THE EPISTEMOLOGY AND ETHICS OF CONSENSUS: USES AND MISUSES OF ‘ETHICAL’ EXPERTISE

ABSTRACT. In this paper I examine the epistemology and ethics of consensus, focusing on the ways in which decision makers use/misuse ethical expertise. The major questions I raise and tentative answers I give are the following: First, are the ‘experts’ really experts? My tentative answer is that they are bona fide experts who often represent specific interest groups. Second, is the experts’ authority merely epistemological or is it also ethical? My tentative answer is that the experts’ authority consists not only in their command over specific matters of fact and/or value, but also in their ability to achieve ‘consensus’ about what is ‘true’/‘false’, or ‘right’/‘wrong’. Third, should the authority of expertise be limited? My tentative answer is that it should be limited in the area of facts but especially in the area of values. Persons who are ethics ‘experts’ must be particularly careful to practice an ethics of persuasion rather than an ethics of compulsion. Their role is not to force their group consensus upon decision makers’ individual moral perceptions and deliberations; rather it is to help decision makers come to their own conclusions about what they ought to do.

Key Words: authority of expertise, consensus, ethics committees, ethics of persuasion, NIH consensus development conferences

At the local, state, and national levels, decision makers increasingly have opportunities to make use of experts’ findings – be these experts panelists on a National Institutes of Health (NIH) consensus development conference or members of a hospital ethics committee. The purpose of this paper is twofold: (1) to examine how decision makers do make use of experts’ findings; and (2) to determine how decision makers should make use of them. While considering this second point, I will raise several epistemological and ethical considerations. First, are the ‘experts’ really experts or are they merely a disparate group of individuals assembled together simply to satisfy the requirements of a complex political agenda? Second, if these ‘experts’ really are experts, does their authority flow only from their accumulated
knowledge or does it also flow from their demonstrated ability to achieve so-called ‘consensus’ under conditions of uncertainty; in other words, is their authority simply epistemological or is it also ethical? Third, if these ‘experts’ have both epistemological and ethical authority, what are the limits of these authorities; if it is a problem in a political society for citizens to proxy away their decision making power to experts, is it also a problem in an ethical community for moral agents to do the same?

Whether each of these three considerations can be answered satisfactorily remains to be seen. But even if they cannot be answered satisfactorily, it is important to raise them in order to focus on what I regard as a disturbing tendency; namely, the tendency to use a group’s consensus as a substitute for an individual’s own moral deliberations and perceptions. Nevertheless, despite my reservations about misusing NIH consensus development conferences and hospital ethics committees, I do think that they are a welcome addition to biomedical decision making provided that their cumulative wisdom is accorded no more than persuasive power.

I. DECISION MAKERS USE OF EXPERTS’ FINDINGS: THE STATUS QUO

Although NIH consensus development conferences were originally established to expose the public to emerging biomedical technologies, within a short period of time their focus had expanded to include existing as well as emerging ones (Mullan et al., 1985, p. 1070). Over the last 10 years, the NIH has convened over 60 consensus development conferences, each of them dealing with a subject that is purportedly (1) medically important to a significant segment of the population; (2) characterized by sufficient scientific uncertainty; and (3) “amenable to scrutiny” on account of the large volume of scientific evidence available (Mullan et al., 1985, p. 1068). The stated goals of a consensus development conference are to assess not only the safety and efficacy but also the cost-effectiveness and ‘ethics’ of a given biomedical technology, and to share that assessment equally with the general public and medical practitioners (Consensus, 1977–78).

