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Core Competencies for Health Care Ethics Consultants: In Search of Professional Status in a Post-Modern World

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Abstract The American Society for Bioethics and the Humanities (ASBH) issued its *Core Competencies for Health Care Ethics Consultation* just as it is becoming ever clearer that secular ethics is intractably plural and without foundations in any reality that is not a social–historical construction (ASBH *Core Competencies for Health Care Ethics Consultation*, 2nd edn. American Society for Bioethics and Humanities, Glenview, IL, 2011). *Core Competencies* fails to recognize that the ethics of health care ethics consultants is not ethics in the usual sense of a morally canonical ethics. Its ethics is the ethics established at law and in enforceable health care public policy in a particular jurisdiction. Its normativity is a legal normativity, so that the wrongness of violating this ethics is simply the legal penalties involved and the likelihood of their being imposed. That the ethics of ethics consultation is that ethics legally established accounts for the circumstance that the major role of hospital ethics consultants is as quasi-lawyers giving legal advice, aiding in risk management, and engaging in mediation. It also indicates why this collage of roles has succeeded so well. This article shows how moral philosophy as it was reborn in the 13th century West led to the ethics of modernity and then finally to the ethics of hospital ethics consultation. It provides a brief history of the emergence of an ethics that is after morality. Against this background, the significance of *Core Competencies* must be critically reconsidered.

Keywords Bioethics · Clinical ethics · Hospital ethics consultants · Post-modernity · Moral pluralism

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An Introduction: Thinking About Ethics After Morality

The American Society for Bioethics and the Humanities (ASBH) has the misfortune of having issued *Core Competencies for Health Care Ethics Consultation* (ASBH 2011) just as it is becoming ever clearer that secular moralities and bioethics are intractably plural and without foundations in a non-socio-historically constructed reality (Engelhardt 2011a). There is agreement neither regarding the moral content of bioethics nor about a conclusive theoretical foundation that would warrant the claims of canonical normativity. The dominant secular culture is passing through a period of dramatic change, variously characterized as the end of modernity, the end of humanism, and the end of metaphysics, a period in which moral pluralism and a loss of ultimate orientation are becoming salient and widely acknowledged. The implications are finally becoming clear of having disconnected morality from metaphysics, from a God's-eye perspective. Secular morality and with it bioethics are being better recognized as a plurality of moralities and bioethics, each within a moral discourse suspended within its own cultural narrative. As Vattimo puts it, "The death of God, which is at once the culmination and conclusion of metaphysics, is also the crisis of humanism" (Vattimo 1991, pp. 32–33). Against this background, this essay critically assesses *Core Competencies* by exploring the question as to how an organization such as ASBH could be in authority to issue *Core Competencies* for the field of clinical consultation as a whole, as well as what it would mean for ASBH to have the expertise to craft a statement of *Core Competencies* with a focus on ethical theory.

These two questions are set within broader framing puzzles concerning the nature of bioethics and the ethics of health care ethics consultation. If there is no one canonical morality, bioethics, or ethics which health care ethics consultants can engage, and if in addition the project of securing a rational justification for the canonical standing of the dominant secular morality in principle fails, how are health care ethics consultants to justify their selection of a normative position, e.g., supporting patient autonomy? The essay concludes that the ethics of secular health care ethics consultation is not a normative ethics, as this might be understood apart from law and public policy. Instead, the ethics of health care ethics consultation is that ethics established at law and in enforceable public policy. This status of the dominant secular ethics as legally, not morally, normative, not only explains the character of the ethics of health care ethics consultants, but also why health care ethics consultants function as quasi-lawyers. An adequate account of the *Core Competencies* of health care ethics consultants will need to recognize the actual context and character of secular ethics and bioethics, including frankly acknowledging the plurality of ethics and their lack of foundation. The ethics of secular health care ethics consultation is that ethics that has become dominant in the sense of becoming juridically canonical through being established at law and in embraceable public policy.

Whose Authority? Which Expertise? What Ethics?

How should one understand the force and authority of the second edition of *Core Competencies for Health Care: Ethics Consultation* issued by the ASBH? Who is

the "we" who speaks through or for the document? As the publication confesses (ASBH 2011, p. 55), only sixty individuals of the some 1,600 members of ASBH provided feedback on the proposed document, although the endeavor was the subject of considerable controversy and public debate. This means that there was a response of less than 4% of the membership. In addition, the document states that some twenty-nine thousand individuals perform ethics consultations each year (ASBH 2011, p. 43; Fox et al. 2007, p. 19). If this figure is correct, this would mean that there was a response from those involved in ethics consultation of only some 0.3%. Another way to understand these data is that at most much less than 10% of those engaged in ethics consultation are members of ASBH, and much less than 10% of the membership responded during the creation of this edition of *Core Competencies*. This state of affairs brings into question the force of the document. Even the first edition produced in 1998 drew on only some two hundred responses. The number of persons who decided to speak directly to the character of the document is by all measures strikingly small.

