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Original Research

Clinical *Ethics* in Name Only? The Case for Moral Realism at the Bedside

SABINE WINTER

kbo Clinic for Psychiatry and Psychotherapy Haar, Munich, Germany

NILS-FREDERIC WAGNER*

Johannes Gutenberg University Medical Center, Mainz, Germany

*Address correspondence to: Nils-Frederic Wagner, Institute for History, Theory and Ethics of Medicine, University Medical Center of the Johannes Gutenberg University Mainz, Am Pulverturm 13, 55131 Mainz, Germany. E-mail: n.wagner@uni-mainz.de

As Clinical Ethics Consultation (CEC) becomes more institutionalized, concerns about its legitimacy and efficacy have grown. We defend a realist orientation, according to which CEC has normative force only if its recommendations answer to stance-independent reasons, not to individual preferences and institutional policies. Public justification can and should proceed through familiar means (e.g., shared mid-level norms and transparent procedures) so that stakeholders can scrutinize the reasoning. We show how neutrality, admirable as a procedural virtue, hollows CEC when treated as a master ideal, leaving hard cases to defaults and institutional inertia. In its place, we develop moral expertise as sustained, transparent reasoning that integrates the clinical picture with the profession's content-full standards. We then construe warranted deference as rational trust in contrastive reason-tracking rather than deference to role. Our comparative thesis holds that shared norms successfully handle routine cases, but persistent disagreement and institutional pressure call for a realist grounding that secures determinate, action-guiding recommendations. On such realist understanding, CEC remains normatively accountable and oriented toward getting things right.

Keywords: *clinical ethics consultation, moral realism, moral expertise, moral deference, neutrality*

I. INTRODUCTION

Clinical Ethics Consultation (CEC) is a structured professional service designed to assist healthcare professionals, patients, and their families (hereafter "stakeholders") in navigating ethically complex situations at the bedside. CEC has become a well-established component of hospital care in many high-income countries. In the United States, a national survey by Danis et al. (2021) found that 97.1% of hospitals reported having a Health Care Ethics Program, which typically includes CEC. In Germany, Schochow, Schnell, and Steger (2019) reported that approximately 49% of hospitals had implemented at least one form of clinical ethics support, with the rate of implementation increasing with hospital size. These findings suggest that while the structures vary by national context, CEC has achieved broad institutional uptake and is likely continuing to expand.

CEC is typically initiated in response to moral uncertainty, conflict, or distress, often arising in contexts such as end-of-life care or surrogate decision-making, where fundamental principles of biomedical ethics come into tension. Usually carried out by trained clinical ethicists, CEC involves a systematic process of gathering relevant medical and ethical information and actively engaging with stakeholders

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to clarify ethical concerns, resolve conflicts where possible, and support decisions that are both ethically sound and clinically appropriate (Orr and Shelton, 2009). Despite its widespread integration, substantial uncertainties persist regarding the appropriate role of clinical ethicists. A major concern is whether clinical ethicists should maintain moral neutrality (i.e., refraining from offering their own moral judgments) or whether they should offer explicit normative guidance. Gasparetto, Jox, and Picozzi (2018) explore moral neutrality in CEC, identifying distinct dimensions such as methodological impartiality, epistemic openness, and axiological detachment. They caution that while moral neutrality seeks to avoid bias and paternalism, it may paradoxically limit clinical ethicists' ability to meaningfully engage in moral deliberation. Further complicating this picture, Casarett, Daskal, and Lantos (1998) highlighted that clinical ethicists often operate without recognized legitimacy to make ethical recommendations that warrant special normative consideration beyond personal opinion. While this observation was made almost three decades ago, the underlying concern remains salient, as ongoing debates continue to question the justification of moral authority in CEC (Evans and Colgrove, 2022). Unlike traditional medical consultants, whose authority rests on their recognized clinical expertise, clinical ethicists often derive their moral authority more implicitly through institutional trust or, more contentiously, through personal communication and facilitation skills. The resulting ambiguity raises important questions about the legitimacy of their ethical judgments, potentially diminishing their capacity to effectively address ethical problems in clinical settings. Recent work shows that the debate is not merely conceptual but practice-shaping. In a pilot study, Turner, Brummett, and Salter (2025) found considerable variation in the sources clinical ethicists cite when teaching and justifying recommendations, suggesting the absence of a stable, shared framework. Such variability heightens the risk that, without firmer normative footing, CEC drifts toward idiosyncrasy or institutional echo. Critics go further, urging the abandonment of normative attributions in bioethics on epistemic and pragmatic grounds (Crutchfield and Scheall, 2024). These practice-level fractures force a prior question: on what basis can clinical ethicists claim the authority to guide action?

The issue is both epistemic and practical. If clinical ethicists are to offer substantive normative guidance, on what grounds are they qualified to do so? At the heart of this question lies the contested notion of moral expertise: that is, the idea that clinical ethicists possess a form of trained ethical competence that justifies their normative recommendations. This, in turn, raises the issue of moral deference: whether, and under what conditions, are stakeholders justified in relying on the moral judgments of clinical ethicists? Claims to moral expertise and deference, one might worry, risk introducing undue moral authority. Yet, without a coherent account of what moral expertise consists in and under what conditions moral deference is justified, the rationale for recognizing CEC as a distinct clinical role becomes unclear. Clarifying both the nature of moral expertise and the grounds for warranted deference is therefore essential to defending the normative authority of CEC.

In what follows, we argue that, without at least an implicit commitment to moral reasons with stance-independent authority, CEC risks being ethics in name only—that is, retaining the formal appearance of ethical deliberation while lacking substantive normative content. We begin by examining calls for neutrality and proceduralism, with special attention to strong forms of "pure neutrality" that bracket substantive moral commitments—content-free, permission-based stances often associated with Engelhardt (2009, 2011b)—and show how such views undercut CEC's normative aspirations. We then develop accounts of moral expertise and warranted deference, arguing that clinical ethicists need trained ethical competence and that, under appropriate conditions, their all-things-considered ethical judgments[1] can warrant deference. At the level of grounding, our comparative thesis is realist: bedside ought-judgments ultimately answer to stance-independent reasons. At the level of public justification and institutional implementation, however, both constructivist and contractualist procedures can serve as standards for transparency, legitimacy, and consensus, and contractualist methods can be truth-conducive within a realist framework (Scanlon, 1998; Rawls, 1999; Arras, 2017). While our account is realist about grounding, nothing in what follows requires metaethical convergence among clinical ethicists: in routine cases, shared mid-level norms and public-reason procedures suffice for guidance. Realism becomes salient only where those resources underdetermine action. Against this background, we defend a realist account of moral reasons and explain why, under deep pluralism, persistent non-convergence, and institutional pressure, realism most robustly grounds CEC and clarifies the point of warranted deference. Finally, we address challenges to this view—moral pluralism, concerns

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about paternalism, and the realities of institutional pressure—and indicate how a realist approach accommodates them.

