


A Sociological Analysis of Ethical Expertise: The Case of Medical Ethics

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Nathan Emmerich¹

Abstract

This article outlines a theoretical and conceptual account for the analysis of contemporary ethical or “bioethical” expertise. The substantive focus is on the academic discipline of bioethics—understood as a “practical” or “applied” ethics—and its relationship to medicine and medical ethics. I draw intellectual inspiration from the sociology of science and make use of research into the idea of “expertise” *per se*. In so doing, I am attempting to move the debate beyond the limitations placed upon it by philosophical or meta-ethical analysis and develop a perspective that can be used to address the sociological reality of (bio)ethical expertise. To do so, I offer the terms *ethos* and *eidos* to provide a basic conceptual framework for the sociological analysis of “morality” and “ethics.” I then turn to an exegesis of Collins and Evans’s account of ubiquitous, contributory, and interactional expertise and situate these topics in relation to academic bioethics and medical practice. My account suggests a particular understanding of the kinds of relationships that “bioethics” should seek to foster with the social fields it endeavors to not only comment on but also influence.

Keywords

ethics, bioethics, expertise, practice theory, interactional expertise

Introduction

Given the fact that “bioethics” and, more specifically, “applied” or “practical” ethics have come to wield an increasing degree of influence (cf. Littoz-Monnet, 2014), there is a pressing need to theorize and thereby comprehend the way such expertise not only works but could be made to work. However, despite a reasonable significant body of bioethical scholarship on the topic (Noble, 1982; Rasmussen, 2005; Singer, 1972), there seems little of normative value. The analysis presented below attempts to move the debate forward by drawing on the work of Collins and Evans (2002, 2007), whose theory of expertise is explicitly positioned as normative. However, my remarks do not consider “bioethics” as a whole but on a particular and, one might add, dominant aspect of this interdisciplinary, namely, “applied ethics” or that part of bioethics that can be considered to be offering a specific and challenging form of *ethical expertise*. Furthermore, my analysis is conducted in the particular context of “medical ethics” and concerns the relationship between ethics in medical practice and the scholarly endeavor of applied (medical) ethics. The exegesis is social theoretical and, broadly, rooted in a contemporary “theory of practice” perspective. As such, my interest is not restricted to a descriptive theorization but represents a critical engagement with implications for the reconstruction of the relationship between, on one hand, clinical practitioners and the health care professions and, on the

other, experts in applied ethics. With this in mind, one might position this essay as a socio-analysis of the *ethics of bioethics* or, more accurately, the ethics of applied ethical expertise. However, in the same way as sociological research into science is indifferent to the methodological and epistemological claims of its object, I am largely indifferent to the internal methodological and meta-ethical commitments embedded in the disciplinary practice I seek to analyze. My analysis is grounded in a sociological or social theoretical perspective; it is self-consciously constituted as external to the philosophical practice known as applied ethics, a mainstay of bioethics. Thus, while it can be understood as a kind of ethical analysis, it cannot be considered a form of applied or practical ethics.

As this introductory paragraph suggests, I am, for the purposes of analysis, distinguishing something called “applied ethics” from “bioethics” or even “ethics” more generally. First, while they can be seen as forming the core of the field, bioethics encompasses more than “applied ethics” or even “ethics.” It is a multi- and inter-disciplinary endeavor that encompasses historical, sociological, and anthropological

¹Queen’s University Belfast, UK

Corresponding Author:

Nathan Emmerich, Queen’s University Belfast, Belfast, BT7 1NN, UK.
Email: n.emmerich@qub.ac.uk



perspectives. Second, my aim is to analyze bioethical expertise in such a way as to face up to what I consider the “hard problem” of a specifically *ethical* expertise. Thus, my focus is on “applied ethics,” which, as a mode of ethical analysis, presents itself with a greater degree sense of *normative conclusion* than other forms of disciplined ethical analysis or even “normative ethics” in general. While the “authority” of such conclusions is, it is claimed, a function of “the argument” rather than “the author,” it is nevertheless the case that, one, applied ethics is a methodologically disciplined, specialist and, therefore, expert activity, and two, it is a mode of analysis that is strongly aimed at being broadly guiding action or *practical*.

Perhaps unsurprisingly, the notion of an applied ethics is not easy to specify, at least not fully. In the first instance, one might note that the application of moral theory to ethical problems is not a simple one (Beauchamp, 1984; Gert, 1984; Hoffmaster, 1991; Kamm, 1988, 1995; Kopelman, 1990; MacIntyre, 1984; Wolf, 1994). Furthermore, despite the supposed differences between them, applied ethics encompasses both “principlist approaches” as well as those that claim to be based in broader conceptions of our “common morality” (Beauchamp & Childress, 2009; Clouser & Gert, 1990; Davis, 1995; Gert, Culver, & Clouser, 1997, 2000; Green, Gert, & Clouser, 1993; Lustig, 1992, 1993; Richardson, 2000). For the present purposes, it is, I think, better to consider applied ethics as a style of argument or a mode of ethical rationality. This approach to ethics is fundamentally philosophical but, nevertheless, has an essentially practical ambition meaning that, as London (2001) suggests with regard to the more general phenomena of normative or “practical” ethics, applied ethics exhibits a certain degree of independence from philosophical moral theories. Nevertheless, applied ethics is not as intersubjectively accommodating as London suggests of practical ethics. Indeed, for the most part, the academic and analytic values embedded in the disciplinary field of practice mean that a virtue is made of robust disagreement and the resulting tenor that colors the exchange of ethical argument.

One way to characterize the practice of applied ethics is by reference to the particular set of values that distinguish it from other forms of practical ethics such as casuistry, discourse ethics, reflective equilibrium, and feminist ethics. Of particular interest is, I think, the way in which the values underpinning ethical analysis affect the relationship between it and the notion of politics and political debate. There are, no doubt, a variety of other reasons one could consider in examining such differences. Casuistry, for example, rejects “the tyranny of principles” (S. E. Toulmin, 1981). However, it is the variation in perspective on “politics” that most clearly reveals important variations in argumentative and analytic style. According to Radcliffe-Richards, applied ethics is prior to—and has priority over—politics. As she puts it, there is “a crucial distinction between debates about policies or actions that are under consideration, and debates about what

constraints or limits should be imposed on those considerations from the outset” (Radcliffe-Richards, 2012, p. 134). Although discourse ethics, reflective equilibrium, and even feminist ethics all offer disciplined forms of ethical argument, there is a less sharp distinction between them and concerns of a more political nature. Indeed, the approach taken to ethics by these analytic modes is not apolitical but shaped by political concerns. While some have questioned the idea that applied ethics is, in fact, apolitical (Evans, 2012; Tronto, 2011), it nevertheless remains a presumption fundamental to the endeavor. Although we need not challenge this conceit at the level of methodology—many of the underlying perspectives presumed by many intellectual endeavors are, when considered sociologically, essentially treated as methodological rather than philosophical commitments—there is no need to adopt it ourselves. Thus my arguments do not, at least not explicitly, aim at the methodological destabilization of applied ethics. Rather they aim to situate the expertise of applied ethicists in its broader socio-cultural and political context and, consequentially, question the ethics of such expertise.