But even if, contrary to fact, a large majority of the membership of ASBH had responded, what force would the *Core Competencies* carry? What kind of authority would ASBH possess if it is not a licensing board, and if its membership evidently compasses only a small fraction of those engaged in health care ethics consultation (Fox et al. 2007, p. 19)? If ASBH were regarded as an association of service providers representing members of a non-licensed trade who had joined together to augment their financial and social standing, one could understand *Core Competencies* as a device to advance the economic, social, and professional standing of its members. And, of course, this is likely to be the motivation of some who celebrate *Core Competencies*. Others are likely seeking to establish themselves as a "professional group" that can realize an informal and legally tolerable restraint on trade so as to advance their social, professional, and economic advantage. Others may wish to wrap themselves in a mantle of rectitude as if they were in authority to speak for all who engage in ethics consultations, or as if they knew the canonical ethics that ought to direct all health care ethics consultants in their consultations.

Supporters of *Core Competencies* may also wish to have the imprimatur of ASBH as a whole, whatever that might be. Given the circumstance that the ASBH membership is quite heterogeneous in its opinions, educational backgrounds, activities, and commitments, it is unclear what the force of the imprimatur would be, beyond a particular majority present at any business meeting or other vote, that is, beyond a narrow institutional significance of being a report issued following ASBH's by-laws. ASBH compasses persons with a variety of terminal degrees ranging from M.D.s, Ph.D.s, and J.D.s to M.Div.s and R.N.s. The membership is divided among (1) scholars with full-time university appointments who are formally engaged in bioethics as their main professional focus, (2) scholars with full-time university appointments who are formally engaged in a traditional academic field such as philosophy, history of medicine, or religious studies, but who in addition have a scholarly interest in bioethics, (3) scholars with full-time university appointments who are engaged in some relatively recently constituted field such as the medical humanities or literature and medicine, (4) physicians, nurses, or other health care practitioners who are engaged in bioethics, medical ethics, nursing

ethics, or the humanities, (5) lawyers who have an interest in issues of law and medicine, (6) persons who from various backgrounds are interested in religion and medicine, (7) persons from various academic backgrounds who are primarily engaged in investigating various sociological and empirical issues bearing on bioethics and the humanities, (8) persons who are primarily engaged in health care ethics consultation, and finally (9) a quite heterogeneous group best put under the rubric "etc." The occupations and professional identities of the membership are quite diverse.

Members from such disparate occupational backgrounds regard ASBH in quite different lights. There is no professional or ideological unity. Indeed, there is significant ideological diversity and different views regarding ASBH's *raison d'etre*. Some see ASBH as (1) a scholarly association providing an opportunity to learn of new scholarly findings in their fields, (2) a professional association that allows an opportunity for networking, (3) a professional association on the model of an unlicensed trade association that will support their professional, social, and economic standing and/or (4) a group that should engage in social and political advocacy. To say the least, there is no unanimity. Indeed, there is instead some significant if not acerbic disagreement as to the nature of ASBH and as to what goals ASBH should pursue. Given the diverse academic origins and professional goals of its members, *Core Competencies* should have generated significant response. That the response rate was low is remarkable.

Of course, there are a number of plausible accounts of this state of affairs. One is that the recommendations were so uncontroversial that few thought a response was necessary or warranted. Another is that many persons were and are of the judgment that, given the incoherence of the field that clusters under the rubric of health care ethics consultation, the proclamation of a set of *Core Competencies* is so misguided that to dignify the endeavor of publishing *Core Competencies* with formal and direct responses from within ASBH would be an error. Many may have judged that, in such circumstances, it would be best to respond through scholarly fora and critical essays. That this may be the more plausible account for the poverty of responses is suggested given the heated discussion at the ASBH panel on October 16, 2009, "Clinical Ethics Consultant: Should It Be a Certified Profession?", as well as the publication in 2009 of critical responses in *HEC Forum* issue 21.3, "The Controversy of Credentialing Clinical Ethics Consultants".[1] One might also note the recent emergence of a revisionary and critical literature regarding much of what has gone under the rubric of bioethics and clinical bioethics. One might think of many of the essays in *Bioethics Critically Reconsidered: Having Second Thoughts*, volume 100 in the Philosophy and Medicine book series (Engelhardt 2011b). This author can report that at least some who engage in clinical ethics consultation abstained from responding regarding *Core Competencies* precisely on the ground that they did not want their responses to convey authority or legitimacy to the publication.

[1] For the development of my views in these matters, see Engelhardt (1999, 2003, 2009). For a brief overview of other reflections in this area, see Caws (1991), May (2001), Moreno (1991, 1988), Tong (1991), Wildes and Kevin (1993), Zaner (1993), Tong (1991), Zaner (1993).