II. THE LIMITS OF NEUTRALITY AND PROCEDURALISM

Following Gasparetto, Jox, and Picozzi (2018), neutrality in CEC subdivides into four loci: (1) methodological impartiality, (2) epistemic openness, (3) axiological detachment, and (4) outcome neutrality. Our principal concern is that, when impartiality is operationalized as reliance on process tools (e.g., 4-box, CASES, phenomenological mapping) together with strict non-directiveness (declining to articulate and defend a determinate ethical judgment), procedure can crowd out the justificatory work needed for action-guiding recommendations. This is not an endorsement of any particular philosophical method of ethical reasoning (e.g., principlism, reflective equilibrium). While (1)–(4) have heuristic value, taken strictly they risk hollowing out the normative core of CEC. To make the stakes concrete, we consider a single ICU case and, for each locus, show how an absolutized neutrality response fares against a normatively engaged consultation that offers a transparent, reasoned recommendation.

Mr. K., 72, suffered a massive intracerebral hemorrhage with herniation. He is intubated, on high-dose vasopressors, and in multiorgan failure. The neurology and ICU teams judge the likelihood of meaningful recovery to be extremely low. Two months earlier, Mr. K. signed a POLST requesting comfort-focused care and 'Do Not Attempt Resuscitation'. The patient's daughter (health-care proxy) favors terminal extubation and comfort; his son, on the other hand, insists on 'doing everything'. The team hesitates and requests CEC.

(1) Methodological impartiality. Clinical ethicists should use consistent, fair, and transparent tools to structure deliberation and resist personal or institutional pressures. But when process becomes the master ideal, CEC collapses into formalism—preserving procedure while sidelining substantive moral engagement and justified recommendations. In Mr. K.'s case, the clinical ethicist rigidly works through a 4-box worksheet, gives symmetrical airtime to each view regardless of evidential or ethical merit, and declines to appraise arguments or state a recommendation. The meeting ends with tidy notes and no guidance; pressors and ventilation continue by inertia. A normatively engaged CEC would weigh the POLST, prognosis, and burdens versus benefits, and issue a transparent, all-things-considered ethical recommendation (e.g., DNAR, terminal extubation, and intensified comfort-focused care), together with the professional standards that justify it.

(2) Epistemic openness. Receptiveness to diverse stakeholder perspectives fosters inclusivity in pluralistic settings. Treated as an overriding constraint, however, it discourages the critical appraisal of clearly problematic views and the articulation of warranted judgments. In Mr. K.'s case, to avoid "silencing" anyone, the clinical ethicist treats all claims as equally weighty—including the son's insistence that "he could wake up if we try harder"—and refuses to identify evidentially deficient views. Inclusivity is preserved; responsible appraisal is not. A normatively engaged CEC would acknowledge the son's concern, state the evidential status and professional guidance plainly, and recommend comfort-focused care.

(3) Axiological detachment. Avoiding the smuggling of personal moral views helps prevent bias, but CEC is not morally neutral. Claims of complete detachment can mask unacknowledged assumptions and silence warranted guidance when it is most needed. Recommendations should anchor in the profession's content-full standards—codes, consensus guidelines, and governing law/policy—rather than private convictions. In Mr. K.'s case, the clinical ethicist presents extubation and continued escalation as equally reasonable "options" and withholds any value judgment. The profession's corpus (e.g., respect for a valid POLST; the moral equivalence of withholding and withdrawing life-sustaining treatment; non-maleficence) goes unused, burdening the proxy with indecision. A normatively engaged CEC would anchor guidance in those standards, explain why extubation aligns with the patient's goals, and recommend honoring the POLST.

(4) Outcome neutrality. Declining to "steer" honors stakeholder autonomy, but in time-sensitive, high-stakes situations it also shifts the moral burden onto defaults and inertia. In acute care, "no recommendation" often means continuing non-beneficial interventions (e.g., full code by default), prolonging burdens the patient would not choose. Non-directiveness can also offload decisional weight onto surrogates who lack clinical grounding, amplifying guilt and conflict, and it can mask

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institutional preferences (risk management, throughput) as neutrality. Professional neutrality, however, is not moral withdrawal: it requires transparent appraisal of reasons and, when reasons converge, a clear, accountable recommendation—while still inviting scrutiny and leaving final authority with legally empowered decision-makers. In Mr. K.'s case, the clinical ethicist concludes that any family choice is acceptable; CPR remains by default despite the POLST, prolonging non-beneficial treatment contrary to stated goals. A normatively engaged CEC would weigh goals, prognosis, and standards, recommend DNAR and extubation with clear reasoning, and offer a path to family consensus and support.

By "neutrality" here we mean only the procedural virtues illustrated above—fair process, openness to stakeholders, discipline about not importing private commitments, and non-coerciveness in conduct—all compatible with offering a reasoned recommendation. A stronger view of neutrality, however, rejects substantive evaluation altogether. On this "unlimited" neutrality—exemplified by Engelhardt's (2011a) secular, permission-based bioethics—the clinical ethicist's role is chiefly mediational and juridical rather than canonically normative. Read Mr. K.'s case through that lens: the clinical ethicist would remain non-directive across the board, treating extubation and continued escalation as equally permissible so long as the parties consent. That stance does not merely restrain; it evacuates CEC's action-guiding point. Our critique targets the risks of absolutizing the limited forms of neutrality—or embracing unlimited neutrality—while our positive account (moral expertise, warranted deference, and a realist orientation to reasons) supports transparent, reasoned, and action-guiding recommendations. Taken together, the forms of neutrality we have discussed outline a model of CEC that privileges process, restraint, and non-directiveness. Yet, as Gasparetto, Jox, and Picozzi (2018) and Rasmussen (2011) argue, such neutrality risks hollowing out CEC's normative core. Watson and Guidry-Grimes (2018) sharpen the point by distinguishing mere facilitation from moral guidance: when institutions confine ethicists to procedural roles, CEC devolves into technocratic process management. Brummett and Eberl (2022) further show that even allegedly "neutral" approaches smuggle substantive commitments—assumptions about personhood, harm, and flourishing that remain unacknowledged in efforts to appear impartial. Attempts to ground CEC in procedural neutrality, whether in its limited or unlimited forms, therefore tend toward conceptual incoherence and moral evasion, obscuring rather than resolving the underlying normative disagreements. Our critique targets these risks; our positive account—moral expertise, warranted deference, and a realist orientation to reasons—aims to secure transparent, reasoned, action-guiding recommendations while retaining the genuine procedural virtues of neutrality.