The approach to ethical analysis adopted by applied ethics achieves its generality (if not universality) through an attempt at ethical objectivity, the form of which is reliant not only on its apolitical stance but also through being socially, culturally, and historically decontextualizing. Different approaches to ethics vary in the degree to which they pursue (or value) the same kind of ethical objectivity and, therefore, the degree to which they are similarly decontextualizing in their analysis. Although feminist ethics seeks to retain and recognize the ethical importance of gender and its associated, and historically variable, socio-cultural norms, discourse ethics can be characterized as something that “embeds the practice of disembedding” (Anderson, 2005, p. 178). The most appropriate way to characterize the distinction between different forms of ethical analysis is, at least for the socio-analytic purposes at hand, not simply by placing them on a spectrum with regard to their socio-political sensitivity but through reference to Wittgenstein’s notion of family resemblance. To anticipate something of the below argument, ethical analysis proceeds according to the particular, and largely implicit, values, norms, and principles that constitute the ethos of the disciplinary field. The differences between different modes of ethical analysis exist at this level, the level ethos; therefore, the relevant family resemblances also exist at this level. Thus, while my analysis focuses on the expertise of applied philosophical approaches to (bio)ethics, it remains an example of the more general phenomena of “normative” or “practical” ethics.

Furthermore, regardless of their methodological stripes or meta-ethical perspectives, we might also note that what expert ethicists actually do is highly consistent. Their primary task is to develop and present ethical arguments and to do so in the form of journal articles. To do so, they read similar articles, remain abreast of the substantive fields they

comment upon, and give presentations to their peers and to other interested individuals or groups. Furthermore, they do so on the basis of their disciplinary knowledge. This is something that is, first, likely to encompass various approaches to ethical analysis and, second, the result of a long period of education and experience. Thus, while applied ethics may claim that any “moral authority” is a function of what Habermas (1993) calls the “unforced force of the better argument” (p. 163), it remains the case that we are not all equally able when it comes to the evaluation of such arguments. Thus, while my concern is with the more “rationalist” form(s) of ethical expertise, this is not because I believe it to be the correct, best, or even most expert form of ethical analysis. Rather, it presents the most compelling challenge to the theorization of ethical expertise, what I have, above, termed the hard problem of ethical expertise. The audience for the arguments of applied ethics is not restricted to other disciplinary specialists (experts) or to those with a formal grounding in any of the various approaches to practical ethics.

For example, while some members of the medical and health care professions may have been exposed to applied ethics, perhaps to the extent of taking a masters level course in the subject, most will have had limited exposure to this disciplined mode of thought. While it is perhaps true to say that it is feasible for non-specialists or non-experts to read academic articles published in specialist applied ethics journals—certainly it would seem more feasible than asking a non-expert to read an article published in an academic biochemistry journal—it is nevertheless the case that some expertise, cognitive skills, or domain-relative reflective capability is required. Indeed, that this is the case would seem to be a motivating assumption for the ethical education of professionals, at least insofar as such education aims at the intellectual (analytic, reflective, or “cognitive”) development of such professionals and not merely at providing them with factual information about existing debates. From this point of view, we need to get to grips with the expertise of applied ethicists. Denying its existence on philosophical or meta-ethical grounds prevents us from engaging with the practical consequences of applied ethics as a specialist, disciplined, and academic endeavor. We must come to some sort of resolution regarding the ethical expertise embedded in this domain if we are to fully address the broader cultural and socio-political role of applied ethics, particularly in the context of bioethics. This point not only applies to ethics in medicine, the topic of this essay, but also to public debates and the broader political discourses within which public policy is formed. Although exploration of this point will have to await another forum if it is to be fully explored, we might note that the conceptual specifics of ethical expertise may well vary over differing contexts. Nevertheless, the following comments present and explore an account that can, at least, be used as a starting point for further analysis of the distinctly modern (or “modernist”) phenomena of applied philosophical (bio)ethics and problem of ethical expertise more generally.

Ethos and Eidos: Morality and Ethics From a Sociological Perspective

Given that bioethics is dominated by philosophical forms of ethical analysis, and that existing analysis of ethical expertise has tended to originate within the field, there would seem to be scope for alternative perspectives to make a significant contribution. Indeed, for the most part, existing work on ethical expertise has neglected the substantial corpus of research into expertise *per se*. This corpus can, I think, be used to illuminate a number of difficulties in this area. Consistent with practice theory, such views “reinforce the conception of ethics as Hegelian *Sittlichkeit* as opposed to Kantian *Moralität*” (Schatzki, 2001, p. 23, Note 8); it suggests we adopt a sociological perspective on practical and applied ethics so that they can be addressed as a form of intellectual, reflective, or analytic practice embedded in disciplinary field(s). Such a view further suggests that we consider this field—and its practices—as a part of a broader moral culture. To do so is to invite the reconceptualization of the relationship between “common morality” and “applied” or “practical” ethics. It is to situate formal ethics (*moralität*) within or, at least, in relation to informal or common morality (or *sittlichkeit*). While the formal nature of applied ethics can be understood as an attempt to eliminate the contingency of moral value in favor of rational argument, the view adopted here is that such practices are nevertheless embedded in a particular culture, a mode of social life. As such, they are, like any other practice, inherently situated and unavoidably *value-laden*.

While some recent developments in philosophical bioethics (cf. Kukla, 2014) compliment this kind of view, it remains a philosophically heterodox account. However, bioethical research conducted from a sociological and/or anthropological perspective more clearly compliments my account. For example, Fox and Swazey (1984) differentiate between “medical morality” and (practical or applied) “bioethics.” Kleinmann (1995, p. 45) offers a similar account, and it can be found in more broadly focused texts (Edel & Edel, 2000, pp. 8-10; Geertz, 1957, p. 421; Gregg, 2003, p. 102). Although I use relatively novel terms—namely, *ethos* and *eidos*¹—to relate (common) morality or “*sittlichkeit*” to ethics or “*moralität*,” they not only stand alongside such views, but I have also made complimentary use of them elsewhere (Emmerich, 2014; in press).² In making use of them here, my aim is to show that any form of ethical expertise can be understood as a historically constituted and socially situated form of expertise, the practice of which is embedded in particular cultural contexts.

The stance I adopt can be considered as an attempt to draw our attention to the difference between the broad normative “social” (sociological) or “cultural” (anthropological) structuring of a society, culture, or a particular *field* and the comparatively narrow conception of normativity attached to “practical” and, in particular, “applied” ethics and the

cognitive structures of individual thought.³ Anyone with a passing acquaintance with the social sciences can perceive the relevance of the perennial debate concerning structure and agency and their role(s) in “causing” action(s) or, nowadays, producing “practices” (Schatzki, Knorr-Cetina, & von Savigny, 2000). In a social theoretical perspective, the individual and society are intertwined, inescapably enmeshed in a (creative) process of mutual reproduction. Consequentially, we might think similarly for “morality,” the normative character of a particular society or culture, and “ethics,” a reflective practice and generalized “mode of thought.” If we adopt the terms *ethos* and *eidos*, this point can be given greater clarity. If we consider morality and ethics as, respectively, *ethos* and *eidos*, then former can be taken to refer to the particular *ethos* of a social field or the normative character of “thick culture.” In contrast, ethics can be taken to refer to a culturally particular *eidos* or the characteristic way of ethical thinking found within a particular culture. Regardless of whether such thinking is considered “thick” or, like bioethics, “thin,” it is always embedded in a particular culture or *ethos*. As such, any *eidos*, any mode of thought, or *sociologic*⁴ is an aspect of *ethos*. *Eidos* names a part of *ethos* that, in some cases, it is useful to identify as it focuses our attention on the nature of reason as a practice, something that is, therefore, shaped by the socio-historical and cultural conditions of its production.