Against this background, one confronts with force the question of the sense in which ASBH is in authority or could possess the moral expertise to issue a document such as *Core Competencies*. The salience of moral pluralism, its intractable character, and the foundationless nature of contemporary secular morality and bioethics undermine the "moral" authority of recommendations made by a group that might be quite unrepresentative of those engaged in health care ethics consultation. Moreover, the authorizing committee, the Task Force, may at best represent only one cluster of moral visions, albeit the dominant cluster of secular moral visions, among the plurality of understandings of morality, bioethics and the ethics of ethics consultation. Insofar as *Core Competencies* proceeds as if there were a common, canonical bioethics and ethics for secular health care ethics consultation, its force is therefore brought globally into question. Given platitudes concerning a common morality and moral consensus, it is important to recall the salient plurality of moral views about when it is obligatory, forbidden, or licit to have sex, reproduce, transfer ownership of property, and take human life, which plurality is expressed in moral disagreements regarding the propriety of such undertakings as homosexual activity, abortion, taxing for social welfare, legally enforcing animal rights, euthanasia, and capital punishment. Moral pluralism and the loss of foundations, when combined with the very low rate of response and the large number of clinical ethics consultants who are not members of ASBH (2011, p. 43; Fox et al. 2007, p. 19), underscore the puzzle as to what kind of authority ASBH would have to possess in order to issue *Core Competencies* as a compelling document for the field of ethics consultation.

The question is not just for whom the document speaks, but what the ethics is about which health care ethics consultants can provide consultation, as well as what competencies under what circumstances are relevant to health care ethics consultation. It is not just that moral pluralism is salient, but that as a result there is a plurality of ways to understand the ethics of ethics consultations, including the division between those who recognize the salience of moral pluralism and those who assert that there is, or act as if there were, a common morality and bioethics, as well as a common view of the ethics of health care ethics consultation. For example, the requirement that ethics consultants be able to rehearse matters of ethical theory is advanced without acknowledging the salience of intractable moral pluralism and loss of foundations, as well as the apparent impotency of theory. *Core Competencies* states, "Knowledge of moral reasoning and ethical theory should include consequentialist and non-consequentialist approaches, including utilitarian approaches; deontological approaches such as Kantian, natural law, communitarian, and rights theories …" (ASBH 2011, p. 26). This requirement is at best one-sided and incomplete in not requiring knowledge of the challenges involved in establishing a canonical ethics or supplying the ethics of health care ethics consultation with a theoretical foundation. Candor, indeed informed consent about the nature of their ethics, would require ethics consultants at least to acknowledge the problem of specifying which ethics it is about which health care ethics consultants should have the competence to consult, as well as why many hold that the project of securing a foundation for that ethics has failed. Absent such a disclosure, ethics consultants may mislead as to what the ethics of ethics consultation is about.

One is thus left with core quandaries. In what sense do health care ethics consultants consult about issues of ethics? And since there is no unanimity on cardinal moral and bioethical issues, there is then the macro-issue that ASBH should be clear whether *Core Competencies* is abstaining from taking a moral position about the validity of any moral claims (e.g., that patients have moral rights of a particular sort). In any event, how and why would ASBH be in authority to take any moral position regarding the ethics of health care ethics consultation, especially since less than 10% of hospital ethics consultants are members of ASBH (2011, p. 43; Fox et al. 2007, p. 19), and because it is unclear what constitutes moral expertise? But beyond the issue as to whether and in what sense ASBH is in authority, or independently might have the expertise, to articulate an adequate statement of *Core Competencies*, there remains the central challenge of giving an adequate account of the nature of the ethics of clinical ethics consultation.

The Middle Ages and the Making of Morality

Many in bioethics have not noticed, and many of those who have noticed have not publicly acknowledged, that there has been a dramatic deflation of the meaning and scope of the morality of the dominant secular culture. Immanuel Kant (1724–1804) affirmed the scope of Christian morality regarding masturbation, fornication, adultery, and suicide, albeit recast as a secular morality supposedly supported by pure practical reason. The secular morality that was initially accepted was materially equivalent to Christian morality without reference to Christ. This secularization of Christian morality (and therefore of bioethics) was plausible because the West had affirmed a morality and moral philosophy that was rooted in and grew out of the 13th-century Western Christian cultural synthesis of Christianity and Aristotelian thought, along with Stoic concerns and Platonic influences. This synthesis produced both Roman Catholicism as a new and separate religion and established a set of aspirations regarding the capacities of moral philosophy. Theologians in the strict sense were no longer recognized as being holy men who through prayer, fasting, and almsgiving had come to experience God. Instead, theologians became considered primarily to be scholars who through engaging forms of reasoning borrowed from Aristotle, Plato, and the Stoics, could among other things argue for various moral propositions often held to be grounded in natural law (Engelhardt 2009). Although Jesus Christ had not come preaching philosophy and natural law, and did not enjoin the establishment of academies of philosophy, a second-millennium Christianity emerged with not only robust academic aspirations but philosophical foundations as well.[2]

This cultural synthesis produced a moral philosophy and a philosophically articulated morality that supported the intellectual assumption that there is one

