personal, and citizenship skills. This four process model provides a holistic understanding of the moral person, who is able to demonstrate keen perception and perspective taking, skilled reasoning, moral motivational orientations, and skills for completing moral action. Experts in the skills of Ethical Sensitivity, for example, are able to more quickly and accurately 'read' a situation and determine what role they might play. These experts are also better at generating usable solutions due to a greater understanding of the consequences of possible actions. Experts in the skills of Ethical Judgement are more adept at solving complex problems, seeing the crux of a problem quickly, and bringing with them many schemas for reasoning about what to do. Their information processing tools are more complex but also more efficient. Experts in the skills of Ethical Motivation are capable of maintaining their focus on prioritising the ethical ideal. Their motivation is directed by an organised structure of moral self-identity. Experts in the skills of Ethical Action are able to keep themselves focused and take the necessary steps to get the ethical job done. They demonstrate superior performance when completing an ethical action. Narvaez and Lapsey specified skills and subskills for each of the four processes in a table that is added as an appendix to this article.

As my main interested of this article is in the moral beliefs and judgements of health professionals, I will concentrate on the Skills of Ethical Sensitivity and those of Ethical Judgement. Let's assume that the majority of people, and therefore the majority of health professionals, do possess these skills. In what respects might the moral skills of health professionals be superior to those of ordinary moral persons – the general moral experts? If there is such a thing as special expertise in medical ethics, this expertise must be acquired by a process of training and practice. I don't think that we may assume that the acquisition of this expertise comes along automatically with the development of more 'technical' professional skills. Generally

spoken, health professionals will possess a specific competence for dealing with medical ethical issues, if they did not receive a specific training for it Fortunately, there are also medical ethical autodidacts – health professionals whose moral sensitivity has driven them to further develop and refine their general moral skills for the domain of their professional expertise. Nowadays, there is a sufficient supply of courses and trainings in medical ethics from which health professionals may choose if they want to enlarge their expertise in medical ethics.

As we have seen, (broad contextualist) empirical ethicists such as Van Thiel and Van Delden are interested in charting the moral intuitions – the fast and automatic moral judgements – of health professionals because they assume that people who live and work in a certain practice, possess moral experience and moral wisdom. My conclusion from the argument above is that this assumption is false. We cannot conclude that health professionals have moral wisdom in medical ethical issues from the fact that they work and live in a specific domain, even if their professional expertise is beyond all doubt. Only some of them are moral exemplars in medical ethics. If empirical ethicists want to examine the moral intuitions of people who have specific moral wisdom in a medical domain, they cannot just chart the intuitions of all the health professionals working in that domain, they need to limit themselves to the intuitions of the moral exemplars among them.

The health professional as a moral practitioner

As I said before, some adherents regard empirical ethics as a critique of, and alternative for, theory-driven normative ethics. The opposition they start from is that between practitioners and theorists. While the health professionals are the practitioners, the professional ethicists – theologians or philosophers – are the theorists. In this section, I discuss the concept of medicine as a practice. In the next section, I will go into the critique of the role of 'theory' in ethics.

These empirical ethicists derive their concept of practice from Alasdair MacIntyre (1981). MacIntyre, and other moral philosophers from the Wittgensteinian tradition, think that a society's morality is not a general, overarching and coherent system of beliefs, but an interlocking whole of moralities embedded in particular practices. MacIntyre defines practice as a "coherent and complex form of socially established cooperative human activity" (1981, p. 187). A practice is an activity in which certain 'internal goods' are realised. Internal goods embody the most essential

qualitative ingredients of practices. They have to be distinguished from external consequences which are contingently attached to the activity. These goods are internal for different reasons (MacIntyre 1981, p. 176; Scheers 2005, pp. 154f.). First, the internal goods can only be fully identified and recognised by competent practitioners. Second, an internal good can only be articulated and defined in terms of a practice and by means of examples from such or similar practices. Third, an internal good can only be experienced and achieved within a particular practice. The internal goods of chess for example are analytic skills, strategic imagination and a competitive intensity unique to chess, while an external consequence is money awarded for winning a chess tournament. The realisation of these goods occurs, according to MacIntyre, as one seeks to achieve standards of excellence appropriate to the activity. Participation in a practice facilitates the expansion of human powers to achieve excellence and broadens our understanding of human goods and ends. Virtues, as a supporting structural element of practices, are 'acquired human qualities the possession and exercise of which enables the goods internal to practices' (MacIntyre 1981, p. 178). The assumption of this model is that, in order to function fully and successfully in any of the practices, one must develop certain character qualities or virtues. These virtues have to be distinguished from technical professional skills.