While the term *ethos* and the idea of a society’s moral character are ripe for further exploration, it is, nevertheless, a reasonably common idea, both in moral philosophy and in sociological and anthropological research. However, the concept of *eidos* and the idea of characteristic way(s) of (ethical) thinking are relatively unexplored and require further exploration. As I use it, *eidos* is an anthropological term and originates with Gregory Bateson (1958).⁵ However, while it is found in Madge’s (1964) *Society in the Mind: Elements of a Social Eidos*, few other authors have taken it up. Bateson’s purpose was to explore the particular “logic” of Itamul culture and to do so in a manner related to its broader *ethos*. However, partially due to its distance from “ethos,” he was dissatisfied with the term *logic* and, on reflection, realized that his conception of *ethos* could be subdivided into “ethos” and “eidos” with the latter encompassing the “logic(s)” of a particular culture (Bateson, 1958, p. 25, Footnote 1; pp. 264-265). To be clear, it is not simply that “ethos” is holistic, collective, and affective or that “eidos” is individualistic and associated with cognition, reflection, and thought. Rather, while one is predominantly associated with the affective and the other with the cognitive, both are dimensions of a particular cultural “whole”—with a particular form of life (or, perhaps more accurately, a specific mode of social life). Furthermore, even when apparently individual, both are inescapably *collective* and, therefore, social phenomena. While they can be conceptually distinguished, they are not separable in practice; any *eidos* is always part of an *ethos*.

In this view, morality and ethics, *ethos* and *eidos*, are both structural aspects of a culture as well as of individuals situated within the relevant contexts. Thus, when Bateson (1958) uses the term *eidos* to name a “general picture of the cognitive processes” (p. 25) native to a specific culture and suggests that the “eidos of a culture is an expression of the standardized cognitive aspects of the individuals, while the *ethos* is the corresponding expression of their standardized affective aspects” (p. 33), it indicates that both can be perceived in a variety of cultural artifacts as well as in the concrete practices (actions and interactions) of individuals. We should, therefore, be able to read the ethical *eidos* of, say, medicine into a wide variety of its cultural products, including guidelines, procedural documents, editorials, and consultations. We might also adopt the view that differing disciplinary approaches to ethics differ in their *eidos* and, in no small part, their (intellectual) *ethos*, what Hämäläinen (2009) terms the *theoretical spirit* of differing moral philosophies. Furthermore, given the connection between bioethics and the moral landscape of modern medicine, it can also be read in the discourse of applied ethics, particularly in venues where the ethical discourses of academics and professionals meet. In suggesting that medical ethics is part of this broad picture of the *eidos* of medicine, we can begin to explore how, and where, it connects with the *ethos* or thick moral culture of medicine. We can also explore how medical ethics differs when located in different social or cultural spaces; consider the difference between medical ethics when pursued as part of applied ethics and when it is a part of medical practice (whether in clinic or as part of broader professional discourses). Consider also the connection or relationships between these modes of thought.

Perhaps the most obvious, or simply succinct, example of a bioethical *eidos* is Beauchamp and Childress’s (2009) (four) *Principles of Biomedical Ethics*. Drawing on Bateson, Madge (1964) considers the *eidos* to be a “predominant character of the whole stock of ideas available in a society or group” (p. 13). “Ideas” are here regarded as “elements in a repertoire or vocabulary of knowledge and belief” (p. 111). Thus, while the four principles of medical ethics might be the dominant repertoire or vocabulary—the preeminent stock of ideas—which characterize (bio)ethical thinking in modern medical practice, there is more to the concept of the ethical *eidos* of medicine. We might first suggest that what characterizes the ethical way of thinking of contemporary medical practice is its “principlism” rather than, simply, four principles. Although its initial introduction to medicine was as a challenge to the moral *ethos* of the time (something we might call paternalism), the fact that it has now been widely adopted by the health care professions indicates that it has become part of medical culture. Over the past five decades, medical morality has developed in such a way as to be compatible with a principlist medical ethics. Indeed, Brodwin (2008) recently positioned them as co-productive. Thus, we can say that the particular ethical *eidos* that exists within contemporary medical culture is related to

that of practical ethics and, in particular, its preeminent form, applied ethics. Nevertheless, we can also maintain the view that the morality of medical culture remains a more expansive concept. Medical morality is the broad normative structure of the field; it is its ethos. As an aspect of medical practice (and governance), the *eidos* of contemporary medical ethics exists within, and is conditioned by, the ethos medicine. This can be contrasted with medical ethics as an academic mode of thought, the *eidos* of which is not embedded in “medical morality” but the alternative ethos of various forms of practical and, in the particular case at hand, applied ethics. In this context, theorizing ethical expertise does not simply concern the specialist practice of applied ethics. If we are to articulate a notion of ethical expertise, we must do so by attending to its relation to the ethically non-expert individuals, fields, and practices that applied ethics not only comments upon but attempts to normatively shape.

Ubiquitous Expertise

The “commonsense view” of expertise is of something necessarily limited to a small section of the population and usually predicated on a body of technical knowledge. In contrast, contemporary perspectives on expertise consider types of expertise that can be assigned to the majority of individuals and do not require any technical knowledge. Thus, for example, driving a car or even simple walking is considered to involve expertise or its performance. These abilities can be further expert when done in a particular social context; thus, walking down a busy street or driving across a city involves not only walking but also the additional expert task of negotiating traffic (people or cars). Such views have emerged from phenomenological critiques of early research into robotics, Artificial Intelligence (AI), and the “cognitive science” that attended such projects (Dreyfus, 1979, 1992).

To accomplish our everyday activities, we must negotiate the moral order or ethos of our socio-cultural setting(s). Our ability to do so can be considered a form of ubiquitous expertise. For the most part, this negotiation is accomplished automatically or intuitively. For example, we do not need to reflect on the requirement to thank those who assist us nor do the Japanese have to reflect on how deep or long to bow when greeting a guest.⁶ Articulating a “practice theory” perspective, Zahle (2013, 2014) recently argued that, as embodied beings, we perceive the normative aspects of social situations *directly*. Thus, the ethos, or moral structure, of a society should be understood as *coloring* the individual’s social perception. Indeed, pace Bourdieu’s (1993) social theory, we might consider ethos to be dispositionally embodied in habitus and, therefore, “a morality made flesh” (p. 86). Certainly, in some cases, our moral responses to social situations are not *simply* a matter of habit, tacit knowledge, or intuition. Some situations require the articulation of reasons for action, perhaps as part of the activity itself, while other situations may actively provoke further reflection on what

the correct course(s) of action might be. In such situations, the individual might reflect and decide, which is to say they might make use of the relevant *eidos*, before acting. However, as this ability is common to all members of the relevant community, it remains a matter of ubiquitous expertise. While research has made it clear that individuals can be morally dumbfounded, this effect can be construed as demonstrating that, in everyday life, our moral intuitions and reflective ethical thinking usually work in concord with each other (Haidt, Bjorklund, & Murphy, 2000). While not denying the existence of “reflective agency,” such “ordinary,” “everyday,” or “mundane” ethical reflections can be considered part of our embodied moral response to particular social situations and cultural stimulus.

