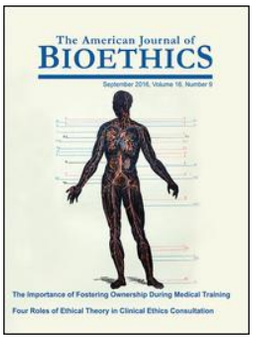

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Do We Need Ethical Theory to Achieve Quality Critical Engagement in Clinical Ethics?

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In spite of this concern, there are obvious advantages to the suggestions of Magelssen and colleagues. For one, pluralist approaches are important in addressing the problems discussed by clinical ethics committees, since "we live in a society with persons who are interested in a wide array of heterogeneous goods" (Boesch 2014, 16). Further, the suggestions offered by Magelssen and colleagues are important in helping to bridge the "chasm" between ethical theory and practice. In order to maintain their important insights while respecting concerns of incommensurability, I argue that we should follow MacIntyre in understanding the exploration of alternative traditions and their approaches to problems of clinical ethics as "a work of the imagination" (1988, 394).

The idea is that clinical ethicists can take up imagined perspectives in which they "perceive and conceive the natural and social worlds as [rival traditions] perceive and conceive them" (MacIntyre 1988, 394–95). So, for example, in taking up a Millian perspective, the clinical ethicists should not just apply Mill's conception of autonomy divorced from the broader context of his work and approach to ethics, but should reimagine the case from the perspective of someone who is an active member of the Millian tradition. Insights will thus be tied intricately to Mill's broader philosophical claims that undergird his account of morality. Through the use of imagined perspectives, the benefits of the uses of multiple ethical theories will not come from a direct comparison of incommensurate concepts. Instead, the four beneficial roles Magelssen and colleagues describe will come indirectly, the result of practical insights about the case gained by the clinical ethicists within the (imagined) context of some tradition. So, for example, a Millian analysis of some case will not be directly compared with a Kantian analysis. Rather, the clinical ethicists will imagine the case from each perspective, yielding practical insights about how the various features of the case hang together and impact one another.

My suggestion in favor of imagined perspectives also offers an argument in favor of diverse clinical ethics committees. As MacIntyre (1988) argues, the perspective of a real member of a tradition is preferable to the imagined perspective, as the perspective of a real person is better than an actor (395). Thus, by having a committee constituted by members of diverse traditions, there will be less need to rely upon imagined perspectives since the various traditions will be locally represented. All the same, even in this case imagined perspectives will remain important in allowing committee members from competing traditions to better understand one another's arguments. ■

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Do We Need Ethical Theory to Achieve Quality Critical Engagement in Clinical Ethics?

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What can determine whether case consultation in clinical ethics is effective? Magelssen and colleagues (2016) offer an insightful analysis of the place of ethical theory in this process. They articulate four roles that knowledge of

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normative ethical theories can play in case deliberations: identification of moral challenges, analysis and argumentation about moral challenges, shaping the deliberation process, and spurring reflexivity.

In this commentary, we draw on debates from a similar field: the role and use of ethical theory in teaching health care ethics. We claim that while sophisticated use of ethical theory is ideal in clinical ethics case consultations, there are both theoretical and practical limits to theory's use in this context. Magelssen and colleagues recognize, but do not resolve, the possibility of ethical theory being applied incorrectly or superficially. There is also a danger that theoretical jargon can distance health care practitioners from their own moral experiences and insights, which is particularly problematic in the clinical ethics setting. Given these limitations, we argue that while explicitly using ethical theory may be helpful in case consultations, it should not be seen as essential. Instead, case consultations require high-quality critical engagement. This can be achieved through other avenues that do not involve the two risks outlined.

NECESSARY OR USEFUL?

There are two possible interpretations of Magelssen and colleagues' argument. The first is that the four roles they outline can *only* be fulfilled by use of ethical theories. That is to say, ethical theory is necessary for good case consultations. The second is that knowledge of ethical theories is one effective pathway to the roles they describe, but not necessarily the only way in which these important aspects of case deliberation can be achieved. On this interpretation, ethical theory is useful for good case consultation, but not intrinsic to its success. We suggest that the second interpretation constitutes the more compelling claim. While sophisticated knowledge of ethical theories is certainly helpful and thus clearly a desirable element of the skill set of a clinical ethics group, we argue that it is not essential to good case consultation.

WHAT IS CENTRAL TO SOUND CLINICAL ETHICS CASE CONSULTATION?

Magelssen and colleagues (2016) describe the four features outlined in the preceding as "core functions or characteristics of a successful CEC" (32). Also implicit in their discussion is the notion that good case consultation is done by a group, rather than an individual ethics expert. Our views on and experiences of case consultation are also group based; and we suggest that fostering the four outcomes described by Magelssen and colleagues is more likely when critical discussion occurs in a group context.

We would also emphasize a further characteristic as essential to good case consultation: that the treating clinicians are involved in the decision making in such a way that they feel empowered by the consultation (regardless of who referred the case to the ethics service). It is often clinicians who must take action following an ethics discussion, so their sense of ownership of the process and decision is crucial. The process of critical engagement by stakeholders is ethically important, alongside any decisions about ethically appropriate courses of action.