Influenced by MacIntyre, David Thomasma and Edmund Pellegrino developed a virtue-based medical ethics. For them, medicine as a form of human activity implies a reliance on *internal goods and standards of excellence*. These are 'moral imperatives' that constitute an "internal morality of medicine – something built into the nature of medicine as a particular kind of human activity" (Thomasma & Pellegrino 1993, p. 42).[5] The internal morality of medicine must be distinguished from its external morality. Henk ten Have and Annique Lelie define 'external morality' as "values, norms and rules prevailing in social, cultural and religious traditions that function as external determinants of medicine" (Ten Have & Lelie 1998, p. 268).[6]

[5] Pellegrino and Thomasma formulate five moral imperatives that characterise the specific human relationship in medicine. They are 1) the inequality of the medical relationship, 2) the fiduciary nature of the relationship, 3) the moral nature of medical decisions, 4) the nature of medical knowledge, and 5) the ineradicable moral complicity of the physician in whatever happens to the patients (1993, p. 420).

[6] John Arras (2001, p. 645) identifies different versions of 'internalism' in medicine in the literature: 1) 'Essentialism', according to which a morality for medicine is derived from reflection on its 'proper' nature, goals, and ends. This is the view of Pellegrino and Thomasma. 2) 'The practical precondition

According to MacIntyre, internal goods can only be fully identified and recognised by competent practitioners. A similar view with respect to the concept of an internal morality of medicine is taken by many adherents (at least by the adherents of the 'historical professionalism' account, and probably also by those of the 'practical condition account'– see note 7). If this view is correct, empirical ethicists are right in saying that they have to turn to health professionals for investigating the (internal) morality of medicine. I doubt that MacIntyre's view that internal goods can only be fully identified and recognised by competent practitioners, also applies to the internal morality of medicine. This morality not only comprehends internal goods – values, goals and ends – but also virtues and deontic elements such as norms and rules. While MacIntyre makes a distinction between internal goods and the virtues that are required to sustain a practice and to function successfully within a practice, the concept of internal morality seems to cover both internal goods of medicine and virtues of health professionals.

MacIntyre's thesis is an epistemological one. I can understand that I, not being a composer, am unable to identify and recognise the internal goods of composing. There is no practice similar to composing that I am familiar with. Although I am not a health practitioner, I am acquainted with other caring practices. Therefore, I don't think that I am completely unable to identify and recognise the internal goods of medicine. Moreover, the fact that the concept of medicine's internal morality also covers the norms and values for the relationship between doctors and patients, makes it even more doubtful that MacIntyre's epistemological thesis still applies to this concept. . Brody and Miller find that the goals of medicine are not static, of necessity they evolve along with human history and culture. New goals of medicine or internal duties of physicians may be seen as properly within the scope of medicine and traditional goals or duties may become subject to re-interpretation (Brody & Miller 2001, pp. 585ff.). Brody and Miller's view seems historically correct. The ongoing discussion about the goals of medicine and the duties of physicians (and other health professionals) has never only been the business of the professionals. The history of

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account', according to which certain moral precepts are derived as preconditions of the practice of medicine, 3) 'Historical professionalism', according to which the norms governing medicine are decided upon solely by the practitioners of medicine – an ethic about physicians, by physicians, and for physicians. 4) An 'evolutionary perspective', according to which professional norms in medicine evolve over time in creative tension with external standards of morality – a view defended by Brody & Miller (2001).

medical ethics proves that changes in the internal morality of medicine can be induced by outside influences (Beauchamp 2001, p. 606). Robert Zussman rightly remarks that the present medical ethics emerged from a set of values and concerns, such as self-determination, which are historically alien to medical traditions (Zussman 1992).

All in all, the practice view of morality doesn't provide strong arguments for the view of empirical ethicists that the moral beliefs and intuitions of health professionals should get special weight in formulating medical ethics.

Empirical ethics, anti-theory, and principlism

Some adherents regard empirical ethics as an alternative for theory-driven normative ethics. What are their objections against ethical theory and ethical theorising?

Many ethicists, both in the Kantian as in the utilitarian tradition, aim at formulating an overarching theory as a source of universal principles binding all rational beings. They regard these principles as superior to the customs, conventions, and rules of particular, local moral traditions. In their view critical moral reasoning consists of the subsumption of cases under these universal principles. The subsumption model characteristically takes the form of deductivism. Proper reasoning thus conceived proceeds by valid deductive arguments, that is, arguments that logically transfer truth from the premises to the conclusion – provided, of course, that the premises are true. In the last two decades, resistance against this type of ethical theorising and the allied subsumptive model of moral reasoning has evolved to a movement known as 'anti-theory'. Commonalities and differences among participants in this movement are well-documented in *Anti-Theory in Ethics and Moral Conservatism*, edited by Stanley G. Clarke and Evan Simpson (1989). In their introduction, the editors state that anti-theorists reject normative (ethical) theory as unnecessary, undesirable, or impossible, and usually for all three reasons (1989, p. 3). *Unnecessary,* because moral reasoning can do without foundational moral principles. *Undesirable,* because moral reasoning that consists of the application of abstract universal principles cannot do justice to the particularities, the uniqueness of a situation. Besides that, the idea of the application of principles reduces the moral actor

to a blind executioner of manual-like prescriptions. *Impossible*, because no philosopher has been able to formulate an ethical theory that convinces everybody.[7]