While certain situations can provoke a reflective response, we should be clear that this activity differs from the task of applied ethics. There is a tendency to assume that our everyday ethical thinking is simply a relatively undisciplined version of the philosophical analysis brought to bear on matters of practical ethics. This is a misguided assumption both empirically and within the theoretical picture being sketched here (Hedgecoe, 2004). While the ethical *eidos* of a society is intertwined with its moral ethos, applied ethicists seek to remove any trace of the affective moral ethos from their philosophical analyses.⁷ The broader social *ethos* cannot be considered that of the academic community any more than the broader social *eidos* can be that of disciplined reflection. Particularly in its applied guides, practical ethics is the *methodological* attempt to construct “objective” ethical arguments that are free of affective content. It is the ethicists’ attempt to fully explicate their intuitive moral judgments and, therefore, render tacit moral knowledge explicit. Of course, the result is not merely a reflection of the original judgment or common morality but the production and pursuit of academic arguments. This is not something that can occur in the flow of everyday moral and ethical practice as they are characterized by our tacit moral knowing and intuitions. This remains the case even when we engage in everyday ethical reflection, dialogue, and debate. Such ubiquitously expert practices should be understood on their own terms and not through the disciplined lens of applied ethics.

The ubiquitous moral and ethical expertise of social actors is reiterated in the context medical practice and education. One aspect of the education of medical students is their moral socialization, a process of induction into the culture, normative structure, and ethos medicine (Hafferty & Franks, 1994). This process runs alongside the formal education of medical students, including their formal education in medical ethics. Attempts to integrate such ethical education into the clinical context, that is, with the more informal aspects of medical education, can be seen as an attempt to forge a pedagogic connection between medical ethics and medical morality. In such a context, we can consider the ethical enculturation of medical students as something that runs alongside, and as a compliment to, their moral socialization (Emmerich, 2013,

2014). During their medical education and beyond, medical students become increasingly able to negotiate the ethos and eidos of medicine. In the case of morality and ethics, this means they become increasingly able to perceive and respond to the normative structure of medicine and medical practice as well as to reflectively comprehend the issues at hand, that is, by reference to the principles of medical ethics, relevant guidelines, or other such formal ethical structures of the medical profession. To successfully practice as doctors, medical students must develop and (re)acclimatize their ubiquitous moral and ethical expertise relative to the ethos and eidos of medicine.

This conception of ubiquitous moral (and ethical) expertise should not be mistaken for reflex responses lacking in creativity. In the first instance, our set of habitual or habituated moral responses provides the basis for our ethical reflections. Furthermore, such reflective practices are not free from habit. Habit or moral disposition should not be seen as the antithesis of our (ethical) autonomy, rather they are a precondition freedom; they provide an essential basis for improvisation and creativity. (Dalton, 2004; Glăveanu, 2012).⁸ We should, then, think of medical professionals as having a particular *habitus*, something that should be seen to *embody* the relevant ethos (Bourdieu, 1993).⁹ In using this term, there are obvious and reasonably felicitous resonances with Aristotelian moral philosophy. However, it is also a term that has undergone significant development (Crossley, 2013) both at the hands of Bourdieu and others. Furthermore, Zahle (2013, 2014) makes use of the term in presenting her thesis that normative states are directly perceptible, while Kukla (2014) recently used it in her analysis of “common morality,” what I would call ethos. Bourdieu (1992) defines *habitus* as “a durable, transposable system of dispositions . . . principles which generate and organize practices and representations” (p. 53). Bourdieu, and practice theory more generally, seeks to demonstrate how social life can appear to consist in rule following but, in fact, nothing of the sort (Taylor, 1993). The *habitus* and its dispositions are social structures and schemas incarnated; they are the embodiment of tacit knowing and, in interaction with the social environment, the principle of the (re)production of practice(s).

One example of this is the (re)action of a General Practitioner (GP) who conscientiously objects when faced with a patient request for an abortion. Such GPs do not find themselves recapitulating the moral and ethical arguments about abortion, conscientious objection, and referring patients who make such request to non-objecting colleagues each time this eventuality occurs. Having made a decision to contentiously object, perhaps through (more or less) extended reflection and analysis of the matter or perhaps simply through a commitment to a (religious) authority or tradition, this is then put into practice, which is to say the individual who conscientiously objects simply follows the relevant protocol or the practice(s) that has been established for such cases. Again, I am not suggesting that doctors behave as if they were automata. Such situations are

not devoid of a requirement to think, speak, and act. The individual might, for example, need to explain their actions to the patient or other members of staff, but such thinking, speaking, and acting are comprised of what Schön (1984) calls *reflection-in-action*. In this view, reflection can be considered a practice, an activity that is part of normal, everyday and mundane course of medical practice. It is, therefore, a product of *habitus* or, more accurately, the medical *habitus* of medical professionals, as it interacts with the social context (field). Needless to say, this is a context that includes others, their (re)actions, and, therefore, practices required to support intersubjective coordination.

As medicine or health care is a particular and relatively autonomous sub-culture that is both of, but nevertheless distinct from, modern society, members or “natives” of this culture possess a ubiquitous moral and ethical expertise not possessed by the population at large. Nevertheless, the ability of health care professionals to develop a ubiquitous moral and ethical expertise relative to their field of practice is predicated on an underlying moral and ethical expertise that is relative to and ubiquitous in society at large. Of course, such culturally relative moral and ethical expertise is not necessarily right or good. The morality of various European cultures in the early 20th century, including the medical culture of the United Kingdom (Booth, 1994), was anti-Semitic, and thus, many members of these cultures were “experts” in negotiating and reproducing a morally flawed society. Ubiquitous moral expertise is normative in the sense that members are required to conform to it, but that does not mean it is necessary, right, good, or the best form for such expertise, something that is clearly troubling when considering a ubiquitous moral and ethical expertise.