[2] David Knowles in a popular volume concerning medieval thought opines, “the world of 1210 [i.e., the year of the publication of Aristotle and the condemnation of Aristotelianism at Paris] was a very different one from that of 1155 both in its institutional forms and in its interior spirit. The monastic centuries had ended and the age of the universities, the scholastic age, had taken their place” (Knowles 1962, pp. 223–24).

morality, which philosophy can disclose and articulate. Morality in the process became a third thing between God and man. The West embraced the rationalistic horn of the *Euthyphro*'s dilemma (i.e., the choice between holding that the good, the right, and the virtuous are so because God approves of them, because they lead to holiness, or instead that God approves of them because there are good grounds independent of God for holding them to be such; Engelhardt 2007). The result was the creation in the early 2nd millennium of a proto-secular account of appropriate behavior that held that morality could in principle be articulated without God. Morality became understood in terms of rationally justifiable norms. In addition, the view became salient that reason could without grace disclose a morality binding all persons. Initially, this vision and its commitments was nested in a metaphysically anchored morality. In particular, the account initially recognized God as the source of, the ultimate rational justification for, and the final enforcer of morality.

From Anselm of Canterbury (1033–1109) and especially from Thomass Aquinas (1225–1274) all the way to Immanuel Kant, who was likely an atheist,[3] it was recognized that at least the idea of God was necessary in order to guarantee the unity of, and a particular content for, morality, as well as to secure the priority of morality's claims over the claims of prudence and self-interest (Engelhardt 2010a). For example, if there were no God and immortality, and if the universe were ultimately meaningless, it would not be rational to act morally if this meant great harm to one's family, friends, and associates, when acting immorally would produce great advantage. In an ultimately meaningless universe, there would be no final rationale for always acting morally. Approaching reality and morality using an atheistic methodological postulate has wide-ranging implications. One should recall that the Middle Ages embraced a philosophical affirmation of God as a metaphysical principle drawn from pagan philosophers such as Plato (427–347 B.C.) and especially Aristotle (384–322 B.C.) on grounds distinct from, and in addition to, those supporting recognizing God as the object of worship. From René Descartes (A.D. 1596–1650), Benedict Spinoza (A.D. 1632–1677), and Gottfried Leibnitz (A.D. 1646–1716) to Immanuel Kant, the importance of a God's-eye perspective, indeed of the idea of God, was affirmed for philosophical reasons that were distinct from religious concerns.

Philosophy in general and moral philosophy in particular were not central to Christian theology prior to the 12th and 13th centuries and then only in the West. Morality and theology were grounded in an experience of God. The original Christianity embraced the moral-theocentric horn of Euthyphro's dilemma, which Plato and the West rejected. Although it borrowed philosophical terminology, it did not render its theology philosophical. One might consider the position of St. John Chrysostom (A.D. c. 349–407), who conveys the suspicion of the Church of the first millennium regarding pagan philosophy.[4] Aside from some peripheral and usually heretical exceptions in Antioch and Alexandria, as well as most importantly the

[3] Kant appreciated the necessity of engaging the idea of God, even though he was likely an atheist. As Manfred Kuehn puts it, "Kant did not really believe in God" (Kuehn 2001, pp. 391–392).

[4] The author sides with and is a member of the Church of the early first millennium that is alive and well in Orthodox Christianity. See Engelhardt (2000).

inheritance of Augustine of Hippo (A.D. 354–430), the Church had regarded pagan philosophy as the source of heresy and misdirection. St. John dismisses

> Plato, who composed that ridiculous Republic, or Zeno, or if there be any one else that hath written a polity, or hath framed laws. For indeed, touching all these, it hath been made manifest by themselves, that an evil spirit, and some cruel demon at war with our race, a foe to modesty, and an enemy to good order, oversetting all things, hath made his voice be heard in their soul (Chrysostom 1994, "Homily I on the Gospel of St. Matthew", vol. 10, p. 5).

In taking this stance, St. John affirms the position embraced by Tertullian of choosing Jerusalem over Athens.

> These are "the doctrines" of men and "of demons" produced for itching ears of the spirit of this world's wisdom: this the Lord called "foolishness" [1 Tim 4:1] and "chose the foolish things of the world" [I Cor 3:18–19] to confound even philosophy itself. For (philosophy) it is which is the material of the world's wisdom, the rash interpreted of the nature and the dispensation of God. Indeed heresies are themselves instigated by philosophy. … What indeed has Athens to do with Jerusalem? What concord is there between the Academy and the Church? what between heretics and Christians? Our instruction comes from "the porch of Solomon," who had himself taught that "the Lord should be sought in simplicity of heart" [Wisdom of Solomon 1:1]. Away with all attempts to produce a mottled Christianity of Stoic, Platonic, and dialectic composition! (Tertullian 1994, "On prescription against heretics" VII, vol. 3, p. 246).

This position, of course, reflects the criticism of philosophy advanced by St. Paul as, for example, when he warns, "Beware lest anyone cheat you through philosophy" (Col 2:8).

