Experiential Learning in Clinical Ethics Consultation

THOMAS MORGENSTERN and GERD RICHTER

Clinical ethics consultation is situated between general bioethical discourse, on one hand, and concrete clinical decisionmaking, on the other. Bioethical discourse is abstract, objective, open minded, and characterized by a multitude of different voices, approaches, and theories. But ethical-clinical patient care on the ward demands definite, real-time decisionmaking. It is influenced by the subjective convictions of those involved; it is subject to hierarchical personnel structures on the ward and other institutional constraints; and it is often complicated by the scarcity of available information. As a result some authors express concern about a gap between bioethical theory and clinical practice.[1]

In what follows we suggest that the distance between theory and practice can be minimized if ethics consultation understands clinicians as ethically competent decisionmakers and conceptualizes their proper role accordingly. We describe the ethical liaison service that has been instituted in our clinic, and the pragmatic-phenomenological understanding of ethics expertise that underlies it. This requires rethinking the concept of ethical knowledge, as well as the role of education in clinical ethics consultation. We analyze the most frequently used forms of ethics consultation as linear models, characterized by a propositional-deductive understanding of ethical knowledge. We then describe the organizational structures and epistemological presuppositions of our model, the complementary ethics liaison service, and propose an alternative perspective on ethical knowledge—ethical competence. The Dreyfus learning model is presented as one possible explication of this kind of knowledge. We suggest that the design of our ethics liaison service and the opportunity it provides for application of the Dreyfus learning model represent a rethinking of central aspects of ethics consultation.

Ethical Knowledge and Common Models of Ethics Consultation

The traditional tasks of ethics consultation are (1) *education* of physicians, nurses, and other staff, (2) *policy development*, and (3) *case consultation* in the course of ongoing patient care.[2] Emphasizing education allows for the tentative formulation of an ideal goal of ethics consultation: when the work of ethicists has been fully successful, ethics consults should become increasingly unnecessary by virtue of having educated all staff sufficiently to deal with ethical problems at the bedside in a knowledgeable and responsible manner. But if education is to be prioritized among those three tasks, how ought ethics education to be understood? What kind of knowledge is to be transferred from educator to student, or in this case, from ethicist to clinician?

The authors thank Haley B. Smith for her thoughtful comments on an earlier version of this article.

Cambridge Quarterly of Healthcare Ethics (2013), **22**, 216–226.

doi:10.1017/S096318011200059X

Common designs of ethics consultation differ in the number of persons involved in consultation and how they are organized.[3] Ethics consultation can be carried out by all members of a healthcare ethics committee (HEC), by a team or subgroup of members, or by a single consultant (CEC) and can be held directly on the ward or in a designated conference room, depending on the circumstances. Consequently, advantages and disadvantages of common models are frequently discussed with reference to these parameters of design.[4]

Although the HEC meeting as a whole is commonly considered optimal for policy development,[5] all three models can have application for the various issues of ethics consultation.[6] Yet neither of these models takes sufficient account of the proper role of education in clinical ethics. In our opinion, two aspects of common models are obstacles to an integration of education into ethics consultation.

First, according to the most frequent institutional arrangements, ethics consultation is fundamentally *reactive*. The usual working procedure of an HEC or CEC is that consultation is initiated once an ethically problematic situation has occurred. Clinical staff will then request recommendation from the HEC or CEC. This suggests that it is the role of the consultant or committee to decide where ethical authority, expertise, and judgment have their place. But this approach tends to misrepresent the role of clinicians, the de facto primary decisionmakers in clinical settings. Hence, ethical education of clinicians does not take priority. Further, if designs of ethics consultation put emphasis on the expertise of ethicists, clinicians might generally feel less responsible for ethical problems arising on the ward. A possible effect of this trend is that clinicians might tend to be less sensitive to the ethical aspects of their work.

The second aspect is the kind of *ethical knowledge* that we think mainly underlies common models. Common designs represent *linear models* of ethics consultation. The defining feature of a linear model is that general ethical knowledge is applied to the particular circumstances of clinical practice.[7] This application of ethical knowledge takes a quasi-deductive form. The expertise of professional ethicists consists in their extensive knowledge of precedent cases and of ethical theories, rules, and principles. In the process of consultation, the particular facts of a case are gathered and examined in the light of general expert knowledge. The process of analysis aims at deducing what ought to be done in the current case and functions according to the prototype of deductive reasoning. Education in ethics then consists in teaching general ethical knowledge and how to apply it in specific situations. But the ethical dimension of clinical medicine is becoming increasingly complex, demanding increasing ethical expertise; in fact, this was the very reason for the establishment of ethics consultation.

In our opinion, a way to overcome these shortcomings is to educate clinicians as ethically competent decisionmakers. However, it is unlikely this will be achieved if ethical knowledge is understood solely in terms of extensive propositional knowledge of ethical theory, precedent cases, and so on, and their apt application in clinical practice. Ethics education of those most proximate to the clinical setting is not what these models are designed to further.

The Theory and Practice of the Ethics Liaison Service

Our ethics liaison service, which we have described at greater length elsewhere,[8]

has been established to address clinical ethical issues. The central tasks of the ethics liaison service are those recommended in the ethics facilitation approach, as found in the ASBH report "Core Competencies for Health Care and Ethics Consultation";[9] these include the identification and analysis of ethical problems in current patient care. The role of the ethicist is as a facilitator, to ensure a fair and inclusive shared decisionmaking (SDM) process.[10] It is crucial to note that the ethicist—unlike the consultant in common designs—is not viewed as the primary decisionmaker.