The Expertise of the Applied Ethicist

Although it is important to recognize that our moral functioning is predicated on the ubiquitous moral expertise of individuals going about their everyday lives, negotiating the ethos of their social and cultural contexts, this perspective is a precursor or social and theoretical hinterland to my consideration of ethical expertise. An expertise in applied or even practical ethics is of a different order to this ubiquitous, everyday or professional, moral expertise, even in its reflective guise. Bioethics—the domain that applied ethics is most clearly associated with—is a disciplinary practice with (inter)disciplinary (multiple methodological) standards. Furthermore, although there might be an “ethos” or normative dimension to the field,¹⁰ applied ethics is not itself the practice of morality. Rather, bioethics is a theoretical practice, the theoretical practice of ethics certainly, but not, in itself, a moral practice. Furthermore, it cannot be considered a moral practice of the kind with which it is concerned. For example, applied ethics often involves the analysis of the ethical problems of medical practice, but it does not, itself, put those analyses or conclusions into (professional) practice; individual ethicists have no

medical responsibility and, therefore, are not enmeshed in the morality of medicine and health care more generally.

In thinking through the idea of ethical expertise, some clarity can be found if we consider the distinction between contributory and interactional expertise; concepts have been recently developed in the context of conducting sociological research into scientific practice (Collins & Evans, 2007). The first specifies the kind of expertise it takes to contribute to a discipline, to engage in the relevant practices, and to produce the relevant products and outputs, while the second encapsulates the fact that some individuals have a high degree of knowledge such that while they are unable to engage in the practices of a particular discipline, they are capable of discursively interacting with its practitioners at a high level. Such interaction is fundamentally social and predominantly linguistic; it involves discussing the discipline and its topics. These are the kinds of discussion that occur during the more social moments of disciplinary life—those that take place in the lunch hour, at the conference (including, to a degree, presentations as well as during wine receptions), and in more public domains, such as in the media or in “popular” science books. The contemporary emergence of “science communication” and science communicators is an excellent example of interactional expertise (Reich, 2012).

However, as Collins and Evans have recently made clear, interactional expertise is not expertise in interacting. Rather, “interactional expertise means grasping the conceptual structure of another’s world” (Collins & Evans, 2014, p. 14, Note 3). Such expertise is, then, dependent on having some grasp of their mode of social life and the ethos of their practices. Thus, in attempting to place one’s ethical expertise in the service of another, we face challenges comparable with those faced by anthropologist. First, is it possible to evaluate a culture if we are not, ourselves, members, and second, is it possible to do so *ethically*? The fact that, like applied ethics, medical culture can be considered a *sub-culture* means that such concerns are somewhat dampened, at least as compared with their importance within anthropology. Nevertheless, the point remains: If the commentaries and arguments of applied (bio)ethicists are to guide the ethical structures of the medical profession and the actions of medical professionals, then they must have a sense of its ethos. Such a sense is required for them to properly grasp the conceptual structure of medical practice and, therefore, subject to it to a morally comprehensive analysis.

Contributory Expertise

An individual has a contributory expertise when he or she is able to contribute to a discipline. We might suggest that, in its strongest form, this means an ability to produce outputs that signify a particular form of expertise. In the case of applied ethics, this can be considered an ability to produce articles that meet the relevant peer-review standard. However, while this perspective is instructive, this is to focus on the

product of expertise rather than the expertise itself. Expertise is what allows experts to produce such outputs. By way of an example, consider Michelangelo’s David. Michelangelo is, we might say, an expert sculptor as evidenced by the statue of David. However, Michelangelo’s expertise in sculpting is what produced David, it is not the statue of David itself. Michelangelo’s expertise was embedded within his practice of sculpting, and thus, we must consider the practices that bioethicists engage in. Contributory ethical expertise consists in whatever ethical experts do to produce peer-reviewed publications, the *sine qua non* of the disciplinary practice.

If we reflect further on the production of David, we might think that, despite his supposed claims to the contrary, Michelangelo did not simply set to work on a piece of marble and reveal David. Similarly, no one simply sits down and writes an article by conceiving an argument and writing it down. The task of writing an article does not involve simply starting with the introduction and working one’s way toward a conclusion. There is a great deal of preparation, of back and forth, of wrong turns and dead ends, and, ultimately, of editing, rewriting, and polishing. We might think of the wider practices involved in the production of academic publications. They are quite mundane and include reading articles; thinking; reflecting on cases and thought experiments; presenting one’s work; talking with colleagues, students, and others, including contributory experts, interactional experts, and those who might have little more than a ubiquitous moral and ethical expertise or who are undertaking to learn about (bio)ethics; talking to those with other forms of relevant expertise such as medical and health care professionals or “expert” patients; and so on. All these tasks can and do contribute to the process of developing an argument, and to reiterate, no ethicist simply sets out to write an academic article with the entire argument in mind.

Thus, the process of writing is the process of crafting an argument. The pen, the typewriter, the post-it note, the scribbled in book, and the word processor are the tools of academic labor, and we do not use them to simply express our thoughts but to develop them. We do not simply think and then write, we think *through* writing (Shore, 1999). The article is not the product of thought *or* of writing but of mutually constitutive thinking *and* writing. The implicit conclusion is that academic articles do not represent what the author thinks, or, at least, they cannot be taken to represent what the author thinks or thought at any *one* time. Rather, as with the sculpture, articles are the final product of an extended, diachronic, and complex process of thinking, writing, rethinking, and rewriting. Articles and the ethical arguments contained within them have been *fashioned* and not simply expressed. An article is *crafted*, produced by a process that involves a variety of tasks, all of them involving some form of expert performance; some form of expertise.¹¹

The conclusion one might draw is that any expertise is embedded within processes and practices not simply within individuals or products. Certainly, individual experts have a

high level of knowledge and experience; one cannot simply participate in a community of experts and expect to be able to authentically reproduce (as opposed to merely emulate, imitate, or copy) the expert practices that define a community. Nevertheless, it is through a process of emulation and imitation—or, one might say, through a process of “apprenticeship”—that the expert is created. Even in the case of those expert practices that are most clearly based on a large degree of technical and factual knowledge, such as medical practice, it is what the individual can do with their knowledge, the ways in which they can put that knowledge into practice, which makes them a contributory expert. Just as the medical student becomes a medical professional through a process of socialization (and enculturation), the bioethicist is similarly reproduced. Perhaps because it is primarily cognitive in character, or perhaps because it lacks a clearly defined and concrete ‘field of practice,’ the idea that becoming an expert ethicist is an essentially “social” process has been neglected almost entirely. Thus whilst the fact that applied ethicists undergo a process of socialization of is much less obvious than it is in the case of, say, medical doctors (cf. Hafferty & Franks, 1994). However, it is clearer that the reproduction of expert ethicists is essentially cultural (Bourdieu, 1990). The task facing the nascent ethicist is to gain entry to a (very) particular cultural institution, the academy and, furthermore, one of its sub-domains—a particular (inter)discipline.¹² The task of becoming a contributory expert in applied ethics is, therefore, more obviously a process of enculturation. Such statements do not undermine the academic seriousness of a discipline, its methodological (or epistemological) rigor, or the relevance of and commitment to various academic and scientific (in the continental sense of the term) values, such as objectivity, to the practice of ethics. It does not undermine the nature of bioethics any more than it would were we to note the same about expert ballet dancers, physicists, health care professionals, or sculptors. It is simply to note that what is involved in the development of a methodologically disciplined and *contributory* expertise in ethics, or any other academic domain (such as medicine, say), is to become an initiate, to become an accepted member of a culture, or, better, to be initiated into a community of practice (Lave, 1991; Lave & Wenger, 1991; Wenger, 1999).