Ant-theorists oppose not only the search for universal, foundational principles, but also the subsumption model of moral reasoning. According to them, the subsumption model with its emphasis on principles, abstracts not only from the particulars of a situation, but also from the qualities which a person needs for wise decisions. They insist that, in moral judging, only persons endowed with the wisdom of 'experience and fine-tuned perception' can properly attend to unique features of particular situations (Nussbaum 1990). Thus understood, a moral judgement is the perception of the right and proper thing to do rather than a conclusion reached by the application of a principle.

What are the consequences of the anti-theoretical stance for the role of ethicists? In the view of anti-theorists, ethicists' knowledge of 'ethical theories' does not make them into moral experts who have skills superior to those of ordinary practitioners. On the contrary, ethical theorists who engage in medical ethics, are in danger of becoming blind executioners of their own invented medical ethical principles. Anti-theorists tend to view principles as mere 'rules of thumb' for the inexperienced. Wise and experienced persons allegedly do not need principles to determine what is right in concrete situations. Here we observe a convergence between the adherents of the skill model of ethics who start from the opposition between experts and laypeople, and the adherents of the practice view of morality. According to the Dreyfus brothers, moral principles are aids for the inexperienced, for

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[7] Robert Louden characterises the anti-theorists by identifying the aims and assumptions they associate with ethical theory and ethical theorists (Louden 1992 p. 8f).

1. All correct moral judgments and practices are deducible from universal, timeless principles, to articulate which it is theory's job.
2. All moral values are commensurable; that is, they can be compared with one another on a common scale of measurement. Theory's task is to construct the requisite scale and then to show which value wins in each particular value conflict and why it wins.
3. All moral disagreements and conflicts are rationally resolvable. There is one right answer to every moral problem, which it is theory's job to find.
4. The correct method for reaching the one right answer involves a computational decision procedure. It is the task of moral theory to provide such a mechanism.
5. Moral theory has no descriptive or explanatory role to play in human life but presumes instead to be able to tell people what to do and how to live. Moral theory is entirely normative.
6. Moral problems are solved best by moral experts, that is, by people who know what rules to apply to the case at hand and who have been trained successfully in formal academic settings in deducing right answers by means of rules.

The anti-theorists' objections to ethical theory are also identified and discussed by Martha Nussbaum (2000, pp. 242-248).

those who still need instruction. On the highest stage in the model of expertise acquisition, the expert leaves rules and principles behind and develops more and more refined ethical responses (Dreyfus and Dreyfus 1991, p. 237).

More recently, the role of anti-theorists as critics of ethical theories as systems of principles has been taken over by the particularists. The counterpart of particularists are not called theorists, but generalists. Particularists and generalists disagree about the extent to which morality can and should be understood in terms of moral principles. The views of particularists are epistemologically much more sophisticated than those of anti-theorists. Sean McKeever and Mike Ridge distinguish five versions or characterisations of particularism (2006, pp. 14-20). The first three focus on whether and to what extent morality can be codified, the last two emphasise the more practical question of whether everyday moral thought and decision-making should involve moral principles. The first three are: 1) *Principle Eliminativism*: There are no true moral principles.[8] A weaker version is 2) *Principle Scepticism Particularism*: There is no good reason to think that there are any true moral principles, 3) *Principled Particularism*: Any finite set of moral principles will be insufficient to capture all moral truths.[9] The last two are: 4) *Principle Abstinence Particularism*: We ought not rely upon moral principles (because they are useless or a hindrance)[10] and 5) *Anti-Transcendental Particularism*: The possibility of moral thought and judgement does not depend on the provision of a suitable supply of moral principles.[11] This is a thesis about what is presupposed by our ability to make moral judgements successfully or correctly, where this includes the ability to have moral knowledge. Anti-Transcendental Particularism is, according to McKeever and Ridge, a much weaker thesis than Principle Eliminativism and Principle Scepticism Particularism. For, the mere fact that moral thought and moral judgement do not presuppose the availability of a suitable stock of moral principles does not imply that such a stock is unavailable, nor does it imply that articulating such principles would be undesirable from both a practical and a theoretical point of view (2006, p. 40).