What arose in the early-second-millennium West was a novel recasting by Western Christians of pagan Greek approaches to understanding theology and as a result moral philosophy and morality. The result was a moral-philosophical view that bound morality and rationality in a philosophical vision that embraced the following cardinal propositions:

1. Morality is anchored in reality, so that there is one canonical morality. Morality, which was held to be equivalent to secular morality, was considered to be right conduct as it would be appreciated from a socio-historically unconditioned and unique God's-eye perspective, with the result that morality was understood to be one and canonical and to have content that was not socio-historically conditioned.
2. A canonical understanding of the right, the good, and the virtuous life can at least in general outline be established by sound, rational, philosophical argument. Western Christianity (although there were exceptions such as William of Ockham [c. 1290–1350]) embraced the rationalistic horn of the *Euthyphro*'s dilemma; it was taken for granted that sound rational argument could establish the general content and canonicity of morality.

3. Since a God's-eye perspective was assumed as the final ground of objectivity, and since it was also assumed that discursive rationality, moral philosophy, could identify the commitments of that perspective, it was further assumed that one morality, which was equivalent to secular morality, could be established as binding all persons, so that all persons could be recognized implicitly as members of one moral community bound by one common, radically grounded morality.
4. There are good reasons, given the existence of God and immortality, always to act morally instead of prudently.

Morality was taken to be nested in rational philosophical foundations that bound persons independently of place and history.

Morality was not regarded as a sociohistorically-conditioned construct. The view that morality is not socio-historically unconditioned required morality to be grounded in the equivalent of a God's-eye perspective. Again, this God's-eye perspective was invoked in Western philosophy for philosophical reasons, not religious reasons. The God of the God's-eye perspective did not serve as the focus of devotion, but had ametaphysical, moral, epistemological, and motivational purposes. The view that morality is anchored in being, the assumption that discursive rationality (i.e., moral philosophy) can disclose and ground a canonical morality, the expectation that one morality governs all peoples, and the assumption that morality will always trump prudential concerns, are all a function of the view of God, reality, theology, and morality that emerged in the West at the beginning of the second millennium and became prominent in the 13th century.

After Morality

In contrast with the moral-philosophical view that took shape through Western Christianity, Orthodox Jews know that God gave seven laws to Noah and 613 laws to Jews, a point recognized by the Christianity of the first millennium. God has given different commandments to different peoples. One is obliged to do what God commands. The cultural synthesis of the High Middle Ages produced a Western culture with a quite different view of proper behavior (i.e., one that steps away from a Divine command account of moral obligations) that led through the rationalism of the Western Middle Ages to produce a rationally accessible God and a rationally justifiable morality, despite the reaction of nominalists such as William of Ockham and the via *moderna* he engendered. When philosophy at the end of the 18th and the beginning of the 19th century became disengaged from a recognition of a God's-eye perspective and lost faith in the existence of a rational foundation for morality, a dramatic rupture occurred in the dominant culture of the West with far-reaching implications that among other things separated the West from its traditional rational faith in a philosophically grounded common morality. The result of this rupture was that one was left with a "morality" after God and after metaphysics. This "morality" could no longer be accepted as having the force of the morality that preceded it. It no longer represented <u>the</u> morally canonical norms that all persons at

all times should obey. It no longer necessarily trumped the claims of self-interest. It was a morality after morality. The ethics of health care ethics consultation is after morality.

In speaking about health care ethics consultation as involving an ethics after morality, what is meant is that, whatever that ethics is, it is one among the plurality of secular post-traditional "moralities" that are left hovering unsupported by being. Each is suspended in one among a plurality of multiple, socio-historically-conditioned moral discourses, each without a secure, unconditioned anchor or foundation. Contemporary secular morality is "after" morality in the sense that the traditional morality of the West that had been rendered into a secularized version of Christian morality can no longer be sustained as a unique, common, canonical morality justifiable by sound rational argument. The result is a radical deflation of the claims of any secular morality, in that any particular morality is only one among a plurality of secular moralities, all without foundation. In particular, the Christian content of morality that had been preserved in such secular moralities as that of Immanuel Kant (e.g., forbidding homosexual acts, fornication, and suicide) was deflated into issues of legitimate life-style and death-style choices.

Secular moral norms came to be recognized as contingent and socio-historically conditioned, in addition to being multiple. This is the force of Hegel's cultural diagnosis in his 1802 essay, "Glauben und Wissen", when he speaks of the feeling in the vanguard culture of the time that "God Himself is dead" (Hegel 1977, p. 190; 1968, p. 414). Hegel is acknowledging a cardinal characteristic of the emerging European culture. It lacks a final unconditioned point of moral reference. The force of Hegel's statement is radical: without a transcendent God's-eye perspective, morality and reality are by default sociohistorically conditioned. This is the case because, absent a transcendent God's-eye perspective, morality is no longer anchored in being as it is in itself. Being and morality are always nested in the various ways in which being is for us. Being and reality have their substance with the various narratives of reality that are embedded in the various cultural perspectives of various societies at various times. Also, without a God's-eye perspective to establish particular basic moral premises and rules of inference as canonical so as to establish a particular morality and bioethics as canonical, moral controversies interminably go in a circle, beg the question, or engage an infinite regress. The various moralities and bioethics become particular normative discourses suspended within a diversity of cultural narratives. The various moralities and bioethics simply float within their particular discourse sustained by their particular narrative, all without an ultimate foundation, much less enduring meaning (Engelhardt 2010b).

