ABSTRACT. This article starts with a brief historical account of the ongoing debate about the status of clinical ethics: theory of practice. The author goes on to argue that clinical ethics is best understood as a practice. However, its practicality should not be measured by the extent to which clinical-ethical consultants manage to mediate or negotiate resolutions to ethical conflicts. Rather, clinical ethics is practical because it is characterized by a profound concern for the well-being of individual patients as well as the moral parameters of swift and urgent medical action in the face of limited supportive information.

KEY WORDS: alternate dispute resolution, clinical ethics, consultation, mediation, negotiation, theory of practice

1. A BRIEF HISTORY OF CLINICAL ETHICS

Ever since the emergence – three decades ago – of medical ethics as an independent discipline, debates have abounded concerning its very nature. The original impetus to the development of medical ethics came from scholars who would traditionally be considered “theoreticians”: moral theologians and philosophers. From that very early beginning, “practitioners” objected against the intrusion of theoreticians into a field that was essentially non-theoretical. Medicine was a “techne,” not an “epistemem,” an art rather than a science. Theoreticians would never be able to get a good sense of what clinical medicine was about. If there was any need for an ethical remake of medicine, it would have to be done by the practitioners themselves. A second development emerged with established clinicians initiating ethics training programs and medical journal sections specifically aimed at and designed for other clinicians and practicing health care providers.1

Naturally, theoreticians were quick to point out that if such practical ethics were to qualify at all as ethics, it would have to be theoretically sound. While applied ethics might be more relevant to clinical practice than traditional philosophical ethics, it would have to be anchored in ethics proper. And so would applied ethicists: “An ethicist who is not also a philosopher or theologian, is equally absurd as a clinician who is not also a physician or psychologist.”2 If one grants that clinicians nevertheless could become familiar with that “foreign” trade of ethics, surely philoso-
phers and moral theologians could become familiar with the art of medical practice.

Not everybody was happy about this new marriage between clinical medicine and philosophical ethics. Some physicians worried that the intrusion of “one more of a growing number of back-seat drivers” would hamper or even undermine the trust that is essential to the patient-provider relationship. The physician must “enjoy total freedom of practice to enable him to make clinical decisions without outside interference.” Others feared that bioethics would hinder scientific progress, and some physicians bluntly stated that medical ethics is none of the philosophers’ business.

Applied ethicists responded that they merely “facilitate” the process of ethical reflection by discovering prevailing moral ideas and assess their applicability. Ethicists point out neglected features in discussions on moral subjects, spotting contradictions, mapping and critically evaluating the conceptual commitments and values conflicts in particular actions and choices, laying out alternatives, scrutinizing arguments, and listing sound reasons pro and con. But otherwise, competent ethicists remain at some distance from the actual provision of care without assuming any responsibility for the clinical decisions.

But that response, in turn, invoked criticism from (mostly continental) philosophers who objected that these “marital” partners simply are not compatible. Ethics is the turf of philosophers and theologians. While medicine justifiably focuses on solving emerging health-related problems, it is not the function of ethics to solve – or even worse – settle moral problems. At best, the ethicist can participate in the interpretation of the moral experiences of those involved in the provision (and reception) of health care. But the ethicist should not pretend to contribute directly to the “management” of moral dilemmas. If she or he does, ethics is likely to become the lubricating oil of the political machinery rather than its critical watchdog.

In the meantime a number of (mostly American) bioethicists – physicians and philosophers alike – did not await the outcome of this heated debate but set out to provide consultations on a regular, formalized, “professional” basis, while abiding by established protocols and ethics codes for clinical ethicists. They obtained beepers and started rounding the wards in white coats, writing consultations into the patients’ files, providing expert testimonies in courts, and voicing professional opinions on television. Naturally, this practical revolution evoked an equally radical critique from theoreticians. One Dutch philosopher of science boldly reacted that all bioethicists should be done away with. Medical ethicists are superfluous.