Particularists and anti-theorists have many commonalities. Anti-theorists think that theorists' ideal of moral argumentation in practical issues consists of applying a

[8] According to McKeever and Ridge, John McDowell (1985) and Margaret Little (2000) endorse Principle Eliminativism.
[9] Endorsed by Richard Holton (2003).
[10] The most prominent representative of this position is David McNaughton (1988).
[11] This position is taken by Jonathan Dancy (1993, 2004), to whom particularism owes its recent popularity.

computational decision procedure. That may be an ideal for decision theorists, but this ideal is not generally shared among defenders of ethical theorising. Particularists, in general, don't worry about this ideal. They are more worried about the idea that morality is codifiable and about the belief that principles are indispensable as action guides for moral judgements and decisions. More than the former one, anti-theorists share the latter concern with the particularists.

Assuming that principles are indeed dispensable for moral judging and deciding, what are the consequences for empirical ethics? Recall that empirical ethics is not just a new name for descriptive ethics. Empirical ethics aims to result in a better form of normative ethics. According to Borry, Schotsman and Dierickx, empirical ethics argues for an integration of empirical methodology or empirical data in the process of ethical reflection. Empirical ethics attaches great value to the (intuitive or deliberate) judgements of practitioners. Suppose that empirical ethicists succeed, by analysing these judgements, in identifying what John Kekes calls the principles that are born out of the practice and those that are born through the midwifery of judgement (Kekes 1989, p. 29). Such a reconstruction of the morality of a practice is useless, if principles are, as particularists argue, dispensable for moral judging and deciding. Such principles may at best be useful for the instruction of novices. If empirical ethicists are convinced that particularism is correct, they need to explain how they think that empirical ethics can substantiate its claim of also being prescriptive.

Empirical ethicists tend to sympathise with particularists because both attach great value to contextuality. However, there are no conclusive reasons for empirical ethics to embrace particularism. In my view, particularism is wrong. Considering the number of publications on the subject of particularism–generalism it is impossible to do justice to all the arguments that are presented by both sides. The arguments I give are mainly derived from McKeever and Ridge's excellent defence of principled ethics (2006).

Particularists derive their main argument against principled morality from the doctrine of holism about reasons. This doctrine holds that a feature that is a reason in one case may not be a reason at all, or an opposite reason, in another case (Dancy 1993, p. 60). The fact that a patient suffers unbearably may be a reason to end his life when he will die anyway because of the illness he has, but not when he has only broken his leg. According to particularists, the role of a reason is not invariant, but

context-dependent. They think that this form of context-dependence is not compatible with the idea of morality being based on principles. McKeever and Ridge argue that particularists do not have a monopoly on holism about reasons. Holism is compatible with the generalist view that morality can and should be codified. Assuming that reasons are context-dependent, it may still be possible that context-dependence is codifiable (2006, p. 28f.). McKeever and Ridge refer to the fact that some principle-based ethical theories are indeed particularist. In classical utilitarianism, the fact that an action promotes pleasure is not always an argument in favour of that action. That depends on the context – in particular on whether the pleasure is sadistic (2006, p. 29). In theory of Kant – an unsuspected proponent of the codifiability of morality – the fact that an action contributes to someone's happiness, is only a reason for doing it if that person has a good will (if he is *glückswürdig*) (2006, p. 31f.). McKeever and Ridge conclude that holism about reasons provides no positive support for particularism. They don't deny that there are interesting connections between holism and particularism, but suggest that the support runs in the other direction: from particularism to holism (2006, p. 43).

As we have seen, McKeever and Ridge distinguish five versions of particularism: the first three focus on whether and to what extent morality can be codified and the last two emphasise the more practical question of whether everyday moral thought and decision-making should involve moral principles. Authors such as McDowell and McNaughton stress that moral judgements seem not to involve the application of a principle, the agent seems to perceive the morally salient features of a case immediately and judge accordingly. McNaughton even regards principles as inimical to the development of a sound outlook (McNaughton1988) For many particularists, particularism and the perceptual model form a package deal. Here we observe an important continuity between particularists and their predecessors, the anti-theorists. McKeever and Ridge rightly remark that the perceptual model has some plausibility for cases in which moral judgement is rather uncontroversial, but not for cases involving controversy and complexity. The perceptual model needs at least to be supplemented.