The implications of this state of affairs for Western morality, bioethics, and the significance of ethics consultation are profound. As already noted, because the dominant secular morality and bioethics are not articulated from a God's-eye perspective, because they are not grounded in being as it is in itself, they are instead contingent in their content and sociohistorically conditioned in their character. They are nested always in a particular way that being is for us. As a consequence, there can be no conclusive sound rational argument to establish any particular morality, bioethics, or ethics to which a health care ethics consultant can appeal as a canonical

moral truth or reality. One already must have conceded as to which basic premises or rules of inference are canonical. Secular moralities, secular bioethics, and the ethics of secular ethics consultants have fragmented into a persistent socio-historically conditioned pluralism. There is no longer a plausible ground for moral considerations always to trump prudential concerns. In all these ways in the dominant secular culture, morality in the traditional sense is gone. The always and everywhere binding morality of Kant, or for that matter of Bentham and Mill, cannot be justified. For example, the calculation of the utilitarians cannot succeed unless one knows God's standards for comparing pleasures and pains, as well as for discounting them over time (Engelhardt 1996, esp. Chap. 2). Given this state of affairs, what can one make of health care ethics consultants or their core competences *qua* ethics consultants? Should not knowledge of this state of affairs and its history fall among the *Core Competencies* of health care ethics consultants so that they can at least disclose (i.e., as a matter of informed consent regarding the ethics services) the nature of puzzles regarding the force of secular ethics to those seeking their consultation? Should not health care ethics consultants at least be obliged to indicate the existence of these fundamental difficulties?

Morality, Bioethics, and the Ethics of Health Care Ethics Consultation

Given that there is a plurality of secular moralities and bioethics all without a foundation in being as it is in itself, with the result that all secular moralities and bioethics are contingent in their sociohistorically conditioned character, and therefore not canonical, what is one to make of the role of health care ethics consultants, or of *Core Competencies*? First, one is brought to confront the deflation of traditional morality that has rendered into life-style choices sexual, reproductive, and end-of-life decisions. Whether one affirms a life framed around heterosexuality, homosexuality, bestiality, or shoe fetishism, from the perspective of secular moralities and bioethics these all have become life-style choices, as do choices about the use of donor gametes and abortion, not to mention physician-assisted suicide and euthanasia (i.e., as death-style choices). The content of such choices becomes in and of itself morally neutral. There is no secular sense of natural law, canons of moral probity, or correct orientation in the cosmos that can be discerned that can give canonical normative direction or establish canonical moral constraints in a world approached through an atheistic methodological postulate in terms of which one acts as if all in the end were coming from nowhere, going nowhere, and for no ultimate purpose. The only moral constraint that is still generally imposed within the dominant secular morality and its bioethics is that one treat other *ex utero* humans as free, equal, and deserving of social justice.

The difficulty is that even these concerns for freedom, equality, and social justice, and their assertion as moral constraints, given the foundationless character of the dominant secular morality, function not as moral *Leitfaden* but as political slogans. Given the state of secular morality and bioethics, they are just as arbitrary and lacking in foundation, as is the content of traditional Western morality bearing on sexuality, reproduction, and end-of-life choices. Concerns about autonomy and

freedom are multiple and incompatible. Perhaps this state of affairs has led Tom Beauchamp to observe that theory in bioethics seems to play ever less of a role, as one would expect if no theory can succeed in providing a foundation for the claims of the dominant morality and its bioethics. "This 'theory' part of the landscape of bioethics I expect to vanish soon, because it is serving no useful purpose" (Beauchamp 2004, p. 210). In this context, commitments to liberty, equality, and social justice become at best political rallying points for political action, for particular political agendas, not moral truths. For example, with regard to equality, it is unclear as to how, in what ways, and why humans are or could be equal. After God and after foundations, assertions such as "all men are created equal" collide with the difficulty that in the absence of the recognition of a Creator Who establishes a canonical sense of equality, the moral and ontological significance of any alleged human equality is merely a sociohistorically-conditioned, contingent moral construct, which for the larger society must function as a political slogan. The same is the case with moral notions of fairness and justice in public policy debates about welfare and health care policy. Moral philosophy has failed to secure foundations and a canonical status for particular claims about justice and welfare as promised by the Enlightenment. They have become at best covert political slogans masquerading as moral truths.