Interactional Expertise

The notion of interactional expertise names an individual who is more or less fluent in the everyday discourse of contributory expert. While contributory experts possess this form of expertise, it can also be found in those who do not have the requisite ability (or inclination) to contribute to some discipline (Collins & Evans, 2007). As suggested, interactional expertise does not involve being expert at social interaction per se but, rather, involves “grasping the conceptual structure of another(s) world” (Collins & Evans, 2014, p. 14, Note 3). In the case of morality and ethics, this notion

can be considered in a variety of ways. First, we might examine the connection and interaction between ethical expertise and the ubiquitous moral expertise of the population at large. Second, we might consider the interaction of expert ethicists with medical and health care professionals both as expert practitioners in the domain the bioethicists seek to comment on and as having a distinct, (sub)culturally relative, form of ubiquitous moral and ethical expertise. These complications express a common concern in bioethics, namely, the relationship between “common” (and medical) morality, on one hand, and applied (bio)ethics (and moral philosophy), on the other (Kukla, 2014).

In the terms I have been using, this is a concern for the relationship between our everyday moral ethos, the ethos of medicine and health care, and, ultimately, the ethos of applied ethics (and moral philosophy). However, while the matter is more complicated in the case of the relationship between moral philosophy and “common morality,” we might suppose that the primary interaction between formal ethical expertise and the practical moral expertise of health care professionals can be located in the interaction between their respective *eidos*, their ways of ethical thinking. This is something that is clearly related to the conceptual understanding that structures their respective perspectives on morality and ethics.

Given the relationship between applied ethics and ethics in medical practice, we should be unsurprised to find that there are a number of individuals who can be considered contributory experts in both domains. There are many individuals who contribute to the discipline of applied ethics while also having the requisite expertise to engage in (or contribute to) medical practice. Such individuals possess more than the ubiquitous moral and ethical expertise that pertains to medicine and, literally, are an embodiment of interactional ethical expertise as well as the interaction between bioethics and medicine, or health care, more generally. Since its inception, bioethics has been conceived of as a practical endeavor; one of its central aims is to contribute to the moral and ethical practices of others, particularly health care professionals. Applied ethics has been part of the field, and a significant part of it aims to be practical. We might take this as indicating that an interactional expertise is a central aspect of bioethical expertise itself. This is because bioethics seeks to influence and engage with domains beyond its academic and disciplinary borders. To do so, the requisite interactional expertise must be acquired, something we might think of as acquired independently from the development of a contributory bioethical expertise, but nevertheless as falling squarely within the central tasks of bioethics and applied ethics.

This point is not a simple one. All disciplinary experts must possess some degree of interactional expertise if they are to engage in the social and cultural practices that surround and constitute some of the practices, such as teaching, that are required to be a contributory expert. However, if

ethical experts are to engage with those who exist outside of applied ethics, they will have to develop an interactional expertise that pertains to domains other than their own and allow this to become an aspect of their own contributory expertise. In the context of science journalism, Reich (2012) discussed a similar idea, suggesting expert journalists possess a “bipolar” interactional expertise that is constitutive of journalism and, therefore, of their own contributory expertise. Thus, their interactional expertise is “bipolar” because journalists are expert at interacting with both academic sources and in communicating with the public or lay audiences; they are expert at taking information from one context and “translating” it into another. This is an ability that requires them to have interactional expertise in two, if not more, domains. However, in the case of ethical expertise, such interaction poses a challenge as what is on offer is not only normative but normative in two senses. It is not only directive in the sense of being substantively *action-guiding* but in the sense of being *methodologically prescriptive*—it does not just suggest *what* decisions should be taken but *how* those decisions should be taken. What applied ethics has to offer is not restricted to substantive ethical arguments and positions but particular ethical concepts and modes of thinking. The disciplinary nature of applied ethics is such that it suggests that ethics *ought* to be done from its particular perspective, from within its particular ethos (and associated eidos), and not from the perspective of, say, medical morality. Nevertheless, no more than they can expect their substantive ethical conclusions to be taken at face-value, ethical experts cannot expect methodological compliance to simply be forthcoming. Only through bringing competing ethical frameworks, moral perspectives, and conceptual structures into dialogue and debate can ethical experts expect to make positive (and ethical) contribution to the broader ethical discourses of the medical professional and the practices of health care more generally.

In this context, we might consider the role of the “consultant” or “clinical” (bio)ethicist, as found in many American hospitals. Such individuals may not be contributory experts in medical practice, applied ethics, or any other bioethical domain. However, we might consider them as possessing a high level of interactional expertise with applied ethics, practical ethics, and bioethics more generally, as well as the cultural domains of medicine and health care. Similar to Reich’s analysis of science journalism, we might consider the consultant bioethicist to have a bipolar interactional expertise; they can negotiate the respective ethos of bioethics and medicine so as to relate their (not unrelated) conceptual ethical structures or eidos. For the most part, they can be considered as “translators” of an “academic worldview” such as that of applied ethics—of its perspectives, methodology, principles, arguments, judgments, and justifications—in such a way that they become more relevant, comprehensible, and aesthetically “palatable” to clinicians, health care professionals, and patients. This is primarily accomplished through an engagement with clinicians, health care

professionals, and patients ideally on their own terms, that is, in such a way as to be consistent with the ethos and eidos of health care and to accord with the patient’s particular understanding and perspective. The contributory expertise of such consultant bioethicists is a “bipolar” interactional expertise, the ability to bring the conceptual structures of a particular form(s) of academic practice into dialogue with the more immediate and practical context of medical practice and its ethos.

If we return to consider the applied (bio)ethicist while we might suggest that they must also have some degree of interactional expertise with medicine and health care, at least to the degree that they can understand “the medical case,”¹³ they may never direct experience or negotiate the moral world of a particular hospital or a particular medical ethical dilemma. However, if they are to be successful in their attempts to intellectually engage with the medical and health care professional, they must interact with medical morality; they must have some interactional grasp of the ethos and, in particular, the eidos of medicine, with the conceptual structure of its reflective ethical practices. However, the gap between the intellectual interaction and practical experience remains. Collins and Evans’s (2007) conceptualization of the difference between polymorphic and mimeomorphic actions can be used to capture this point. Such activities are, respectively, social and representational and, therefore, correlated with our practical and reflective abilities. Polymorphic activities are inescapably bound up in thick social and cultural contexts. In contrast, mimeomorphic actions are such that they can be (re)presented as asocial or acultural.¹⁴ One of the best examples of this is the difference between simply riding a bike (or bike-balancing) and riding a bike across a city. Engineers can model the former such that they can construct a machine that can accomplish the same task. The latter necessitates social and cultural interactions between the rider, the environment, other road users, and pedestrians. It, therefore, necessitates thick social, cultural, and intersubjective understanding that is beyond the capabilities of any mere machine.¹⁵

Medical practice and, therefore, the ethical issues that arise within it take place in a polymorphic context. However, these same ethical issues are given what we might call a mimeomorphic representation within bioethics and, in particular, applied ethics.¹⁶ This idea requires a good deal more examination than the account I can offer here. However, it is sufficient to point out that when ethical issues arise in practice, they involve specific patients, particular doctors, and health care professionals, all of whom are socially, culturally, and historically situated and stand in particular relationships to one another. The eidos of applied ethics is to eliminate or ignore this context, perceiving it to be extraneous to ethical analysis. Consequentially, the “cases” of medical ethics are often populated by roles rather than individuals and by those assigned a generalized “personhood,” or moral status, rather than by people considered as concrete individuals.