Social psychologists such as Jonathan Haidt argue that most of our moral judgements are intuitive, that is, they result from the intuitive process which regulates everyday moral judgements in a rapid, easy and holistic way. He defines moral intuition as:

> the sudden appearance in consciousness of a moral judgment, including an affective valence (good–bad, like–dislike), without any awareness of having gone through steps of searching, weighing evidence, or inferring a moral conclusion. Moral intuition is therefore the psychological process that the Scottish philosophers talked about, a process akin to aesthetic judgment. One sees or hears about an event and one instantly feels approval or disapproval. (Haidt 2001, p. 818)

Intuitive judgements are non-inferential, while deliberate judgements are non-inferential. Haidt's definition suggests that intuitive judgements are perceptual. The Dreyfuses think that the intuitive character of their judgements is what distinguishes the judgements of experts from those of laypeople. Laypeople – novices – have to reason to a conclusion, while experts see what needs to be done (Dreyfus & Dreyfus 1991, p. 235). Particularists such as McNaughton seem to think perception is the only model that is appropriate for moral judging. So do the Dreyfuses. Contrary to them, Haidt does not seem to suggest that deliberate judgements are inferior to intuitive ones. I don't want to go into the relation between moral intuiting and moral reasoning. All I want to say now is that we may recognise that perception has a role in moral judging without denying that some moral judgements are deliberate, or even that all moral judgements should be deliberate.

The conviction that judgements are fine-tuned perceptions does not force one to reject principled ethics. A judgement, attained by perception or any other means, can always be logically reconstructed as a conclusion of an argument with a principle among the premises. Moreover, even wise and experienced persons still need principles to guide their actions and to justify their decisions, 'to navigate among descriptions of situations' (O'Neill 1987, p. 64). These need not be the principles searched for by radical generalists. Instead, we may agree with John Kekes that principles are "born out of the practice they subsequently guide, and are born through the midwifery of judgement" (Kekes 1989, p. 129). This is not to deny that principles require interpretations that fit concrete situations. As Onora O'Neill states: "Principles and rules must be indeterminate, so cannot specify all the boundary conditions or all the details of their own application in varying contexts. We cannot deduce their applications" (O'Neill 1987, p. xx). We need principles to guide – not to determine – our judgements and decisions, we need them in moral discussions. Without principles, it would also be difficult to regulate cooperation with others.

Ethical theory and empirical ethics

We need principles, but do we also need ethical theories? Surprisingly, the question is positively answered by Martha Nussbaum (2000) who in her earlier work (1990) stressed the importance of Aristotelian practical wisdom. She gives the following definition of ethical theory: "[..] a set of reasons and interconnected arguments, explicitly and systematically articulated, with some degree of abstractness and generality, which gives directions for ethical practice" (2000, p. 233f.).[12] She formulates six criteria for ethical theories. Ethical theories 1) give recommendations about practical problems, 2) show how to test the correctness of beliefs, rules and principles, 3) systematise and extend beliefs, 4) have some degree of abstractness and generality, 5) are universalisable, and 6) are explicit (2000, 234ff). An ethical theory is not a system of rules. Nussbaum distinguishes three items: our concrete ethical practice, rules of conduct and ethical theory. Ethical theories formulate the point and purpose of rules, which enables us to determine when the point is better served not by following a rule, but by making an exception to the rule. Unlike systems of rules, ethical theories also give arguments for what they conclude (2000, pp. 236-241).

As ethicists, empirical ethicists should be involved in ethical theorising. All 'applied', 'practical', 'concrete' or 'specific' ethics should be empirical ethics. Empirical ethicists do not theorise about morality in general, but about particular moral practices. Thus, their theories can be expected to have a lower level of abstraction and generality than the grand ethical theories of, for example, Kant or Mill. Moral practices aim at realising values and goals. I agree with Brody and Miller that these values and goals are not static, but subject to an ongoing discussion. Notwithstanding the historicity of these values and goals, there is always a tension between the actual practice and an ideal concept of the practice. Actual practices may be non-ideal because the practitioners' activities do not answer to certain standards of excellence, but also because they are badly structured. Although moral practices are

[12] The role of an ethical theory and criteria for good ethical theories are also discussed by Robert Louden (1992) to whom Nussbaum refers. According to Louden, a good ethical theory should

1. be empirically well-informed, that is, be supported by knowledge of moral psychology, of history, and of the values, practices, and structures of the field at which the theory is directed;
2. do justice to the plurality of values and provide room to irreducibly plural categorial schemes;
3. be able to identify moral conflicts (even unrecognised ones) and to explain why these conflicts occur (Louden 1992, p. xx).

characterised by specific values and goals, they are part of the broader social life of a community or a society. Therefore, practices should be embedded in a broader view of the good society and the good life. As *ethicists*, empirical ethicists should have knowledge of ideals of the good life and the good society, and of the place of a practice within society and the relation between the values and goals of a practice and the good life. As *empirical* ethicists, they should be well-informed about the structure and the culture of a practice, about its processes and procedures and about the wider institutional and cultural context. Empirical ethicists should be engaged, well-informed, and critical outsiders to a practice.