But because most NIH panelists are scientists and/or physicians, they have tended to focus on the factual issues of safety and efficacy and to view medical practitioners as their primary audience. As a result, NIH conferences have increasingly
borrowed from either the judicial process model, where scientific evidence is heard by knowledgeable, presumably unbiased judges/jurors, or the scientific meeting model, where science experts discuss their work in a collegial manner. They have increasingly relied on the town meeting model, where a forum is provided for all interested parties, knowledgeable or not, expert or not, to express their views (Mullan et al., 1985, p. 1068). Despite this trend, the NIH's original intent to inform the public about biomedical technologies continues to be honored in the structure of the standard NIH consensus conference, which usually runs for two and one-half days. On the first day and one half, speakers present papers to the panelists and the public at large. Toward the end of the second day, the panelists go into executive session in order to formulate their findings. (Although this session almost always lasts past midnight, panelists insist that they remain intellectually alert and morally sensitive throughout it!) Finally, on the morning of the third day, during a public press conference, the panelists announce their findings in the form of written recommendations and/or guidelines. Supposedly, these findings have no regulatory status. They are meant only to be useful to medical practitioners and, it is added, "to those patients who choose to avail themselves of the statement" (Mullan et al., 1985, p. 1070).

The ultimate usefulness of the experts' recommendations/guidelines depends, of course, on how ably the NIH disseminates them to decision makers and how willingly decision makers implement them. Remarkably, the media have reported conference results in a largely thorough and objective manner, a state of affairs indicating that literate patients as well as attentive medical practitioners do have some opportunity to be informed about biomedical technologies (Perry, 1987, p. 486). In addition, JAMA and other prestigious medical journals routinely publish conference results, and the NIH automatically mails them to over 21,000 individuals and organizations. Nevertheless, telephone surveys suggest that only 15–20 percent of all physicians, and 40 percent of specifically targeted physicians, can recall hearing about a given NIH consensus conference (Mullan et al., 1985, p. 1072). Evidence also indicates that when medical practitioners change their behavior in ways that apparently accord with conference recommendations, they would have done so in any event (Riesenberg, 1987, p. 2738). According to Ann Greer, NIH
panelists may like to think of themselves as “leaders”; that is, as specialists on the cutting edge of new developments in biomedical technology. In point of fact, NIH panelists are frequently “laggards”, simply articulating in abstract theory what is already going on in concrete practice (Greer, 1987, p. 2740). What adds credence to Greer’s observations is the fact that panelists tend to achieve consensus only when there is little debate in the scientific literature (Greer, 1987, p. 2740). Since lack of debate in the scientific literature generally indicates lack of division in medical practice, the NIH’s consensus often serves simply as an “imprimatur” or seal of approval for an already existing and/or emerging medical practice (Lomas et al., 1988, p. 3004).

To date, NIH consensus development conferences have not prescribed “cookbook medicine” for medical practitioners, whereby doctors become “automata” who mechanically follow the dictates of an elite group (Perry, 1987, p. 486). Few physicians religiously consult NIH documents, ultimately trusting the wisdom of local experts rather than the ‘findings’ of distant experts with whom they have never had a personal encounter. In addition, litigants have not appealed to NIH conference results as authoritative statements of what constitutes good medical practice (Kosecoff, 1987, p. 2712). Courts still invoke traditional standards of good medical care in malpractice and/or negligence suits. Finally, third-party payors have not refused to pay for medical procedures simply because they lack the NIH seal of approval. At most, the results of NIH conferences have simply been used as yet another piece of evidence justifying non-payment or payment of a given procedure.