The underlying conception of the ethical subject of applied ethics, and related approaches to ethical analysis, is that of the Cartesian rational actor. Consider, for example, Rawls's (1999) veil of ignorance or the debate about "personhood" (Tooley, 2010). This approach is taken further by many paradigmatic examples that form the foundations of bioethics and bioethical thinking, that is, its *eidos*. Consider James Rachels's (1975) "Bathtub Case" as an attempt to represent the distinction between killing and letting die and active and passive euthanasia. Alternatively, consider the argument Thomson (1971) presents with regard to "The Violinist" and the way it purports to encapsulate the ethical issues that surround abortion. Finally, consider the way organ markets are justified, the demonstrative and experimental purpose of Trolley Dilemmas, and the various ways in which individuals can be morally dumbfounded (Erin & Harris, 2003; Haidt et al., 2000; Thomson, 1985). All involve mimeomorphic representations of ethical "reality," they are all constructed for the purposes of illuminating our ethical intuitions and (at best) their interplay with our ethical reasoning in producing ethical judgments.

Such cases seek to starkly represent those factors considered to be ethically relevant while preventing any other factor from being an obstacle to our understanding. As such, they require us to respond in a certain way, from within a certain ethos, namely, a mimeomorphic one. It is against the rules of the game to introduce polymorphic social life into the examples by, say, insisting on the gendered nature of the ethical subject hidden behind the veil of ignorance, wondering about the character of a person who would not kill his nephew but would "merely" let him die, questioning the social differences between a violinist attached to an individual and a fetus growing within a woman's womb, pointing out that no market can be mimeomorphic in practice, suggesting that no one who encountered the trolley dilemma in "real life" could ever be entirely sure the fat man would dislodge the carriage, or taking the view that no one could truly be sure that the siblings would not experience negative emotional consequences after having sex with each other. When actually encountered, all ethical dilemmas are polymorphic; they involve real people, with real histories and relationships, with open and uncertain futures. This is not to say that representing ethical dilemmas mimeomorphically is flawed or has nothing to contribute to the ethical issues embedded within concrete polymorphic practices. Clearly, they do. However, it is to say that the way in which bioethical analysis seeks to "encounter" ethical dilemmas is different from the way they are, in fact, encountered. The practices of applied ethics are not the sum total of ethics, let alone moral practice.

In representing ethical cases, applied philosophical bioethics strips out the moral ethos of medicine focusing on the *eidos* as a way to fully concentrate on "the ethical." One result is that we can distinguish between the ubiquitous moral and ethical expertise of health care professionals from the contributory expertise embodied by the "practical" or

applied philosophical (bio)ethicist. Nevertheless, the various forms of expertise, and the individuals who possess them, necessarily meet and interact, giving rise to various forms of interactional expertises that inform both the ubiquitous polymorphic (interactional, affective, and cognitive) moral and ethical expertise of health care professionals and the mimeomorphic (reflective and predominantly cognitive) ethical expertise of the bioethicist.

Conclusion

In the context of psychiatry, Brodwin (2008) argued that medical morality and bioethics are co-productive.¹⁷ This view gives further color to Toulmin's (1982) claim that medicine saved the life of ethics and, I think, holds true across the medical specialties and health care professions more generally. There is a reflexive and mutually supportive relationship between the ethical *eidos* of modern medicine and "applied ethics" or (normative) bioethics. From a historical point of view, one might suggest that in the late 1960s, ethics—in the broad sense of theology, law, and philosophy—was fused with medicine and subsequent developments, not least an increasing secularization of the medicine and the public sphere, and gave further impetus to practical, normative, and applied (bio)ethics. This phenomenon has continued to develop and mutate since that time, reflexively influencing several of its source disciplines and wider society as a whole. So successful was this fusion that bioethics can rightly be called a cultural phenomenon and one that has influenced not only its culture of origin, American medicine, but also American and other (trans)national cultures as a whole (Wilson, 2014). Bioethics has also given rise to various forms of contributory and interactional expertise and fundamentally altered the ubiquitous moral and ethical expertise of health care professionals by fundamentally altering the conceptual structure of health care practice, which is to say by significantly affecting its culture.

Through distinguishing different forms of moral and ethical expertise, we can renew our appreciation for the connection between applied (bio)ethics and forms of common morality, particularly medical morality. The analysis of ethical problems offered by applied ethicists are mimeomorphic (re)constructions of those encountered in practice. In so doing, the thick polymorphic social reality or ethos in which those problems are embedded is neglected. Thus, there is a qualitative difference between encountering (and thinking about) an ethical problem in practice, conducting an academic analysis and the respective expertise required for each task. On this ground, we can differentiate between the moral responsibilities of health care professionals and the scope of the ethical authority of the expert ethicist. The expert analysis offered by ethicists has limited scope and, therefore, cannot authoritatively determine the ethics of acting within a thick moral context. This being the case, there is a space within which we can maintain the moral and ethical authority

of the individual actor while acknowledging the ways in which ethics offers expert analysis and, ideally, a form of dialogical engagement rooted in an interactional form of ethical (and moral) expertise.

This view indicates that “applied ethics” is not and cannot be the sum total of “ethics” or ethical practice. It can often seem that applied ethics is positioned as *the* way to do ethics. However, pace Narvaez and Lapsley’s (2005) critique of phenomenism, it is erroneous to view only those actions undertaken reflectively as “moral” or “ethical.” The view I have presented here encourages recognition of our “mundane” and “everyday” moral and ethical practices, practices that exhibit varying levels of intuition as well as reflection. In my view, such activities are best understood as being dispositional, a function of habitus, and, therefore, as intimately related to the social, cultural, and structural conditions that produced the relevant dispositions and habitus (Emmerich, 2013). Bioethics and, indeed, applied ethics is a central part of the social, cultural, and structural conditions within which the professional practices of contemporary health care takes place. Thus, we must seek to understand the relationship between the moral practices of health care and the expertise of bioethics in cultural and social theoretical terms. The conceptual foundation developed above offers one way in which we might do so.