Moral 'expertise' and ethical expertise

In the previous section, I outlined the role and the place of an empirical ethicist, without relating it to what I said before about the moral expertise, the 'moral wisdom' of the professional. Ethicists contribute to the medical practice in different ways. Academic ethicists may comment on the judgements and decisions of professionals in their writings, give them advice or, as members of ethical committees, share responsibility for the judgements and decisions. In a recent, interesting article, Norbert Steinkamp, Bert Gordijn, and Henk ten Have (2008) attempt to do justice both to the practice model of (medical) morality with its distinction between the internal and the external morality of a practice, and to the need for theoretical reflection by professional ethicists. Steinkamp, Gordijn and Ten Have do not specifically deal with empirical ethicists, they speak of professional ethicists in general. They accept the Dreyfus brothers' phenomenological description of the nature of the 'ethical expertise' of ordinary moral persons which they, as I do, prefer to term 'moral competence'. However, they also recognise that professional ethicists have relevant expertise which they term 'ethical expertise'. In their view, ethicists and non-ethicists, may "[…] employ divergent styles of argumentation and that this divergence and the complementarity of styles of argumentation bring out the strength of both sides. The moral competence of non-ethicist professionals does not involve explicit reflection about ethical notions and arguments, but lies in the competence to deal with the moral particulars of a situation that occurs within a particular professional field" (2008, p. 186). They go on saying that ethicists should focus primarily on the analysis of moral questions and moral reasons as well as on the facilitation of deliberation, and not on the determination of what ought to be done.

Non-ethicists should receive the support necessary to verbalise morally relevant aspects of situations in practice, articulate moral quandaries from their professional practice and take responsibility for the decisions that have to be made (2008, p. 186f.).

This is an interesting proposal for a division of labour that aims to make room for the kind of expertise that professional ethicists can offer while respecting the moral competence of practitioners. I assume that their model is only meant for situations in which ethicists act as advisors to professionals. As members of ethical committees or institutional review boards, ethicists share responsibility for the decisions that have to be made. In that case, the relation between medical professionals and ethicists cannot be determined by reflecting on the relation between the moral competence of the professionals and the theoretical expertise of the ethicists. All members of such committees or boards must be assumed to have sufficient moral competence for the tasks that are assigned to them. However, if ethicists act only as advisors, it does make sense to ask how their theoretical expertise relates to the moral expertise of the professionals.

The problem with the model of Steinkamp, Gordijn and Ten Have is that it is doubtful whether recognising the value of ethical expertise is compatible with the Dreyfuses' view on moral competence. According to the Dreyfuses, being an expert means that one has left rules and principles behind and now develops more and more refined ethical responses (Dreyfus and Dreyfus 1991, p. 237). It would be a mistake, the Dreyfuses remark, to think that the expert does not deliberate. They distinguish between *involved* deliberation which occurs when an expert is facing a familiar but problematic situation, and *detached* deliberation when an expert is confronted by a novel situation in which he has no intuition at all. Involved deliberation means that the expert deliberates about the appropriateness of his intuitions. Thus, it is based on intuition (p. 240f). In case of detached deliberation, the expert must, according to the Dreyfuses, resort to abstract principles, like a beginner. However, detached deliberation is only required in 'cases of total breakdown' (p. 247). It seems more in line with the Dreyfuses' view that professionals consult other professionals when it is unclear to them which of their intuitions is most appropriate than that they would ask advice to ethicists. Ethicists might be useful for professionals in what the Dreyfuses call 'cases of total breakdown'. Considering what has been said about the role of ethical theory, ethicists cannot be expected to agree with this modest role.

One might object to my conclusion by saying that it is the distinctive characteristic of an empirical ethicist that he accepts the moral expertise of the practitioners. For this reason, empirical ethicists should agree with the modest role that I described above. I think that this objection must be rejected for several reasons. First, recall what I said in the second section. The moral expertise of the professional is always shaped by a particular moral tradition. There is no tradition-neutral medical ethics. Secondly, professionals who are technical experts in their discipline might not have moral competence on the same level. Not all of them are 'moral exemplars'. A good health professional has practical wisdom, also with regard to the moral aspects of his work, but not all professionals are good professionals. Steinkamp, Gordijn and Ten Have state that ethicists should focus primarily on the analysis of moral questions and moral reasons as well as on the facilitation of deliberation, and not on the determination of what ought to be done. Non-ethicists should receive the support necessary to verbalise morally relevant aspects of situations in practice, articulate moral quandaries from their professional practice and take responsibility for the decisions that have to be made (2008, p. 186f.).