Like NIH consensus development conferences, hospital ethics committees have a relatively short history. Commentators trace the roots of today’s ethics committees back to special committees in the 1920s to review sterilization decisions, in the 1950s to review abortion decisions, and in the 1960s and 1970s to allocate scarce renal dialysis machines. Not until 1976, however, did hospital ethics committees become an object of significant interest. That year, in the Karen Ann Quinlan case, New Jersey Supreme Court Justices relied on an article in which Karen Teel stated that she considered hospital ethics committees an invaluable resource for morally-perplexed health care professionals (Ross et al., 1986, p. 6). Despite the fact that ethics committees were few and far between, the Justices ruled that if a hospital ethics committee
agreed with the prognosis of Quinlan's attending physician that there was no reasonable chance that she would ever return to a "cognitive, sapient state", then she could be allowed to die upon her family's request (Ross et al., 1986, p. 6). As it has been repeatedly noted, the Justices had obviously confused prognosis committees with ethics committees. Nevertheless, spurred on by the Quinlan decision, many hospitals did establish full-fledged ethics committees, whose functions differed from those of prognosis committees. Within a short time, however, interest in ethics committees waned only to wax again in the 1980s with two Baby Doe cases, both of which involved nontreatment of seriously ill newborns, the quality of whose lives was judged minimal. As a result of a 1983 Presidential Commission report, DHHS recommendations, and American Academy of Pediatrics recommendations, many hospitals set up Infant Care Review Committees (ICRCs),1 which like Institutional Review Boards (IRBs)2 focus only on a narrowly specified set of ethical issues. Over the last five years or so, hospitals have also shown interest in establishing less narrowly specified ethics committees. However, these newer ethics committees have not always been able to articulate their broader mandate. As a result, many of them have remained relatively indistinguishable from risk-management committees, public-relations committees, legal-watchdog committees, consciousness-raising committees, and communications-facilitation committees as well as from the more narrowly-specified ICRCs and IRBs. Even when one of these newer ethics committees is confident that its broader mandate permits it authoritatively to invoke ethical principles such as autonomy, beneficence, non-maleficence, truth-telling, and justice as 'musts' in the hospital environment, its members may be divided about the way(s) in which to perform this task. Should an ethics committee be in the business of ethics education only, they ask, or should it also engage in policy recommendation and case review (either prospective or retrospective)?

Currently, most ethics committees have decided that theirs is a multifunctional role. Although decision makers seem generally sanguine about the educative and even policy recommendation functions of an ethics committee, they are sometimes troubled by its case review function. Their concern is that in reviewing a case prospectively, an ethics committee might insist that its view of ethically justified (non)treatment ought to substitute for that of medical practitioners', families', and/or patients'; or, that in
reviewing a case retrospectively, an ethics committee might accuse medical practitioners and possibly families of ethically unjustified conduct. Largely due to these understandable concerns, ethics committees generally follow the so-called optional-optional model. No one – be s/he a medical practitioner, a family member, a patient, or other concerned party – is required either to bring his/her ‘ethics issue’ to the ethics committee or to follow its recommendations/guidelines/advice/counsel. So concerned are hospital ethics committees about the enormously complex political ramifications of their deliberations that few of them have adopted one of the other three proposed models for ethics committees: the optimal-mandatory model (x need not approach the ethics committee, but should x decide to do so, x is bound by its determinations); the mandatory-optional model (x must approach the ethics committee in all or some cases, but x is not bound by its determinations); and the mandatory-mandatory model (x must approach the ethics committee in all or some cases, and x is bound by its determinations) (Levine, 1984, p. 11).

Recently some critics have faulted ethics committees for being too secretive, too inaccessible, and too inattentive to procedural safeguards (Lo, 1987, pp. 46–49). In some hospitals, patients and family members as well as medical practitioners know about the ethics committee’s existence and are encouraged to use it if necessary, but in one study less than 8 percent of patients and family members even knew about its existence let alone had access to it (Youngner et al., 1984, p. 23). This state of affairs is starting to change, however. Not wanting to be burdened with the reputation of being Star Chambers, an increasing number of hospital ethics committees are making themselves accessible to all members of the hospital community. Ironically, by becoming more ethical (at least more democratic), hospital ethics committees have often exposed themselves to greater legal scrutiny. So far the courts have been divided as to what importance to assign to ethics committees recommendations. In re L. H. R. the court ignored an ad hoc Infant Care Review Committee’s determination that it was ethically permissible to remove from a respirator a terminally ill infant in a chronic vegetative state with no hope of cognitive functioning. Since the court viewed this case as a decision to forgo death-prolonging rather than life-prolonging treatment, it believed the decision should belong completely to the family – for “the state has no interest in prolonging death” (Wolf, 1986, p. 13).
Neither court nor ethical committee has an ‘expert’ role to play in such a case. In contrast, in two other cases, Torres and Spring the courts suggested that ethics committees’ recommendations may constitute not only relevant evidence of what medical practitioners and/or families should have done, but also evidence which the court can regard as highly persuasive (Wolf, 1986, pp. 13–14).