Proceduralism

Closely tied to neutrality is proceduralism, the view that clinical ethicists ought to enable fair and inclusive dialogue but not, as it were, prescribe normative conclusions. This is frequently reflected in CEC frameworks that prioritize communication quality and consensus-building. While these are valuable objectives, they do not exhaust the moral content of CEC since complex clinical problems require ethically justified recommendations, not just value mapping. Along those lines, Finder and Bartlett (2024) critically examine the expectations surrounding CEC, arguing that clinical ethicists are increasingly pressured to conform to institutional priorities rather than engage critically with moral authority. They argue against overly procedural approaches, emphasizing that genuine CEC inevitably requires clinical ethicists' to resist unrealistic institutional expectations and explicitly articulate well-reasoned moral judgments. Proceduralism, then, strips away the distinctively ethical aim of CEC: the reasoned evaluation of competing moral claims in the pursuit of what is the right thing to do. Empirical evidence supports the concern that Proceduralism often displaces substantive ethical guidance.

A scoping review by Bell et al. (2022) found that many CECs emphasize communication and stakeholder satisfaction over the delivery of concrete moral recommendations. Anderson et al. (2024) similarly report that in a regional U.S. health system, over half of CEC prioritized general facilitation rather than explicit ethical analysis. In Germany, where CEC is less uniformly institutionalized, Schochow, Schnell, and Steger (2019) found that even in hospitals with formal ethics services, CEC often lack clear normative outcomes, reflecting both institutional under-resourcing and conceptual hesitation. Rasmussen (2011) captures this moral vacuum, noting that decisions in CEC are often unavoidable

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high-stakes, and require robust ethical engagement. In such cases, Proceduralism is not a retreat from judgment. Rather, it constitutes a form of judgment itself, one that risks passively endorsing prevailing institutional norms without adequate ethical scrutiny.

Neutrality and proceduralism may have legitimate heuristic roles, but they cannot define the ethical core of CEC. Since the moral legitimacy of CEC cannot rest solely on facilitative processes and institutional functions, it must instead be grounded in the moral authority of those who provide it. This authority, in turn, presupposes a form of moral expertise, one that goes beyond epistemic competence to encompass the normative standing of clinical ethicists themselves.

III. MORAL EXPERTISE AND DEFERENCE

The idea that clinical ethicists may possess a form of moral expertise has been met with skepticism, both in theoretical discussions and in applied clinical contexts, where concerns about the legitimacy of moral claims remain unresolved (Watson and Guidry-Grimes, 2018). Unlike methodological standards in other clinical settings, CEC lacks both a standardized approach for adjudicating disputes and a universally accepted framework for validation. As Iltis and Sheehan (2016) emphasize, this absence of consensus extends to the very definition of moral expertise itself, as well as to the question of how such expertise could be reliably identified and assessed. This lack of clarity has led some to deny that moral expertise exists in any meaningful sense, arguing that without shared standards for its definition and assessment, it cannot provide a legitimate basis for moral authority in clinical practice (Matheson, McElreath, and Nobis, 2018).

Such skepticism is grounded in a number of longstanding conceptual concerns. Ethical questions are often severely contested, shaped by divergent normative convictions. Similarly, moral expertise appears to lack the kind of predictive power that characterizes scientific expertise. Furthermore, the inclusive impulse to treat all moral agents as equal in standing makes the idea of someone having "better" moral judgment appear elitist. Nevertheless, as Iltis and Rasmussen (2016) argue, rejecting the very possibility of moral expertise may be too hasty. Clinical ethicists are routinely called upon to help others think both more systematically and more justifiably about complex moral problems. Accordingly, clinical ethicists are expected to navigate competing values, interpret ambiguous bioethical principles in context, and support level-headed decision-making in morally fraught circumstances. Even if moral judgment lacks the precision of empirical science, it does not follow that all moral claims are equally reasonable. Thus, the conceptual concern is not whether clinical ethicists can issue infallible moral facts, but whether they possess a distinctive kind of competence that enables them to contribute something more than procedural neutrality. The question, then, becomes not whether clinical ethicists are moral authorities in any absolute sense, but whether they can be regarded as possessing a legitimate form of moral expertise.

Contemporary accounts of moral expertise have proposed a range of models, each offering a different understanding of what it means to be an "expert" in moral matters. These models can be broadly categorized into theoretical, procedural, and pragmatic approaches (Rasmussen, 2011, 2016; Iltis and Rasmussen, 2016).

The *theoretical model* equates moral expertise with mastery of ethical theory. On this view, clinical ethicists are experts because they are trained in normative-ethical theory and can apply these systematically to clinical cases. This conception draws on analogies with legal expertise, where specialized knowledge of a normative system is considered sufficient for guiding action. However, this model risks overemphasizing abstraction and may offer limited practical utility in morally pluralistic settings of healthcare.

In contrast, the *procedural model* favors facilitative skills over substantive ethical knowledge. Here, the clinical ethicists' role is not to identify the correct course of action but to assist stakeholders in clarifying their own values, identifying sources of disagreement, and reaching ethically sound resolutions. Proponents of this view often emphasize neutrality and respect for autonomy, aligning CEC with mediation. While this model avoids the charge of moral authoritarianism, it risks rendering clinical ethicists morally inert, especially in situations where normative clarity is called for.

An increasingly influential alternative is the *pragmatic* or *deliberative model*. On this view, moral expertise is not a matter of imposing final answers but of being trained in the skills of ethical reasoning and

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context-sensitive judgment. Such expertise includes the ability to synthesize diverse values and formulate well-reasoned recommendations that are sensitive both to ethical principles and to the clinical realities at hand. Rasmussen (2016) describes this as making "all-things-considered" ethical judgments, reflecting both theoretical fluency and practical reasoning.

The aforementioned models are, of course, not mutually exclusive, and many clinical ethicists implicitly draw on elements of all three. However, these distinctions matter, as each model carries different implications for the aim of CEC and the role clinical ethicists should play in it. The theoretical model justifies a more directive stance; the procedural model counsels restraint; and the pragmatic model strikes a middle path, emphasizing reasoning over rules and engagement over neutrality. In clinical practice, which model is adopted shapes the expectations placed on clinical ethicists and the kind of moral expertise their recommendations are presumed to carry.