This seems to me an artificial separation. Of course, those who have to carry out a decision are responsible for that decision. It should be their decision. Ethicists should not prescribe health professionals what they should do. They should indeed facilitate discussion, but also participate in general discussions about the values and goals of medicine, and also about the relevance of medical interventions in the light of these values and goals. All these discussions have an impact on 'the determination of what ought to be done'.. I want to close this paper by a long quotation from McKeever and Ridge about two prominent roles that moral practice gives to principles:

> First, the articulation of moral principles is taken to be at least one important aspect of moral thought and discourse. Whether we consider the sophisticated methods of professional philosophers or the thoughtful discussions of citizens, the identification of a sound moral principle is often taken to be a primary goal. Viewed in this light, the identification of a principle is a product of successful moral thinking. […] A second role for principles […] is that of guiding virtuous agents. If moral principles can provide guidance to virtuous agents, the one reasons or devoting moral thought to articulating them will be to acquire valuable tools for guiding action (2006, p. 176)

The identification of sound moral principles for an practice should be a common endeavour of professionals and ethicists. Professionals need principles as guides even

if they are virtuous, have moral competence or moral expertise. Having principles is not sufficient, professionals also have moral competence. Participating, together with professionals, in the identification of sound moral principles for a moral practice, and helping them to improve their moral competence – reasoning skills and sensitivity – that is what empirical ethicists should do.

References

Arras, J.D. (2001), A method in search of a purpose: The internal morality of medicine, *Journal of Medicine and Philosophy*, 26, pp. 643-662.

Borry, P., Schotsman, P. & Dierickx, K. (2004), Editorial. Empirical ethics: A challenge to bioethics, *Medicine, Health Care and Philosophy*, 7, pp.1-3.

Carens, J. (2004). A contextual approach to normative theorizing about culture and identity, *Ethical Theory and Moral Practice*, 7,

Clarke, S.G. & Simpson, E.(eds.) (1989), *Anti-theory and moral conservatism*, SUNY Press: Albany.

Chi, M.T.H., Glaser, R., Fair, M.J. (1988). *The nature of expertise*. Hillsdale, NJ: Erlbaum.

Curlin, F.A., Lawrence, R.E, Chin M.H. & Lantos J.D. (2007), Religion, conscience and controversial practice, *The New England Journal of Medicine*, 356, pp 593-600

Dancy, J. (1993). *Moral reasons*, Oxford: Blackwell.

Dancy, J. (2004), *Ethics without principles*, Oxford: Oxford University Press.

Dreyfus, H.L. & Dreyfus, S.E. (1991), Towards a phenomenology of ethical expertise, *Human Studies*, 14, pp. 229-250.

Ericsson, K.A., & Charness, N. (1994), Expert performance: Its structure and acquisition, *American Psychologist, 49*, pp. 725-747.

Haidt, J. (2001), The emotional dog and its rational tail: A social intuitionist approach to moral judgement. *Psychological Review*, 108, pp. 814-834.

Have, H.A.J.M. ten & Lelie, A. (1998), Medical ethics research between theory and practice, *Theoretical Medicine and Bioethics*, 19, 263-276.

Holton, R. (2003), Principles and particularism, *Proceedings of the Aristotelian Society*, suppl.., pp. 169-??

Kekes, J. (1989), *Moral tradition and individuality*, Princeton: Princeton University Press.

Little, M.O. (2000), Moral generalities revisited. In: B. Hooker & M.O. Little (eds.), *Moral particularism*, Oxford: Clarendon Press.

Louden, R.B., (1992), *Morality and moral theory*, New York: Oxford University Press.

McDowell, J. (1985), Values and secondary qualities. In: T. Honderich, *Morality and objectivity*, London: Routledge & Kegan Paul, pp. 110-120.

MacIntyre, A. (1981). *After virtue: A study in moral theory*. Notre Dame: University of Notre Dame Press.

McKeever, S. & Ridge, M. (2006), *Principled ethics: Generalism as a regulative ideal*, Oxford: Clarendon Press.

McNaughton, D. (1988), *Moral vision*, Oxford: Blackwell.

Miller, Frank G. & Broady, H. (2001). The internal morality of medicine: An evolutionary perspective, *Journal of Medicine and Philosophy*, 26, pp. 581-599.

Musschenga, A.W. (2005), Empirical Ethics, Contextsensitivity and Contextualism, *Journal of Medicine and Philosophy* 30, pp. 1-24.

Nussbaum, M.C, Why practice needs ethical theory: Particularism, principle, and bad behaviour. In: B. Hooker & M.O. Little (eds.), *Moral particularism,* Clarendon: Oxford, 2000, pp. 227-256.

Nussbaum, M.C. (1990), "Finely aware and richly responsible:" Literature and the moral imagination. In: *Love's knowledge. Essays on philosophy and literature*, New York: Oxford University Press, pp. 148-168.