II. DECISION MAKERS USE OF EXPERTS’ FINDINGS: RECOMMENDATIONS FOR THE FUTURE

From what has been said so far, it seems that decision makers – medical practitioners and/or the general public – have not been particularly beholden to the recommendations of NIH consensus conference and hospital ethics committees. Under no obligation to defer to the experts, decision makers have felt as free to ‘leave’ their advice as to ‘take’ it. Some advocates of NIH consensus development conferences and hospital ethics committees have lamented this situation, arguing that decision makers should rely more heavily on the collective wisdom of these two bodies. It is better, say these advocates, to err by attaching too much weight to the recommendations of experts than by attaching too little weight to them. Giving pause to these advocates’ arguments, decision makers are increasingly moving in the direction of obligating themselves to defer to the experts’ advice. Although this new tendency is not entirely misguided, what I shall argue is that when it comes to the experts’ distinctively ethical advice, decision makers should not defer to it simply because it ‘belongs’ to the experts. Rather decision makers should think the experts’ ethical advice through for themselves, accepting it only if it fits their own reasoned moral point of view. Second-hand ethics is no substitute for first-hand ethics in a community of equally autonomous moral agents.

A. Are the ‘Experts’ Really Experts?

If decision makers are moving in the direction of accepting the authority of expertise, then NIH panelists and ethics committees members had better be real experts – that is, they had better know more than the decision makers do. Since NIH panelists’ forte is supposedly ‘the facts’, and since ethics committees’ forte is supposedly ‘values’, I propose to look at these two groups of experts
separately. Given that most NIH panelists are scientists, it is not clear that decision makers should be obligated to follow any of their ethical recommendations. NIH consensus is a two-step process: "agreement among the experts that a given innovation is deemed potentially feasible for introduction into practice", followed by agreement between these experts and health care representatives that it is "suitable" as well as "feasible" to make these innovations given their economic and/or ethical ramifications (Perry, 1978, p. 485). Implicit in this description of the consensus process is the message that two groups of panelists participate in NIH consensus development conferences: a large group of scientific experts who deal in "the facts", and a small group of healthcare representatives who "provide value judgments" whether or not they have a recognized expertise in ethics (Perry, 1978, p. 485).³

But if this is the case, by requiring medical practitioners, for example, to follow the NIH's ethical recommendations, we require them to follow the advise of health-care representatives who have no more expertise in ethics than they themselves have. Nevertheless, an argument can be made that even if medical practitioners do not have an obligation to follow the NIH's ethical recommendations for the reason just given, they may still have an obligation to follow its factual recommendations. As appealing as this line of reasoning is, the point of the matter is that so-called factual recommendations about 'safety' and 'efficacy' are not entirely value-free; and to the degree that they are not value-free, the recommendations of scientific experts about 'safety' and 'efficacy' may be no more authoritative than those of any random group of medical practitioners.

That 'safety' and 'efficacy' are the kind of concepts in which facts and value merge is clear. Consider the concept of 'safety'. When it comes to biomedical technology, for example, no one disputes either that safety is a good or that most, if not all, biomedical technologies are risky. Instead, everyone agrees that what is called for is risk assessment: a two-step process that requires the expert (1) to estimate the magnitude and probability of an adverse effect occurring; and (2) to judge just how acceptable to the public the occurrence of this adverse effect would be (Tong, 1986, p. 25).

Both steps of the risk-assessment process are riddled with epistemological problems. Risk estimates are tricky because they
require the risk-benefit analyst to pit objective ones against subjective ones. Objective risk estimates describe real risks. Using either mathematical calculations or experimental evidence, the analyst estimates, for example, the statistical probability of a random person contracting AIDS as a result of a blood transfusion. In contrast to objective risk estimates, subjective ones describe perceived risks. Relying on either personal experiences or anecdotal information, the analyst estimates the likelihood of himself/herself contacting AIDS as a result of a blood transfusion. Not surprisingly, objective and subjective risk estimates do not always agree (Tong, 1986, pp. 25–26); the real risk of contracting AIDS as a result of a blood transfusion may be far less than the perceived risk of so doing.