Now, even if one grants that clinical ethicists may possess some form of moral expertise, questions about their moral authority remain. In clinical settings, moral authority is not simply a matter of epistemic credibility but also of institutional legitimacy and normative justification. Clinical ethicists' moral authority, then, lies primarily in the persuasive force of their ethical argument and the institutional recognition of their role. This, however, makes the grounding of clinical ethicists' moral authority uniquely fragile. One major challenge is the epistemic status of moral claims. Unlike in empirical disciplines, moral reasoning does not frequently yield consensus, and disagreement persists even among highly trained clinical ethicists. Such persistent disagreement might encourage skepticism about whether any one clinical ethicist's judgment should be treated as morally authoritative. Granting clinical ethicists a privileged moral expertise risks, one might argue, conflating ethical argument with moral imposition, especially when stakeholders hold divergent moral views. Another challenge comes from moral egalitarianism: the view that all moral agents, by virtue of their autonomy and capacity for reason, are equally entitled to form sound moral judgments. From this perspective, the idea that clinical ethicists should enjoy greater moral expertise appears incompatible with ideals of equal moral standing—implicitly suggesting that stakeholders ought to "outsource" their moral deliberation, which, at a first approximation, appears intuitively objectionable.

However, as Iltis and Rasmussen (2016) point out, these concerns may misrepresent what kind of moral expertise clinical ethicists are claiming. Clinical ethicists are not asserting infallibility or demand unquestioning compliance. Rather, they offer well-reasoned moral judgments; recommendations grounded in ethical argument, not institutional power. On this view, moral expertise is not derived from hierarchical position nor from personal moral superiority, but from the capacity to engage in sustained, publicly defensible moral reasoning under conditions of clinical complexity, applied to, and constrained by, the shared corpus of professional medical ethics and made transparent when proposing justified departures from it. Moreover, there are strong analogies to be drawn with other professional roles in healthcare. Just as clinicians are expected to apply their expertise in, say, pharmacology to decisions about medication selection, so, too, are clinical ethicists expected to apply their expertise in ethical reasoning to morally challenging situations in, say, end-of-life care. While patients are not required to defer to clinicians' recommendations, they often find such guidance helpful and trustworthy. The same logic can support a more defensible, dialogical form of moral expertise: one that is persuasive rather than prescriptive, and justified not by certainty but by deliberative rigor. Ultimately, then, the legitimacy of clinical ethicists' moral expertise rests on the quality of ethical reasoning and the transparency of the deliberative process, not on claims to moral expertise as superior moral judgment. Whether clinical ethicists' judgments warrant deference, then, depends on how well they demonstrate this expertise in practice.

Deference to Moral Experts

Unlike in medicine, where deference to experts is standard practice, deferring to others on ethical questions seems not only unnecessary but possibly objectionable. Enoch (2014), however, defends the idea that moral deference can be epistemically appropriate under certain conditions, particularly when the deferring agent reasonably believes that the other party is more likely to be right. Drawing an analogy to familiar forms of deference in science, Enoch argues that our reasons for trusting experts in those fields (e.g., limited cognitive resources or past accuracy) also apply, at least in principle, to the domain of moral reasoning. What matters is not the nature of the subject matter, but the asymmetry in

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deliberative competence, which is especially relevant in CEC. Clinical ethicists are trained to integrate clinically relevant facts—as explained by the treating clinicians—with ethical analysis in order to identify morally salient features that might otherwise be overlooked and to formulate transparent, action-guiding recommendations. However, clinical ethicists do not claim independent medical expertise. Rather, they elicit and scrutinize clinical judgments (e.g., prognosis, risks/benefits, capacity assessments) and normatively integrate those judgments with the patient's values and the profession's shared standards. Now, some clinical ethicists are also practicing clinicians, which can enhance consultation; even so, CEC should not presume expertise across medical domains, and dual-trained clinical ethicists should defer to responsible specialists outside their certified scope. To avoid role conflicts when clinical ethicists are also treating clinicians, dual roles should be disclosed and separated (e.g., by engaging a co-consultant, avoiding primary recommendation on one's own service, or recusing when appropriate). Deference to clinical ethicists' all-things-considered ethical recommendation can be epistemically responsible when it amounts to rational trust in the ethicists' comparative reliability at tracking reasons under clinical complexity, given transparent methods, articulated standards, and openness to critique. Importantly, this kind of moral deference does not undermine moral agency. Enoch is careful to distinguish between epistemic deference (i.e., trusting someone's judgment because they are more likely to be right) and moral outsourcing, where one avoids moral responsibility altogether. In clinical settings, stakeholders may defer to clinical ethicists not to absolve themselves of moral responsibility but because they recognize their own limits in the face of high-stakes moral decisions.

Justifying moral deference, however, has not gone unchallenged. As Matheson, McElreath, and Nobis (2018) argue, persistent disagreement among moral experts complicates the case for deference. If equally well-trained clinical ethicists regularly arrive at different conclusions, the credibility of any one clinical ethicist's judgment is called into question. Moral deference, then, must be both context-sensitive and provisional: justified not merely by credentials, but by the quality of the moral reasoning offered in each case. On this view, deference is not akin to epistemic submission but a recognition that others may be better positioned, through training and experience, to formulate sound ethical recommendations. Clinical ethicists must earn deference by presenting their moral judgments as reasoned, transparent, and responsive to stakeholders' values and concerns. When offered in this manner, moral deference can serve as a useful deliberative aid, a way for stakeholders to critically engage with ethical perspectives they may have otherwise not fully considered.

The recent professionalization of CEC, through formal training programs and certification processes, aims to establish clearer professional standards and institutional expectations. Initiatives such as the ASBH's competency framework and certification process reflect a broader shift toward recognizing CEC as a distinct professional field. Most relevant to our argument, this professionalization supports the view that clinical ethicists can function as moral experts whose judgments may warrant deference by embedding ethical reasoning within a structured and accountable role. However, professional credentials alone neither guarantee moral expertise nor justify deference. Professionalization should, therefore, be seen not as definitive proof of moral expertise, but as a scaffold that facilitates the recognition and institutional legitimacy of ethical judgment in clinical practice. The point is vividly illustrated by the recent debate on what moral content should guide CEC recommendations. Brummett and Watson (2022a) argue that, given stakeholder expectations and the field's current practice, clinical ethicists should offer contentful recommendations grounded in a transparent, consensus-tracking directive document. Fiester (2022) responds that such standardization risks values imposition and urges a more procedural posture in pluralistic settings. In response, Brummett and Watson (2022b) contend that content recommendations are inescapable in CEC and that the real task is to make them public-reason-justifiable and open to critique over time. This exchange points to the idea that professionalization can scaffold recognition and legitimacy, but it cannot by itself supply the normativity of recommendations. Doing so requires an account of how clinical ethicists track and weigh reasons in ways that warrant epistemic deference when appropriate.