Furthermore, expert ethicists and bioethicists must seek a similar understanding of the way in which they contribute to the moral and ethical dimensions of medicine and health care. The academic literature is not the entirety of this contribution. Ethicists can, do, and should interact with medical and health care professionals in a variety of fora including conferences, committees, and via process that can and do (re)form professional and institutional guidelines. Such fora are, however, not opportunities for professionals to be turned into (applied) ethicists or to be shown how to do ethics “properly.” We must abandon the idea that professionals simply *ought* to make ethical decisions in a manner that imitates the arguments contained in academic articles or, indeed, the methodology of applied ethics. This idea must be abandoned because it is not the case that health care professionals *can* make decisions in this way. Even if, thanks to bioethics, we consider the respective ethical *eidos* of medicine and applied ethics to be related, their respective *ethos* differs significantly. Finally, while interactional expertise is not an expertise in interacting, social interaction is vital if interactional expertise is to be realized, exercised, and exercised well. If academic (bio)ethics is to engage with medicine (and vice versa) to the fullest degree possible, then the development of an expertise in interacting, in bringing these two worlds and their conceptual structures together in a particular discursive context, and in a practical, mutually enlightening manner has a lot to recommend it. I imagine this is an important facet in the success, or otherwise, of bioethics consultations and, in my experience, of clinical ethics committees.

To be clear, such experts and practices exist. However, the methodological conceits of applied ethics have, thus far, constrained our understanding of the nature of such endeavors. Medical and health care professionals are not, and cannot be, expert applied ethicists. However, by bringing the expertise of applied ethicists and health care professionals into dialogue, which is to say *interaction*, there is opportunity for mutually enlightening experiences and for expert (bio)ethicists to properly contribute to the moral and ethical reconstruction of health care.

Notes

1. Rather than suggesting ethics or *Moralität* is *eidos*, it would be more accurate to say that *eidos* represents the socio-logic of *Moralität* or ethics—a point I make in more detail below.
2. While a fuller account of *ethos* and *eidos* is needed, they must be articulated and defended on their own terms, consistent with the intellectual and theoretical practice of sociology and anthropology; this must proceed hand in hand with their deployment in concrete attempts at socio-analysis. My use of them here is as part of one such project.
3. As Doris and Nichols (2012) have pointed out, the cognitive sciences, moral psychology, and, one might add, empirical ethics uncritically adopt the asocial individualism that is the prevailing assumption of modern moral philosophy. The thesis presented here is consistent with their recommendation that the role of human sociality in morality and ethics, and the collaborative nature of reason, ought to be more fully explored.
4. The term *socio-logic* or *sociological* is used to emphasize the way in which *eidos* refers to the *logic of practice* rather than what Bourdieu (1992) calls the logic of the logician. It refers to the normative sociological order—or *ethos*—within which practices, including the practices of thought, are organized or structured. The *eidos* is not thought itself, but the embodied and tacit dimensions of thinking out with explicit reflection cannot be considered to take place. Thus, computers do not think or reflect; they calculate. See the distinction between mimeomorphic and polymorphic drawn below.
5. Bateson’s, and therefore my, use of the term has almost nothing to do with the phenomenological conception of *eidos*. One might also add that it has little to do with the way Aristotle uses the term. That said, there is a sense in which Bateson means *eidos* to capture the essence of a culture, at least insofar as its logic or “way of thinking” can be considered as part of this essence.
6. Narvaez and Lapsley (2005) discuss the “principle of phenomenism,” the tendency of moral philosophy (and moralized psychology), to define moral behavior as that motivated by moral judgments, thereby ruling out automatic or intuitive moral responses as being rightly categorized as “moral.” They argue for a “psychologized morality” and, therefore, adopt an expanded conception of “the moral” similar to the one at play in this article. In a not dissimilar manner, Abend (2013) argues for the importance of an expanded conception of morality in social studies of the phenomenon. My use of the term *ethos* aims to fulfill a similar function. However, it is balanced by the term *eidos*, which I use to maintain a focus on formal ethical thinking as the phenomenon of particular interest in the study of ethical expertise.

7. If, as Anderson (2005) has suggested, contemporary academic culture inhabits an “anti-ethos ethos” (p. 173), then we might take applied philosophical (bio)ethics to be a particularly illuminating example. As such bioethics cannot be considered as unproblematically objective—as “a-cultural” or “a-political”—but, rather, inhabiting a complex culture of ethical objectivity, that is, one where objectivity is understood to be a cultural or disciplinary value, an aspect of its ethos. Such a view is, I think, consistent with Miller’s (2003) analysis of the ethos of expertise as involving the transformation of ethos into logos, a transformation that facilitates the denial of ethos.
8. While the idea that habit is the antithesis of freedom or autonomy is widespread, it is, as a tranche of recent publications have amply demonstrated, not only fundamentally mistaken but in conflict with the concepts of history (Carlisle, 2014; Lumsden, 2013; Ravaisson, 2008; Sparrow & Hutchinson, 2013).
9. The idea that an ethos/habitus is a morality made flesh is consistent with the broader conception of morality that I have adopted here. It is also worth noting that in this passage, Bourdieu also rejects the notion of eidos, something he previously drew upon in a manner similar to my own (and, therefore, Bateson’s). However, it is a term he later readopts and does so in a way that gives me confidence in the term as I use it here (Bourdieu, 2000).
10. Consider, for example, Daston’s (1995) analysis of “The Moral Economy of Science” and how her perspective can inform our understanding of any disciplinary practice, including bioethics and its various sub-practices such as applied philosophical bioethics, feminist ethics, empirical ethics, and so on.
11. This point is consistent with the view that journal articles “are not themselves examples of explicit knowledge. They are, rather, the means by which explicit knowledge is transmitted. They are like the germs which cause a disease rather than being the disease itself” (Collins, 2013, p. 26).
12. We might distinguish between what is required of an (applied) ethicist if they are to join a philosophy department and a medical faculty. Nevertheless, the point reinforces the cultural nature of the academy and the place of bioethics and bioethicists within it.
13. Perhaps in a manner analyzed by Anspach (1988) whose perspective in this matter can be transferred to the medical ethical case as a kind of genre (Chambers, 1999, p. 3; Emmerich, 2013, pp. 31, 77; Emmerich, 2014, p. 11).
14. As Collins and Kusch (1999) point out, mimeomorphic actions, activities, or, as I will be discussing, representations may contain elements of culture. A bicycle is, obviously, a cultural artifact. Nevertheless, bike riding (balancing) can be represented mimeomorphically, and therefore, a machine can be programmed to accomplish the task. Similarly, the philosophical examples discussed below contain elements of culture, a bathtub, a violinist, a market, a trolley. Nevertheless, these examples are all attempts to (re)present ethical dilemmas mimeomorphically.
15. We need not make the claim that no machine could ever be constructed that could ride a bike across a city in traffic. Rather the claim is that if we made such a machine, and it appears Google has gone some way to doing so in the case of a self-driving car, then it would accomplish the task in a mimeomorphic

manner. It would be completing the same activity but not the same action. The introduction of such cars will alter the rules of the road and may even make it impossible for human beings to safely drive.

16. We might understand alternative approaches to ethical analysis, such as feminist ethics, as attempts to develop and reintroduce a degree of polymorphic to the mimeomorphic representations created by and underlying the approach adopted by applied philosophical bioethics.
17. See also Reubi’s analysis of the development of medical ethics in the United Kingdom, given in terms of a thought-collective (Reubi, 2013).

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Author Biography

Nathan Emmerich is a visiting research fellow in the School of Politics, International Studies, and Philosophy at Queen's University Belfast. His interests lie with the social, cultural, and political role(s) played by bio- and applied ethics.