It is for this reason that Hegel substitutes the state, the political realm, for God. It is through the state, through politics, that one morality is established at law and finds enforcement through state power. State power rather than God realizes as far as possible in a particular society at a particular time a harmony between the right and the good, as well as the realization of an appropriate relationship between worthiness of happiness and happiness (i.e., the state punishes and rewards). As Hegel understands, the state is "the march of God in the world [*Es ist der Gang Gottes in der Welt, dass der Staat ist*]"; the state is the "actual God [*der wirkliche Gott*]" (Hegel 1991, p. 279, Sect. 258 Zusatz). Hegel also recognizes that without a transcendent God secular morality cannot be a canonical or a common morality but only that dominant morality established through law and public policy in a particular jurisdiction. It is enough for health care ethics consultants to recognize that a particular sociohistorically-conditioned morality can succeed in being the ethics that has entered into law and public policy. State force realizes the morality that *de jure* guides. It is because of the inability to secure a moral view *sub specie aeternitatis* that the later Rawls despairs of giving a moral or metaphysical account of justice, settling instead for only a political account (Rawls 1985).

Following Hegel's insight, one can identify the ethics of health care ethics consultants as the ethics established at law and in public policy. One can also appreciate why health care ethics consultants function to such a great extent as quasi-lawyers by giving advice about law and public policy bearing on decisions regarding the engagement of medicine and the biomedical sciences (e.g., by answering questions as to who is in authority to act as a surrogate decision-maker for a patient and within what constraints). Again, the ethics about which ethics consultants within the cultural domain of the dominant secular ethics can be legitimate experts is that the ethics to which they make reference as the ethics which in a particular jurisdiction is established as the dominant ethics through law and

public policy. As established at law and in public policy, this morality achieves a quasi-canonical, indeed legally canonical character. In this light, one can understand the role of health care ethics consultants in giving legal advice and in aiding in risk management. For example, health care ethics consultants, like lawyers, can aid physicians in recognizing that they should avoid crafting notes in patients' charts that might support future possible litigation (e.g., physicians should avoid recording critical interchanges among each other in the patients' hospital records), as well as by ethics consultants entering notes into the patient's record to substantiate that due diligence has been exercised in coming to a decision on a controversial matter. The third significant role of health care ethics consultants, that of mediating disputes among disputing parties (e.g., among patients, the families of patients, physicians, nurses, and others) also mirrors the role of lawyers as mediators: health care ethics consultants function as counselors, similar to how some lawyers are counselors.

In summary, the ethics of secular health care ethics consultants can be recognized as that particular secular ethics that has become established at law and public policy regarding medicine and the biomedical sciences. This "ethics" is a political or legal, not a moral fact of the matter. The canonical character and force of this ethics are juridical, not moral. One cannot in any morally non-partisan way hold that this circumstance is morally good or bad. It is simply what has occurred in the face of moral pluralism and in the absence of foundations, so that the morality that is established at law and in public policy becomes morality's higher truth. Law and established public policy declare what legally ought to be done. In this context, hospital ethics consultants are those who give advice about how to negotiate controversial decisions regarding medicine and the biomedical sciences, within the constraints of the ethos that is established at law and in public policy.

Against this background, one can then identify *core competencies* and rules of thumb for the services offered under the rubric of health care ethics consultant, such as:

1. Health care ethics consultants should have a good knowledge of applicable law and public policy in their particular jurisdiction, as well as any applicable institutional rules.
2. Health care ethics consultants should appreciate that the ethics of secular hospital ethics consultants is nothing more or less than the ethics that in a particular jurisdiction is established at law and in public policy and should in honesty disclose this to those engaging their services.
3. Health care ethics consultants should understand how in grey zones of law and of public policy they can effectively negotiate these grey zones, without violating law and public policy, to advance the goals of those who engage their services. As with lawyers, so, too, with ethics consultants, health care ethics consultants should advocate, in ways similar to lawyers, the goals of those who retain their services (e.g., the pursuit of the "ethics" mission statement of their hospital). In addition, as long as health care ethics consultants act within the constraints of law and public policy, it is no more unethical to be a well-paid partisan ethicist for hire than for a lawyer to be the well-paid advocate of a client.

4. Health care ethics consultants should have an appreciation of how to work as mediators with those who are in disagreement in order to achieve the goals of those who hire them (e.g., achieve quality of care in a hospital, commensurate with the institution's understanding of appropriate care) within the constraints established at law and in public policy.
5. Health care ethics consultants for religiously-affiliated hospitals, which hospitals take the affiliation seriously, and whose religion takes its theology seriously as representing non-negotiable theological truths, should expect its ethicists to support the norms of conduct demanded by that religion, even if this involves violations of law (e.g., not referring for physician-assisted suicide, were that required). For a health care ethicist hired by a religiously affiliated hospital, competency would require expert knowledge of relevant religious norms, along with faithful religious dedication.
6. Given the service-directed character of the field of health care ethics consultation, hospital ethics consultants should recognize that they are service providers whose particular roles, and therefore competencies, are most plausibly defined by the purchaser of the services who determines the mission and the context in which the services are to be provided. Ethicists do not have a professional integrity, history, and character that are independent of the institutions purchasing their services, as is the case with regard to the professional integrity of physicians and lawyers who can practice independently of hospitals or law firms.