To regard clinical ethicists as moral experts whose judgments can legitimately offer normative guidance presupposes that there is something objective to be an expert about. Moral questions, on this view, are not merely matters of personal opinion but admit of better and worse answers, and, at times, of clearly right or wrong answers. The plausibility of both moral expertise and moral deference in CEC thus hinges on some form of moral realism—the view that there are objective moral facts that can, at

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least partially, be accessed through reasoned deliberation. Without such a metaethical foundation, CEC risks devolving into rhetorical maneuvering, leaving it vulnerable to manipulation and instrumentalization for purposes unrelated to sound ethical judgment.

IV. GROUNDING CEC IN MORAL REALISM

Moral realism is the view that moral claims are truth-apt and that at least some of them are objectively true. On this view, the truth of moral claims does not depend on individual attitudes or social conventions. Moral judgments, therefore, do not merely express subjective attitudes but aim to track normative facts about what is objectively right or wrong. Moral realism does, however, imply neither certainty nor agreement. Rather, it maintains that there are better or worse answers to moral questions, even in the absence of certainty and agreement.

Among the most influential contemporary defenses of moral realism is David Enoch's (2011) account of "robust realism." Enoch characterizes moral facts as objective, irreducible, and stance-independent, and argues that our practical lives presuppose their existence. His central "Deliberative Indispensability" argument claims that when we engage in moral deliberation, particularly in situations of conflict and normative urgency, we do so presupposing that there are correct answers to be found. Moral reasoning, Enoch tells us, is not a matter of expressing preferences or negotiating compromises, but of trying to get things right. For Enoch, the internal structure of deliberation itself is evidence for moral realism. When we deliberate morally, we do so as though we are to discover something that is already true, rather than merely constructing it. Without objective moral facts, Enoch argues, moral deliberation would lose its normative character as an effort to reach conclusions justified by reasons that transcend individual and collective attitudes.

Derek Parfit (2011) ofsfers a complementary defense of moral realism in his influential *On What Matters*. Parfit sets aside metaphysical concerns about moral facts in favor of a reason-based account. In so doing, Parfit argues that there are normative reasons that apply to moral agents independently of their desires, beliefs, preferences, and endorsements. These reasons, on Parfit's view, are neither natural properties nor subjective attitudes; they are moral facts that structure what we have reason to do, and by extension, what we ought to do. Parfit's "Triple Theory" brings together key elements from deontological, consequentialist, and contractualist views, proposing that these leading normative theories often converge on the same moral conclusions. This convergence supports a framework that is pluralistic in method but still objective in its claims. Parfit's moral realism is marked not by foundational certainty but by the conviction that moral reasons can be better or worse and that ethical deliberation aims at uncovering them.[2]

Precisely because CEC purports to adjudicate moral disagreement and justify ethically sound recommendations, it requires the conviction that some ethical claims are more justified than others. Yet, this conviction has been challenged on the grounds that moral realism leads to implausible commitments. For example, critics have argued that moral realists are bound to accept conditionals such as: "if non-natural moral facts do not exist, then nothing is objectively wrong." Enoch (2021) responds by reframing these conditionals as instances of what he calls "junk knowledge": propositions that may be true but are not appropriate to rely on when reasoning about what to do. According to Enoch, the practical weight of our moral convictions, and the role they play in deliberation, gives us good reason to set aside such abstract possibilities. In the context of CEC, this means that clinical ethicists committed to moral realism need not worry that acknowledging the metaphysical contingency of moral facts undermines their expertise to make recommendations. Instead, they can consistently treat moral reasons as action-guiding and stable, even while conceding that certain skeptical scenarios are logically possible but irrelevant to practical moral judgment. This view not only shields moral realism from the charge of moral insensitivity but also supports the idea that moral realism, while metaphysically ambitious, does not undermine moral deliberation in practice. Such a defense is especially relevant in the context of CEC, where the risk of appearing morally dogmatic must be balanced against the need for normative traction.

Enoch's defense of moral realism's practical coherence is complemented by Nortvedt's (2012) observation that healthcare practice itself implicitly presupposes a realist moral framework. The moral demands clinicians encounter (such as obligations to relieve patients' suffering and respect their

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autonomy) are experienced not as mere preferences, but as normatively binding imperatives. On Nortvedt's perceptual realism, clinical practice discloses morally salient features, often first registered in the lived experience of the case (e.g., the pull of suffering), that present themselves as stance-independent reasons for action. Of course, such perceptions are fallible and open to articulation and critical scrutiny.

At the same time, we recognize the resources of agreement-based and constructivist accounts: on Scanlon's (1998) contractualism, wrongness is fixed by principles no one could reasonably reject. On Rawls's (1999) justice as fairness, justification proceeds by what free and equal persons would choose in the original position behind the veil of ignorance. And, on Street's (2008) metaethical constructivism, the correctness of normative judgments is constituted by their withstanding reflective scrutiny from within an agent's web of commitments. Our claim is realist about the grounding of bedside ought-judgments: they answer to stance-independent reasons. This differs in kind at the level of grounding from agreement or procedure-based accounts that locate authority in actual or hypothetical agreement. Under deep pluralism and persistent non-convergence, agreement-based procedures often yield multiple, reasonable but divergent constructions (e.g., equity vs. benefit in scarcity), leaving action underdetermined. A realist grounding supplies stance-independent reasons that can adjudicate among these constructions and justify a determinate recommendation. Under institutional pressure, realism also provides an external critical standard to identify and resist policy convenience masquerading as moral reason. Finally, realism explains warranted deference as epistemic—a fallible but rational trust in comparative reason-tracking reliability—rather than deference to the mere successful navigation of procedure. For example, in scarcity protocols, equality and benefit can yield divergent directives. When reasonable constructions conflict and consensus fails, CEC must still issue a recommendation. A realist grounding explains why that recommendation carries authority beyond procedure.