LOOKING TO THE ROLE OF ETHICAL THEORY IN HEALTH CARE EDUCATION

Given this centrality of stakeholder engagement in the clinical ethics process, we can draw on scholarship relating to the role of ethical theory in health care education to suggest that there are two important ways in which we might be wary about the explicit involvement of ethical theory in clinical ethics case consultation.

First, there is a parallel debate regarding the role of ethical theory in teaching health care students (Benatar 2007; Benatar 2009; Cowley 2005; Lawlor 2007; Lawlor 2008; Saunders 2010; Webb and Warwick 1999). Some commentators argue that "moral theories should not be discussed extensively when teaching applied ethics" because of the dangers of presenting this material superficially (Lawlor 2007, 370). Given the comprehensive and detailed curricula taught to health care students, a focus on ethical theory may lead to a learning and application of relevant theories that poorly reflects their theoretical complexity. Magelssen and colleagues (2016) recognize this problem in the clinical ethics setting, acknowledging that "a little learning is a dangerous thing" (32). However they offer no resolution for this challenge.

Second, alongside this problem of poor or superficial use of theories, the literature points to another challenge: the potential for technical language and jargon to distance thinkers from their own ethical insights and experiences. Cowley, for example, argues that teaching ethical theory in the standard ways can lead "students and practitioners into ignoring their own healthy ethical intuitions and vocabulary" (Cowley 2005, 739). However, we recognize that this concern may rule out only certain ethical theories. Some theories mentioned by Magelssen and colleagues, such as casuistry, may not lead to this issue. Indeed, in our experience in teaching health care ethics to students and professionals, rich descriptions of cases often promote engagement and can facilitate learning. Others share similar views regarding using cases as an "entry point" to teaching ethical theory (e.g.Saunders 2010).

We suggest that clinical ethics case consultation has parallels with health care education. Time for discussion may be short, those involved may not have an academic background in philosophy, and there is a risk of superficiality. Additionally, the worry over whether nonreflective use of theory could lead to a "moral distance" from important or informative ethical intuitions is particularly applicable to the clinical ethics context, given the importance of clinician ownership of decisions made in ethics discussions. An ethical theory that risks "distancing" may not fulfil the roles that Magelssen and colleagues set out to promote.

FOSTERING CRITICAL ENGAGEMENT IN CLINICAL ETHICS CASE DISCUSSION

Explicitly discussing ethical theory can nevertheless be helpful. As Benatar points out in a teaching context, "non-philosophers, often without realizing it, appeal to theoretical frameworks when discussing practical moral problems" (Benatar 2007, 671). However, we claim that it is high-quality critical engagement that is fundamental to good clinical ethics case consultation, rather than explicit use of ethical theories. By critical engagement, we mean a refined set of skills that involve identifying an issue, unpacking the problem in relevant and productive ways, and reasoning soundly to a position. Nuanced and thoughtful use of ethical theory can sometimes facilitate such critical engagement, but it can also be achieved through other means. Given the risks of superficiality and distancing involved with the explicit use of at least some normative ethical theories, we suggest that clinical ethics services focus primarily on developing and teaching skills of critical engagement, rather than prioritizing increasing members' knowledge of ethical theories. Substantial time and resources are necessary to ensure that ethical theories will be applied in a way that is appropriately nuanced and complex; these will not be available in many clinical ethics services. And even services that are well resourced in terms of time, knowledge, experience, and expertise may still face challenges when, for example, trying to decide which theory to apply to a particular case.

We have argued that ethical theory is not the only method with which to achieve the kind of critical engagement that we believe is necessary for good clinical ethics case consultation. But how can good critical engagement be fostered? We submit that a good way to achieve this is through developing and applying ethical reasoning skills. These include the capability to distinguish facts and values, recognize valid and invalid arguments (and types of arguments, such as slippery slopes), use conceptual analysis, and undertake thought experiments (Hope 2004; Hope, Savulescu, and Hendrick 2008).

Magelssen and colleagues conflate the use of substantive ethical theories with some of the elements of good argumentation and structuring valid arguments. Their second, third, and fourth roles for ethical theory (analysis and argumentation about moral challenges, shaping the deliberation process, and spurring reflexivity) are also achievable by the use of skills of critical engagement. We accept that their first role for ethical theory, identifying moral challenges, may not be as easily achieved by critical engagement. Yet ethical theory is not essential to this either—it can be just as effective to encourage health professionals to seek case consultations when they sense that their professional morality conflicts with a decision that is being made or that they are experiencing discomfort for other morally relevant reasons. Further, there are other "framework"-based approaches that are widely and effectively applied in clinical ethics (e.g., Jonsen, Sigeler, and Winslade 2015) that may incorporate ethical theory or principles but do not inherently rely upon them.

To achieve a case consultation that demonstrates sound analysis and argumentation, has adequate deliberation, and is reflexive is not easy. While ethical theory may have a role to play in supporting these ends, we have argued that it is not essential and may not always be desirable. Just as pedagogical debates on teaching ethical theory to health care students have emphasized the "nice to have" property of ethical theory as opposed to its being an inherent requirement, we argue that skills of critical engagement, combined with rich case analysis, can also achieve a good-quality case consultation. ■

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