When objective and subjective risk estimates conflict, NIH experts rely on the objective ones, discounting the subjective ones as much as possible. Although their predilection for objectivity over subjectivity may not be particularly comforting to the public, NIH experts insist that the perception of risk is not the reality of risk, and that what is ultimately the most effective protection against real risks is not to indulge non-experts' fantasies about perceived risks. Common sense suggests that if parents should not cater to their children's irrational fears of gremlins, goblins, and ghosts, then medical practitioners should not cater to their patients' ungrounded suspicions, phobias, and paranoias about (relatively) safe biomedical technologies. Nevertheless, objective risk estimates are not always more accurate than subjective ones. Objectivity is enormously difficult to achieve because experts are far from infallible. They make more mathematical and scientific errors than they care to admit. And even when objective risk estimates are accurate, the mere fact that experts are able to make them does not give them the right to impose them on anyone other than themselves.

What makes an estimated risk acceptable is not the fact that some expert determines that it is acceptable, but the fact that the individuals who must bear the costs of that risk determine that it is reasonable for them to take that risk. According to Joel Feinberg, there are at least five considerations that distinguish a reasonable from an unreasonable risk:

(1) the degree of probability that harm to oneself will result from a given course of action, (2) the seriousness of the harm being risked, i.e., "the value or impor-
tance of that which is exposed to the risk," (3) the degree of probability that the
goal inclining one to shoulder the risk will in fact result from the course of action,
(4) the value or importance of achieving that goal, that is, just how worthwhile it
is to one (this is the intimately personal factor, requiring a decision about one's
own preferences, that makes it so difficult for the outsiders to judge the
reasonableness of a risk), and (5) the necessity of the risk, that is, the availability
or absence of alternative, less risky, means to the desired goal (Tong, 1986, p. 29).

Given these five considerations, when NIH panelists state that the
risks of a given biomedical technology are ‘acceptable’, they are
judging that it is reasonable for people other than themselves to
accept those risks. But given condition four above, the ‘intimately
personal factor’, it seems morally presumptuous for experts to
force their assessments of risk acceptability upon agents whose
assessments may differ from their own. A surgery with a 60
percent success rate might be an acceptable risk to an expert, but
not so to a woman with a 40 percent of dying and leaving behind
her husband, infant, and career. For her, a handicapped life with
an 80 percent chance of survival might be more acceptable. No
one can tell her otherwise without dictating her preferences and
her life to her. Clearly such control is unjustified.

If the expertise of NIH consensus development conferences is
limited in a number of ways, so too is that of ethics committees – a
point that decision makers need to ponder before deferring to
their recommendations. First, most members of ethics committees
are health care professionals who have had little, if any, formal
training in ethical reasoning.

Second, even if all the members of an ethics committee had
formal training in ethical reasoning, only their procedural skills as
professional ethicists – and not also their substantive conclusions
as moral agents – could be non-problematically offered to other
moral agents. Ethics is not a set of conclusions that experts pass on
to non-experts; rather, it is a set of decision making tools that non-
experts as well as experts must use if they are to reach their own
conclusions about what is morally permitted, required, or forbid-
den to them. We cannot blindly follow others’ truths and hope to
gain knowledge to guide our lives and choices. Morality is a
personal quest.

Third, not only is it possible for experts and non-experts to
produce substantively different moral conclusions using the same
procedural lines of moral reasoning, it is also possible for them to
disagree about these procedures. For example, professional
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Ethicists usually refer to a cluster of five moral principles - autonomy, truth-telling, beneficence, non-maleficence, and justice. But which one of these principles should moral agents honor when two or more of them conflict? Suppose an ethics committee is asked whether it is morally permissible to withdraw a ventilator from a terminally ill and very-aged man. Depending on which principle(s) dominate(s) its deliberations, the committee may reach a 'consensus' that another committee, with a different ranking of ethical principles, might not reach. And yet, when ethics committees publicize their findings, very rarely do they reveal which ethical principles governed their discussions and how they came to rank autonomy or justice above beneficence, for example.

Fourth, and finally, ethics committees usually have little, if any, direct contact with the people who populate the paper cases brought to their attention. But if it is true, as I think it is, not only that values shape facts but also that facts shape values, then the soundness of an ethics committee's value judgments may ultimately be a function of their degree of exposure to the concrete facts of a given case. Abstract thought, detached from faces and real-life situations, depersonalizes all involved. Small groups of experts debating over a child's cancer treatment may lose touch with the human element of the case. Ethics committees must be careful lest their attempt to be impartial makes them treat people as equal, faceless, interchangeable atoms in the universe.