Even so, constructivist and contractualist frameworks remain the standards for public justification and institutional implementation. Retaining their usefulness for transparency, legitimacy, and consensus, while leaving room for stance-independent reasons to critique those frameworks. On Nortvedt's view, this realist orientation is already implicit in practice. Clinicians and clinical ethicists treat certain case features (e.g., the pull of suffering, a valid advance directive) as intrinsically reason-giving, not merely as outputs of agreement or procedure. Thus, such reasons can critique and, when necessary, override policy or consensus when they conflict with what is morally required—justifying CEC's aim at truth-apt, reasoned recommendations rather than procedural facilitation alone. Nortvedt's perspective, then, reinforces the view that moral realism is not merely a metaethical asset, but a conceptual structure embedded in the very fabric of CEC. Consider, for example, ethically charged decisions about end-of-life care or the allocation of scarce resources. These scenarios cannot be resolved by merely identifying stakeholder values and facilitating dialogue. Instead, they require moral judgments about what ought to be done that are responsive to reasons and principles not determined by institutional norms alone. In these contexts, clinical ethicists are expected not only to clarify competing values, but to weigh them and to explain why some considerations override others.

Such normative work presupposes that there is something to be right or wrong about. Moral realism secures this normative ambition. Enoch's argument from deliberative indispensability shows that moral reasoning, even when conducted amidst disagreement, aims at truth and justification, not mere agreement. Parfit's account reinforces the claim that clinical ethicists should aim to identify justified moral conclusions by grounding moral deliberation in objective normative reasons that apply independently of institutional conventions. Absent such a realist commitment, the moral legitimacy of CEC becomes difficult to justify. Moral realism is, then, not an abstract philosophical luxury. Rather, it enables clinical ethicists to move beyond procedural facilitation toward reasoned moral judgment.

We now turn to situating our realist view in relation to constructivist and contractualist approaches. These approaches preserve their role in public justification, but realism better grounds determinate judgment when procedures and consensus fail to determine action.

Realism in Relation to Constructivism and Contractualism

A common objection holds that realism is not the only metaethical outlook capable of supporting action-guiding judgment in CEC. Constructivist and contractualist views hold that moral guidance can be generated by public-reason procedures or tests of justifiability (e.g., principles no one could reasonably reject or those chosen by free and equal citizens behind a veil of ignorance), without appeal to

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stance-independent moral facts. On Rawls's (1999) political constructivism, principles are the output of a fair choice procedure yielding publicly justifiable yet stance-dependent norms for social cooperation under pluralism. On Scanlon's (1998) contractualism, the wrongness of an action depends on whether it would be disallowed by principles that no one could reasonably reject, given the burdens such principles impose on each person. This test disciplines partiality and keeps justification person-centered in ways that map readily onto bedside deliberation.

At the level of practice, Arras (2017) argues that applied ethics can proceed by method pluralism (e.g., principlism, reflective equilibrium) without first resolving central questions in metaethics. The aim is to furnish public reasons that interlocutors with diverse commitments can recognize. In this sense, Rawlsian and Scanlonian tests supply the public-reason standards that Arras's method pluralism can employ: Principlism and reflective equilibrium can proceed case-by-case, while justification to persons (Scanlon) and fair choice procedures (Rawls) discipline and validate those mid-level methods without settling metaethics. On our view, these justificatory devices remain in place at the level of public justification, while a realist grounding explains the authority of determinate recommendations when reasonable constructions diverge. Nothing in our view denies the utility of these approaches. Indeed, they can be read as truth-conducive public-reason devices within a realist framework: contractualist and constructivist procedures help surface and test the very considerations that, on a realist account, answer to stance-independent reasons. This compatibility sits comfortably with Parfit's picture of cross-tradition convergence on weighty reasons and with robust realism about irreducibly normative truths. Accordingly, when presenting non-realist positions, we describe their deliverances neutrally as constructed, stance-dependent, and procedurally justified, reserving the substantive disagreement for whether reasons ultimately have authority independent of endorsement. Our claim here is metaethical rather than methodological. Contractualist and constructivist procedures—appeals to publicly accessible reasons, fair processes, and person-centered tests of justifiability—can be used by realists as public-reason devices for surfacing and testing considerations that, on a realist view, answer to stance-independent reasons. What strains purely procedural accounts is that they inevitably smuggle in substantive commitments at the points that matter most for guidance; realism makes those commitments explicit and evaluable (Brummett and Eberl, 2022).

The practice landscape reinforces the point. Evidence that clinical ethicists and educators do not in fact draw on a common set of sources (Turner, Brummett, and Salter, 2025) raises the risk that recommendations track institutional habit or personal preference rather than reasons that others have independent cause to accept. A realist orientation supplies an external standard (i.e., one whose authority does not depend on social agreement, institutional convenience, or policy uptake) against which procedures and policies can be criticized when they go wrong, while leaving contractualist and constructivist tools in place as the mechanisms by which reasons are articulated and made publicly justifiable. Because our concern is how these views perform in practice, we frame the comparison accordingly: under recurrent stressors in CEC, realism better secures the action-guiding aim. Entrenched non-convergence (e.g., in contested treatment futility, end-of-life conflicts, or risk/benefit disputes) often exhausts the conciliatory resources of public-reason tests. Procedural devices can organize deliberation yet still terminate in indeterminacy or lowest-common-denominator compromise. Yet, when stalemates persist, clinical ethicists must still issue a recommendation. A realist orientation understands such recommendations as attempts to track reasons that do not depend on uptake, which renders them intelligible even when sincere parties continue to disagree. Moreover, if normativity is wholly constructed by procedures or agreements, policy convenience can masquerade as moral reason. Treating reasons as independent standards permits principled criticism of "house norms" when they go wrong—an urgency underscored by dispersion in what clinical ethicists cite and teach across CEC and education (Turner, Brummett, and Salter, 2025).

The realist alternative we defend, then, is more demanding and truer to the practice at its best: using contractualist and constructivist procedures as public-reason methods that discipline deliberation and make recommendations justifiable to those affected, while aiming those procedures at stance-independent reasons that explain why certain recommendations are not merely procedurally acceptable but correctable by argument and evidence over time. Moreover, a realist orientation positions the field to engage contemporary proposals to abolish moral attributions in biomedical ethics on grounds of epistemic burden and error (Crutchfield and Scheall, 2024). Even if such proposals identify real risks of

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overconfident obligation-talk, their conclusion—that clinical ethicists should renounce moral claims—collapses the distinction between caution and silence about normativity that clinical ethicists cannot in fact avoid.