Narvaez, D., & Lapsley, D. (2005), The psychological foundations of everyday morality and moral expertise. In: D. Lapsley & Power, C. (eds.), *Character psychology and character education*, Notre Dame: University of Notre Dame Press, pp. 140-165.

Narvaez, D. (2006), Integrative ethical education. In: M. Killen & J. Smetana (eds.), *Handbook of moral development*, Mahwah, NJ: Erlbaum, pp. 703-733.

O'Neill, O. (1987), Abstraction, idealization, and ideology in ethics. In: J.D.G. Evans (ed.), *Moral philosophy and contemporary problems*, Cambridge: Cambridge University Press. pp. 50-70.

Pellegrino, E.D. &. Thomasma, D.C. (1993), *The virtues in medical practice,* New York: Oxford University Press.

Rest, J. (1983), Morality. In J. Flavell & E. Markman (Eds.). *Cognitive development. Manual of Child Psychology*, 4th ed., vol. 3, ed. P. Mussen, New York: John Wiley and Sons, pp. 556–629.

Scheers, P.C.J.M. (2005), *Towards a complex perfectionism*, Leuven: Peeters.

Steinkamp, N, Gordijn, B & Ten Have, H.A.J.M. (2008), Debating ethical expertise, *Kennedy Institute of Ethics Journal*, 18, pp. 173-192

Thiel, G.J.M.W. van Delden, & J.J.M. (2009), The justificatory power of moral experience, *Journal of Medical Ethics* (accepted).

Pellegrino, E.D. Thomasma, D .C (1993), The *virtues in medical practice,* New York: Oxford University Press.

Timmons, M. (1999). *Morality without foundations: A defense of ethical contextualism*, New York/Oxford: Oxford University Press.

Zussman, R. (1992). *Intensive care: Medical ethics and the medical profession.* Chicago/London: The University of Chicago Press.

Appendix

Narvaez and Lapsey's Four Processes, Their Skills, and Subskills (Narvaez & Lapsey 2005, pp. 156, 157)

Sensitivity	*Judgement*
ES-1: Understand Emotional Expression Identify and express emotions Finetune your emotions Manage anger and aggression *ES-2: Take the Perspectives of Others* Take an alternative perspective Take a cultural perspective Take a justice perspective *ES-3: Connecting to Others* Relate to others Show care Be a friend *ES-4: Responding to Diversity* Work with group and individual differences Perceive diversity Become multicultural *ES-5: Controlling Social Bias* Diagnose bias Overcome bias Nurture tolerance *ES-6: Interpreting Situations* Determine what is happening Perceive morality Respond creatively *ES-7: Communicate Well* Speak and listen Communicate nonverbally and alternatively Monitor communication judgment	*EJ-1: Understanding Ethical Problems* Gathering information Categorizing problems Analyzing ethical problems *EJ-2: Using Codes and Identifying Judgment Criteria* Characterizing codes Discerning code application Judging code validity *EJ-3: Reasoning Generally* Reasoning objectively Using sound reasoning Avoiding reasoning pitfalls *EJ-4: Reasoning Ethically* Judging perspectives Reason about standards and ideals Reason about actions and outcomes *EJ-5: Understand Consequences* Analyzing consequences Predicting consequences Responding to consequences *EJ-6: Reflect on the Process and Outcome* Reasoning about means and ends Making right choices Monitoring one's reasoning *EJ-7: Coping* Apply positive reasoning Managing disappointment and failure Developing resilience

Motivation	*Action*
EM-1: Respecting Others Be civil and courteous Be non-violent Show reverence *EM-2:Cultivate Conscience* Self command Manage influence and power Be honorable *EM-3: Act Responsibly* Meet obligations Be a good steward Be a global citizen *EM-4: Help Others Cooperate* Act thoughtfully Share resources *EM-5: Finding Meaning in Life* Center yourself Cultivate commitment Cultivate wonder *EM-6: Valuing Traditions and Institutions* Identify and value traditions Understand social structures Practice democracy *EM-7: Develop Ethical Identity and Integrity* Choose good values Build your identity Reach for your potential action	*EA-1: Resolving Conflicts and Problems* Solve interpersonal problems Negotiate Make amends *EA-2: Assert Respectfully* Attend to human needs Build assertiveness skills Use rhetoric respectfully *EA-3: Taking Initiative as a Leader* Be a leader Take initiative for and with others Mentor others *EA-4: Planning to Implement Decisions* Thinking strategically Implement successfully Determine resource use *EA-5: Cultivate Courage* Manage fear Stand up under pressure Managing change and uncertainty *EA-6: Persevering* Be steadfast Overcome obstacles Build competence *EA-7: Work Hard* Set reachable goals Manage time Take charge of your life