B. The 'Authority' of Consensus: Just How 'Moral' Is It?

So far I have argued that the expertise of NIH panels is one largely confined to their ability to make factual observations rather than to make value judgments. I have also argued that the expertise of ethics committees is one largely confined to their ability to order the procedural principles of ethics rather than to achieve substantively 'right' moral conclusions. Why, then, do some advocates of NIH panels and hospital ethics committees not only urge decision makers to recognize such groups of experts as moral authorities but also to defer to their judgments? My own view is that these advocates are basing the moral authority of NIH panels and ethics committees on the simple fact that, unlike many groups debating value-laden issues, these panels and committees have been able to come to agreement: to reach so-called 'consensus'. But, as positive
as this achievement is for the groups involved, it is my view that the ability to reach so-called ‘consensus’ does not, in and of itself, transform a group of experts into a group of moral authorities – and this is true whether consensus is understood as a product or as a process, a point that philosopher Jonathan Moreno has made.\(^4\)

On the one hand, if consensus is understood as a product – that is, the agreed-upon conclusions of a group’s deliberations – then we should recall that just because conclusions are agreed upon does not mean that they are right. A group may come to an understanding simply because some of its members are exhausted or passive; or a group may fall under the spell of a particularly strong leader whose ideas they self-deceptively accept as their own; or a group may become so comfortable with each other that they start to think alike. Thorny issues might be avoided, problems glossed over, adequate delving for information neglected, secondhand opinion accepted at face value, and devil’s advocates silenced in the push for consensus (Lo, 1987, p. 48).

On the other hand, if consensus is understood as a process – that is, the creation of a climate in which people can deliberate together – there is no good reason why a group of people capable of creating their own consensus should not do so, relying instead on some other group’s ability to create consensus. I suppose if players in a real life ethical drama come to dead ends rather than to consensus, they may find it useful to see what other people, role-playing their situation, determine as the correct path of action. For example, if physicians and family members try to create a climate in which they can deliberate together about what is in grandma’s best interests but fail to reach a consensus, then it makes sense for them to approach an ethics committee. But in no way should they simply acquiesce to the solution of an ethics committee that will, after all, be discussing their ethical dilemma not as a lived experience but as a vicarious experience. The same detachment that allows a ‘role-playing’ ethics committee to break stalemates and come up with new solutions may cause it to distort the realities of an ethical dilemma whose subleties cannot be captured on paper.

**C. The Limits of Consensus**

But despite the reservations I have just expressed about NIH consensus development panels and especially ethics committees, I
believe that an increasing number of decision makers are going to keep moving in the direction of greater deference to the authority of expertise. Bombarded by more information than they can possibly process, fatigued by interminable debates during which people doggedly defend conflicting viewpoints, uncertain not only about what to uphold as a value but about what to recognize as a fact, decision makers are increasingly impressed by the ability of any group to come to consensus, and they are increasingly willing to believe that they may not have what it takes to make their own moral decisions. Decision makers' growing diffidence is compounded by the fact that some critics question not only the ability of decision makers, especially medical practitioners, to sort through a moral dilemma but also their 'good-faith' willingness to do so. In a much-cited article on ethics committees, law professor John Robertson notes that hospitals set up IRB's to protect research subjects from the excesses and/or defects of research scientists (Robertson, 1984, p. 92). He then observes that like some medical practitioners, some medical researchers are prone to ignore patients' rights – or even to be oblivious to them – in certain areas of their practice. Infant care, suggests Robertson, may be one of those areas. Although it is debatable whether medical practitioners have in fact mistreated severely defective infants, as the result of heavy political pressure and unfavorable publicity, most hospitals have set up ICRCs. Supposedly acting in the best interest of severely defective infants, these committees often require medical practitioners to do 'everything' to keep them alive. (I wonder, as do several critics, whether some ICRCs really belong to the genus 'ethics committee'. To the extent that an ICRC refuses to entertain the question whether a given baby should survive it seems to be asking only the far different question of whether it can survive (Weit, 1987, p. 108)). Robertson favors ICRCs as well as IRBs, and thinks that the IRB/ICRC model may be profitably extended to ethically charged areas such as sterilization of the retarded, bone marrow or other transplants from minors, and withholding of treatment from incompetent but non-terminally ill patients (Robertson, 1984, p. 92–93). In fact, he has argued that the recommendations of ethics committees should follow not the mandatory/optional model but the mandatory/mandatory model. Admittedly, the mandatory/mandatory model would have the welcomed consequence of making ethics committees' deliberations more public. No longer would
ethics committees be permitted to apply their own idiosyncratic rules to the cases brought before them; rather they would be required to apply publicly scrutinized rules to them. But even if the mandatory-mandatory model has the virtue of being more accountable to the public, it has the vice of 'de-moralizing' non-experts in at least two ways. First, ethics committees can effectively discredit the ethical decisions that medical practitioners, patients, and/or families make. As a result, these discredited 'non-experts' may become either alienated (aggressive) or apathetic (passive). Second, a very visible and vocal ethics committee can easily erode medical practitioners', patients' and/or families' desire to make their own ethical decisions. As a result, patients lose their immediate support group, as families and physicians give up their involvement in the decision making process, deferring to the authority of the 'ethics experts'.