This series of reflections on *Core Competencies* is guided by the recognition that the dominant secular morality and bioethics become canonical insofar as they are established at law and in public policy without any claims about that morality or bioethics being morally canonical or a common human morality.

All of this leads to the conclusion that the professional integrity and *Core Competencies* of health care ethics consultants must be foundationally reconsidered. At the outset, such a reconsideration will require

1. a critical and honest reappraisal of the meaning and focus of secular morality and bioethics after God and after the loss of an anchor for morality in a socio-historically unconditioned reality, as well as in the face of intractable moral pluralism;
2. a forthright acknowledgement that the ethics of secular health care ethics consultants is the ethics that has succeeded in establishing itself at law and in public policy;
3. a frank acknowledgement of the circumstance that health care ethics consultants have become recognized as persons who are allowed to provide special forms of legal advice and services without being admitted to the bar;
4. an open acknowledgement that any opinions offered by ethics consultants beyond indicating what is required by the ethics established at law and in public policy have the force of personal adiaphora.

Facing the actual character of secular morality and bioethics with its plurality and foundationlessness should lead to reconsidering the role of health care ethics consultants and the proper character of their *core competencies*.

Health Care Ethics Consultations and Consultants: After the Rupture

In the early 1970s at Georgetown University, bioethics came into existence under that rubric, shaped by persons who were preponderantly former Christian ministers, seminarians, or Roman Catholics. The latter, albeit to various extents, shared with their university a faith in natural law, or at least moral philosophy, that as held able to establish the content of the canonical morality. This ethics for the most part had a pre-post-modern faith in morality, justice, and progressive politics supported by a synergy of late Western Christian and Enlightenment commitments to freedom, equality, and social justice, along with a faith in the powers of reason to be able to ground these commitments. As with the journey of the early Rawls of ethics and justice to the later Rawls of politics and a social-democratic constitutional vision, secular morality and bioethics has in great measure ceased to aspire to be a theory-based moral and bioethical vision and has instead become ever more frankly a "progressive" political movement.

As a consequence, one must radically and honestly reconsider the "moral reasoning and ethical theory" component of the *Core Competencies* (ASBH 2011, p. 26). As it stands, identifying "moral reasoning and ethical theory" as integral to the *core competencies* of ethics consultants without a clear warning concerning the controversies regarding the force and significance of secular morality and bioethics involved supports what in many cases may largely be an important, albeit misleading, intellectual ritual of repeating moral distinctions before giving legal advice. In encouraging ethics consultants to make reference to deontological, consequentialist, and virtue-based concerns in ethical decision-making, this ritual may falsely suggest that there is a canonical secular ethics with a conclusive justifying intellectual foundation about which health care ethics consultants have expert knowledge and could give moral guidance. It may even suggest that a health care ethics consultant may possesses the moral expertise necessary to be a *phronimos*. This is not to say that ethics consultants are intentionally engaging in deception. Rather, the point is that what many took secular morality and bioethics to be cannot in fact be the case. In particular, the ethics of the ethics consultant cannot be what many hoped it to be, namely, an intellectually justified moral vision that can be sustained and given foundations through "moral reasoning and ethical theory". Again, the ethics of health care ethics consultants is simply the ethics that is established at law and enforceable public policy.

Beginning with Hegel, and in various ways acknowledged by John Rawls, Richard Rorty, Gianni Vattimo, and many others, the dominant secular morality has come to be ever better appreciated as justifiable only in terms of a particular political vision established at law and in public policy. The moral and metaphysical have been replaced by the political. Rather than providing sound rational argument for a particular morality and bioethics for which one is a moral partisan, moral philosophy can show that by default those within the dominant secular culture are left with using rhetoric to entice others into their political vision which often masquerades as a rationally justified moral vision so as to establish a particular political vision at law and in public policy. Their goal, among other things, of anointing their ethics as the ethics for secular health care ethics consultants cannot

be understood in traditional moral terms. Under the cover of supporting a particular set of moral and bioethical commitments, they function as partisans for a particular legal and public policy vision, as supporters of a particular political vision. In this circumstance, appeals to "moral reasoning and ethical theory" serve as an intellectual ritual to convey intellectual authority to the activities of health care ethics consultants.

If this diagnosis of our moral and metaphysical context is correct, then one will need openly and forthrightly to acknowledge the real role of health care ethics consultants, namely, that of giving quasi-legal advice, providing risk management, and mediating conflicts. If health care ethics consultants can face this truth, they will then need honestly to inform the public (i.e., give informed consent) as to the real nature of the ethics of health care ethics consultation. Much will have to be rethought regarding bioethics and health care ethics consultation in a post-modern culture after God, after metaphysics, and indeed after morality.

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