Beyond showing that realism is compatible with constructivist and contractualist methods of public justification, there is a further level of disagreement about grounding. The contrast is metaethical: realists hold that bedside ought-judgments answer to stance-independent reasons, whereas anti-realists deny this. Yet anti-realists often deploy the very same professional corpus and procedures. We grant the overlap: in many cases both camps affirm the same content-full standards and converge on the same recommendations. The difference, however, lies in how the authority of those norms is secured, and in how resilient that authority remains when norms are contested. On anti-realist views, the corpus carries weight by virtue of agreement, coherence, or social usefulness, thus remaining stance-dependent. On a realist view, it carries weight insofar as it tracks reasons that obtain independently of agreement—hence is stance-independent—so policy and consensus can be corrected when they misfire.

Return to the ICU case: despite a valid POLST and a clinical trajectory favoring comfort-focused care, local defaults and risk-management concerns pull toward continued full code and escalation. Both realist and anti-realist orientations can cite the corpus. The realist, however, can also say why recommending DNAR and extubation is not merely professionally permissible but morally warranted. This is so because the salient features of the case (the directive, now disproportionate burdens, and the aim to avoid non-beneficial intervention) supply reasons that do not depend on agreement. On a realist orientation, it is this grounding in stance-independent reasons that gives CEC's recommendations their distinctive authority and clarifies the basis for warranted deference when agreement runs out.

Moral realism does not entail that clinical ethicists should always issue a directive recommendation. In value-sovereign decisions, where a competent patient's ends rightly governs the choice, an interpretive stance is appropriate. That is, clarifying options, surfacing values, and supporting deliberation without "pointing the way." By contrast, when the reasons at stake are stance-independent (e.g., preventing serious harm, honoring valid directives, meeting professional duties or ensuring fair allocation), or when defaults and inertia risk substituting for judgment, a clear, reasoned recommendation is warranted. Realism helps explain this difference by tracking the reasons that apply; some clinical contexts make those reasons directive, others do not.

A further advantage of a realist orientation concerns the shape of warranted deference. On a stance-dependent picture, deference risks collapsing into deference to process ("we followed the right procedure") or to office ("the clinical ethicists role licenses the recommendation"). On a realist view, deference is epistemic: a fallible but rational trust that clinical ethicists' training and methodology make them comparatively reliable at identifying and weighing reasons that apply regardless of current endorsement, given the clinical facts. This both explains why deference can be warranted and clarifies why it should be resisted when clinical ethicists' reasoning does not bear the right relation to those reasons (e.g., when it merely mirrors institutional preference).

Finally, situating realism against "pure neutrality" clarifies why facilitation alone cannot discharge the action-guiding aim. Strong permission-based neutrality—often associated with Engelhardt—treats CEC as bracketing substantive moral commitments and confining itself to mediation or the articulation of legally grounded policy norms. On Engelhardt's (2011a) own account, the ethics of secular consultation reduces to what is established at law and in enforceable policy; clinical ethicists thereby function as quasi-lawyers within a post-foundational landscape. Earlier, Engelhardt (2009) proposed more broadly that, absent foundations, morality fragments into lifestyle choice and political slogan. Whatever the diagnostic power of that narrative, the conclusion—that CEC should eschew substantive moral evaluation—is neither required by pluralism nor adequate to bedside practice. Clinical ethicists who never take a view about which reasons are weighty cannot explain why some options should be ruled out even when all parties remain unconvinced.

In short, constructivist and contractualist methods remain integral to a public-facing CEC. But realism better explains and justifies the action-guiding and accountability-inviting character of recommendations under deep pluralism, persistent non-convergence, and institutional pressure. That is why, in what follows, we continue to speak of moral reasons as having authority that does not reduce to endorsement, even as we insist that CEC articulate those reasons in terms others have cause to accept. Where shared norms and public reason procedures settle the matter, realism largely recedes into the

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background: it underwrites why those norms rightly guide practice. Where they do not, realism's role becomes explicit. Realism earns its keep by underwriting (i) determinate, action-guiding adjudication when reasonable constructions diverge—not because only realists can recommend (anti-realists can too), but because realism explains their authority when endorsement runs out. Competing constructions are treated as rival attempts to track stance-independent reasons, and the one that better fits the case's salient features and professional standards outweighs the other; (ii) principled critique of misfiring policies—anti-realists can, of course, criticize policies by appeal to shared values, but a realist grounding supplies a further basis when broad agreement itself points the wrong way by appeal to an external standard (i.e., stance-independent reasons whose authority does not derive from institutional endorsement; e.g., the duty to avoid non-beneficial intervention despite a "full code by default" policy); and (iii) the epistemic sense of warranted deference as rational trust in comparative reason-tracking rather than deference to process. Many norms now treated as routine (e.g., the moral equivalence of withholding and withdrawing treatment; ANH as a treatment that may be refused) were once contested; their endurance is plausibly explained by the fact that they better track stance-independent reasons.

V. CHALLENGES OF PLURALISM, PATERNALISM, AND INSTITUTIONAL PRESSURE

Moral Pluralism

A major objection to grounding CEC in moral realism seems to be that such an approach appears incompatible with the apparent moral pluralism in contemporary clinical contexts. Such pluralism, one might argue, makes it difficult, if not impossible, to justify moral conclusions that purport to be objectively valid without risking cultural insensitivity.

Stoeklé and Hervé (2024) offer a particularly illustrative account of this challenge. In their survey of ethical reasoning in hospitals, they identify twelve distinct moral frameworks that shape stakeholder values, ranging from Catholic to Islamic and utilitarian outlooks. Each framework appears internally coherent, normatively rich, and embedded in a broader metaphysical system. In light of such pluralism, the authors caution against "universalist" approaches in CEC that override cultural and personal sources of moral authority. Instead, they advocate for an approach sensitive to varied moral outlooks that is attentive to the ways in which they shape ethical expectations in clinical care. A potential risk of moral realism, then, is that it may exclude or devalue moral outlooks that do not align with its ontological assumptions. However, this objection mischaracterizes what moral realism, particularly in its contemporary formulations, entails. Moral realism does not imply moral uniformity. Rather, it allows that many moral questions admit of reasonable disagreement while maintaining that some answers are better justified than others. The moral realism defended by Enoch is "stance-independent", not absolutist; that is, it is compatible with the existence of contested cases and with the need for interpretive sensitivity in pluralistic settings. Similarly, Parfit's moral realism, grounded in reasons rather than metaphysics, is explicitly pluralist in structure. His "Triple Theory" does not collapse all normative reasoning into a single method but instead shows how deontological, consequentialist, and contractualist traditions often converge on what we have most reason to do. This convergence lends support to the idea that moral disagreement need not undermine the pursuit of objective moral facts. The existence of diverse moral frameworks may reveal multiple paths to the same justified conclusions, not evidence that no such conclusions exist. Moral realism, then, does not deny the fact of pluralism. It acknowledges it as part of the moral landscape, while also affirming that ethical reasoning is not reducible to religious and cultural diversity. Clinical ethicists operating within a realist framework remain attuned to stakeholders' diverse moral commitments without abandoning the aspiration to reasoned moral judgment. Moral realism does not override moral pluralism, it provides a framework for engaging it without collapsing into moral relativism.