III. CONCLUSION

Some people argue that we may have opened Pandora's box with the use of consensus committees. Now that NIH consensus development conferences and ethics committees exist, it is only a matter of time before their recommendations become mandatory. Even if that was not their founders' intention, our culture is such—and our distrust of each other is such—that experts' findings will be invoked as authoritative norms. I am not certain that this state of affairs can be totally avoided, but I think that it can be largely blocked without having to deprive ourselves of the excellent information and advice that NIH panelists and ethics committees members do have to offer. Perhaps these groups can help prevent their own apotheosis by getting clearer on their consultative nature and function; that is by refusing to let themselves be used as definitive authorities. Perhaps ethics committees will have to emphasize their educative and policy-making roles and to de-emphasize their case review role. Perhaps NIH consensus development conferences will have to emphasize their information-delivery role, eschewing a standard-setting role.

What we need to develop is an ethics of persuasion. We must keep in mind that although we may attempt to convince some people to change their behavior, we may never force them to do so, as we will disempower them, depriving them of their sense of autonomy. As John Stuart Mill argued in On Liberty, an individual
... cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise, or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him, or visiting him with any evil in case he does otherwise (Mill, pp. 70–86).

Critics have, of course, not been entirely satisfied with Mill’s distinction between persuading and compelling. In order to convince someone to change his behavior, we may legitimately tell him that unless he changes for the better we will not associate with him; but, unless he is harming other people, we cannot organize a campaign to get him fired from his job or expelled from his school. For due to people’s need for greater or lesser social approval, critics fear that the least expression of displeasure may cause at least hyper-sensitive people to rethink their entire way of doing and being – changing it sometimes to the detriment of themselves. Therefore, critics urge that if we must err between not being persuasive enough and being too persuasive, we should err in the direction of not being persuasive enough. Otherwise we risk having a chilling effect on each other’s personality and on each other’s actions. Still, this risk may be one to take, lest we become moral isolationists who refuse to talk to each other for fear of having our minds changed.

If we want NIH consensus development conferences and ethics committees to be used properly, we need to create an atmosphere in which people both seek and heed advise; in which experts offer their knowledge to non-experts in order to spare them the pain of unnecessary mistakes – especially if these mistakes will seriously jeopardize the well-being of innocent third parties. Thus, there is an argument to be made that medical practitioners should regard the recommendations of NIH consensus development conferences as useful reference tools: not the rulings of philosopher-kings, but the attempt of thoughtful people to share their knowledge – albeit imperfect – with other people. Likewise, there is an argument to be made that physicians, patients, and families should regard ethics committees as allies rather than adversaries – as friends to go to when they are having a difficult time sorting through things, rather than as foes who are out to get them. We suffer from too much egoism, isolation, and the belief that strong decisions are made alone. It will take a long time to change this – but one way
to begin is by developing an ethics of persuasion. The NIH should disseminate its recommendations in local forums as well as national press conferences so that medical practitioners have the opportunity to think through their results with them. Ethics committees should invite the patients, physicians, and/or families who have sought their recommendations to listen to their deliberations. Some of the points an ethics committee raise may, after all, bring clarity to the petitioners' confusion. But if clarity is not forthcoming for the petitioners, or if their vision finally differs from that of the ethics committee, the committee must refrain from crossing the line between persuading and compelling. Their consensus – whether it is understood as a product or a process – is theirs: all the easier to achieve because of their distance from the concrete particularities of the cases brought to their attention.

The fact that ethics committees (and for that matter, NIH panels) operate at a distance from 'the particulars' of a case reminds me of a passage from the *Nicomachean Ethics.* In it Aristotle expresses how difficult it is for a person to respond to a situation in a morally appropriate way; that is, to achieve a condition 'intermediate' between an excessive over-reaction and a defective under-reaction:

In summary, then, if we do these things we shall best be able to reach the intermediate condition. But no doubt this is hard, especially in particular cases, since it is not easy to define the way we should be angry, with whom, about what, for how long; for sometimes, indeed, we ourselves praise deficient people and call them mild, and sometimes praise quarrelsome people and call them manly. Still, we are not blamed if we deviate a little in excess or deficiency from doing well, but only if we deviate a long way, since then we are easily noticed.

But how far and how much we must deviate to be blamed is not easy to define in an account; for nothing perceptible is easily defined, and [since] these [circumstances of virtuous and vicious action] are particulars, the judgement about them depends on perception (Aristotle, *Nicomachean Ethics* II 9, 1109b, 12–24, trans. Terence Irwin).

It seems to me, at least, that particulars and perceptions, not universals and abstractions, are the key to ethical decision making in the medical and biomedical context. Like NIH consensus development conferences, ethics committees can help decision makers think through confusing moral issues. What they should not do, however, is to force their 'abstractions' on decision
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makers. Although an NIH panel and/or ethics committee may help clear up a decision maker's clouded view in a medical dilemma, it can never see that dilemma through his or her eyes. Decision makers should pay heed to ethics 'experts' not to the degree that they are able to achieve consensus among themselves, but to the degree that they are able to help 'non-experts' perceive what they need to perceive in order to make their own decisions. As wonderful as group consensus is, it is not the aim of ethics; rather individual perception is. The final decision about what to do in any situation must rest, then, with those whose perception of it is the most immediate - that is, with those who can see, hear, touch, and/or feel 'what is going on' and not with those who can only think about 'what is going on'.

NOTES

1 According to Weir, these committees have become less like ethics committees and more like legal watchdogs. As he sees it, ICRC's are deviating from their founding purpose of trying to decide whether prolonging the life of severely premature and/or handicapped infants is in an infant's best interest; gradually, they are changing into medical busybodies, concerned with promoting "adherence to the law." Fear of civil and/or criminal liability also inhibits ethics committee members and makes them overly concerned about legal issues to the neglect of explicitly ethical issues (Weir, 1987, p. 107).

2 An IRB is a "system of review of research with human subjects" and an ancestor to ethics committees (Robertson, 1984, p. 86).

3 Occasionally, a philosopher, theologian, or someone else with recognized expertise in ethical reasoning sits on a NIH panel, but this is far from the rule.

4 Jonathan Moreno has recently made the distinction between consensus as a product and consensus as a process. As he sees it, consensus should be understood as a process:

Thus consensus should not be thought of as a goal of ethical deliberation but, more broadly, as a condition for the successful resolution of a controversy. The consensus itself is at one from the substantive discussion, for in order to know if consensus has been reached the group as a whole must step back from the discussion it has just pursued and inspect the group process. Put another way, the conclusion of a group's deliberation is distinct, both logically and psychologically, from the group's collective awareness that it has reached a conclusion. "Consensus" is literally the sense that the group shares, it is the way the group perceives in common its own interactive situation (Moreno, 1989, p. 15).
REFERENCES

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