Paternalism

When clinical ethicists claim moral expertise grounded in objective moral facts, a legitimate concern arises that they may overstep their role by imposing personal judgments under the guise of moral expertise. This risks veering into paternalism, where clinical ethicists' perspectives override the moral agency of stakeholders. Shea (2025) argues that many clinical ethicists already operate within what he

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calls a "conventional" framework, one that derives normative guidance primarily from law, policy, and institutional norms, but presents this guidance as ethically authoritative. CEC may thus unintentionally function as an enforcer of institutional ideology, rather than as a genuine moral deliberator. The danger, then, is not simply that moral realism licenses paternalism, but that it may mask power dynamics already embedded in clinical practice. However, moral realism does not entail dogmatism. Enoch and Parfit emphasize that moral facts are not private revelations but they are public, defeasible, and subject to reasoned argument. Enoch holds that moral deliberation is not about asserting conclusions but about offering reasons open to revision. Parfit, in turn, grounds moral realism in the idea of impartial reasons that apply regardless of one's particular preferences and professional roles. Both Enoch and Parfit thus reject paternalism, emphasizing the reason-giving nature of moral realism in a shared deliberative space.

Moral realism does not empower clinical ethicists to impose their views, but it does oblige them to provide transparent and well-reasoned judgments. Realist clinical ethicists must engage with others' perspectives not only out of respect, but because understanding them is essential to determining which course of action is most ethically justified. Moral realism, properly understood, encourages normative humility, precisely because it treats moral facts as something to be discovered, not dictated. Rather than undermining the role of stakeholders, moral realism enhances it. It treats moral disagreement not as a barrier to ethical analysis, but as a reason to deliberate more seriously. Moral realism supports clinical ethicists' responsibility to offer judgments, but only insofar as those judgments are supported by reasons that others could, in principle, accept. Far from entrenching paternalism, moral realism enables a model of CEC that is both normatively robust and dialogically inclusive.

Institutional pressure

Another concern stems from the institutional context in which CEC takes place. Even when clinical ethicists are prepared to make moral judgments grounded in moral realism, they may frequently encounter structural limitations that inhibit the expression and implementation of such judgments. These constraints are both formal and informal, ranging from organizational policies and legal norms to unspoken expectations about clinical ethicists' appropriate scope of practice. Shea (2025) observes that clinical ethicists in the U.S. are routinely expected to avoid issuing substantive ethical recommendations, a mode of practice that takes institutional consensus as its operative ethical framework. On this view, clinical ethicists' task is not to determine what is ethically right, but to clarify existing institutional norms and help stakeholders navigate them. Such institutionalization of "moral modesty," while often well-intentioned, presents a fundamental challenge to CEC's ethical legitimacy.

Yet, the presence of institutional constraints does not entail the abandonment of moral realism. Rather, it calls for a more honest reckoning with clinical ethicists' role as institutional, moral agents. A moral realist framework does not require that clinical ethicists always succeed in enacting normative conclusions within institutional parameters, but it does require that they remain committed to articulating those conclusions when ethically warranted. Moral realism, then, offers a counterweight to institutional drift, reminding clinical ethicists that their primary responsibility is not to preserve institutional agreement but to reason well about what ought to be done. Moreover, moral realism provides a defensible basis for pushing back against institutional norms when they fall short of ethical adequacy. Allowing clinical ethicists to frame their resistance not as a matter of personal conscience, but as a principled stance grounded in reasoned moral judgment. This is especially important in settings where power asymmetries and bureaucratic inertia may obscure the moral stakes of clinical decisions. Without the normative grounding of moral realism, such interventions risk appearing as overreach.

VI. CONCLUSION

CEC earns its place only when it does more than manage process. Its point is to answer, as clearly as the facts and reasons allow, what ought to be done. A realist orientation makes that aim intelligible. It treats bedside judgments as responses to reasons that do not depend on preference, and then renders those judgments in the language of public justification such that they can be scrutinized and contested. Contractualist and constructivist procedures, together with shared mid-level norms, supply that public language.

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We have shown how absolutized neutrality drains CEC of normative substance. By contrast, moral expertise is the practiced capacity for sustained, transparent reason-giving. Recommendations sometimes warrant moral deference not because of title or ritual but because, given the clinical facts and the profession's standards, they more reliably track the reasons that apply. Where shared norms and routine procedures settle the matter, nothing further is needed. Where they do not—under deep pluralism, persistent non-convergence, or institutional pressure—a realist grounding does additional work. It supports determinate, action-guiding recommendations when reasonable constructions diverge and provides an external standard for challenging policies that are convenient yet morally off-course. Such realist orientation is fully compatible with pluralism and institutional legitimacy. In practice, recommendations anchor in the profession's content-full corpus and take shape in dialogue with the treating team, which supplies and interprets the clinically relevant facts. Where clinical ethicists are dual-trained, clearly defined role boundaries ensure that clinical and consultative responsibilities do not conflict. Taken together, realist commitments keep CEC principled, transparent, and normatively accountable. And, just as importantly, honest: fallible and corrigible, yet oriented toward getting things right. On a realist understanding, CEC does not collapse into policy facilitation or institutional appeasement, but it retains its ethical core.

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NOTES

1. By an "all-things-considered ethical judgment," we mean the ethical verdict that integrates the salient clinical facts as explained by the treating team, the patient's values, and the profession's content-full standards. This differs from an institution's all-things-considered decision, which may additionally weigh legal risk, finance, operational constraints, and other non-ethical considerations.
2. While we focus primarily on Enoch's robust realism and Parfit's reason-based account, it is important to note that moral realism is a diverse field. Russ Shafer-Landau's non-naturalist realism, for example, defends the objectivity of moral facts without metaphysical robustness. Thomas Scanlon's contractualism suggests that moral truths arise from what no one could reasonably reject, maintaining objectivity without invoking irreducible moral properties. These variations differ in metaphysical ambition, but they share the conviction that some moral claims are objectively more justified than others. Our emphasis on Enoch and Parfit primarily reflects their relevance and suitability for clinical ethics.

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