Unlike an HEC, which may meet on a regular schedule, or a CEC, who responds only when called in, the ethics liaison service is defined by weekly scheduled ethics rounds, which take place during the normal ward rounds. We hold that the frequent presence of an ethicist offers unique advantages. It allows early recognition of even minor ethical problems and accommodates the dynamics of ethical and clinical goal setting in the course of patient care. Most importantly, the regular and nonauthoritative participation of an ethicist in normal ward rounds allows for continuous ethical education of staff within everyday clinical routine. In focusing on facilitating ethical clinical decisionmaking, the ethicist seeks to empower physicians and other staff to deal appropriately with ethical problems by themselves. Because of its proactive approach, this design can make a significant contribution to preventative ethics—reducing the number of emergent ethical problems in clinical ethics, rather than serving primarily as a resource to be called in after ethical problems have already arisen.

Clinical Pragmatism

The ethics liaison service differs from common models in terms of not only its organizational structures but also its epistemological presuppositions. The structure and the priorities of our service have been based on some basic ideas of *clinical pragmatism,* a bioethical approach inspired by the philosophy of John Dewey. This approach aims for global, rather than specialized or isolated, *ethical competence*. Developing the ethical competence of the clinicians operating within the clinic is a central objective of the service. An intuitive understanding of ethical competence relies on Dewey's distinction between "knowing-that" and "knowing-how." Dewey considered the kind of knowledge represented by scientific theories, contained in books, or common to our everyday explanations of routine life—the explicit knowledge that he called knowing-that—only a part of what people actually know. In addition, we know *how* to do a lot of things: "We walk and read aloud, we get on and off street cars, we dress and undress, and do a thousand useful acts without thinking of them."[11]

Dewey elaborated this twofold approach in his theory of inquiry, in which he aimed at bridging the traditional gap between naturalistic science and non-naturalistic "morals," which clinical pragmatism adopts in its conception of ethical problem solving.[12] Inquiry is understood as a general method of problem solving of human beings applied to issues of everyday life, as well as to the complex challenges of science. In interacting with our environment, we cope with many circumstances reflexively or habitually. But when human beings face a problematic situation, they suspend habitual conduct and deliberately reflect on the current issue—we can stop and think. The dynamic method of the ethics liaison service parallels the steps of inquiry as described by Dewey: "(i) a felt difficulty; (ii) its location and definition;

(iii) suggestion of possible solutions; (iv) development by reasoning of the bearings of the suggestion; (v) further observation and experiment leading to its acceptance or rejection.''[13]

Clinical pragmatists suggest that knowledge—conceived of here with special regard to ethical knowledge—is fundamentally context dependent.[14] We can imagine that whenever we perform ethical thinking and conduct, we already possess some ethical knowledge; for example, we learn that we are not supposed to lie as we grow up, and we usually do not do so; we have, in our everyday lives, a notion of what it means to be "good" to other people, and, for the most part, we act accordingly. So we carry with us—and we are determined by—the sum of our implicit and explicit ethical knowledge. However, some situations that we experience in life baffle us, and it is then that we interrupt our usually seamless habitual conduct and have to deliberate about what we ought to do. In other words, when the specific circumstances and stimuli, the context of a situation, somehow conflict with the status quo of our ethical knowledge, this gives rise to ethical thinking. Deliberation will then suggest a solution or answer to the problem, and we will act accordingly.

Clinical pragmatism views the physician–patient relationship neither from the traditional paternalistic perspective nor in terms of the opposing autonomy model of consumer sovereignty but embraces Katz's model of shared decisionmaking (SDM).[15] SDM most appropriately corresponds to Dewey's conviction that, by nature, resolution of ethical problems requires equal respect for all parties involved.[16]

If ethical knowledge, that is, ethical competence, is understood in terms of both knowing-that and knowing-how, the results of deliberation—the possible solution—must work when executed in practice, that is, under the specific circumstances of the emerging problem. We will therefore evaluate our thinking and conduct and eventually alter it to finally solve the problem in a satisfying, ethically competent manner. Hence, practice is *constitutive* for this understanding of ethical knowledge. The Dreyfus learning model supplements this epistemological presupposition with our service's strategy of putting it into practice and suggests further aspects of ethical competence that are relevant to the ethics education of clinicians.

Experiential Learning

The learning model of skill acquisition presented by Hubert and Stuart Dreyfus is a general, phenomenological account of how people learn certain skills.[17] Dreyfus and Dreyfus distinguish five stages of learning: novice, advanced beginner, competence, proficiency, and expertise.[18]

Novice: The novice is represented as a total beginner without any theoretical or practical knowledge in the new skill. The novice will therefore be introduced to guidelines by an instructor. These guidelines have the form of *context-free rules*. Without experience of the actions demanded by the skill, the novice is characterized by his limitation in applying those rules, as he lacks sensitivity to the circumstances of a particular situation. Even a good novice will often not be successful in exercising a new skill. A novice car driver told to "shift gears according to speed" might well stall the engine on a steep hill.

Advanced beginner: The advanced beginner has already gained some experience in the new field. She has, by experience, learned that rules have to be applied depending on the changing circumstances of a given situation. For the advanced beginner, rules take the form of *maxims*. The more the advanced

beginner learns, the more attention he will pay to the particular aspects of the situation. At this stage, it might become increasingly difficult to make explicit all the information relevant for the advanced beginner's conduct.

Competence: At the third stage of learning, information available to the competent performer in a concrete situation becomes overwhelming. Competent performing, therefore, requires that the executer of a skill define a goal of action and make a plan on how to achieve that goal. In light of this plan, some aspects of the situation stick out as important, and others become irrelevant. In general, the competent performer's conduct is characterized by "detached planning, conscious assessment of elements that are salient with respect to the plan, and analytical rule-guided choice of action followed by an emotionally involved experience of the outcome."[19] The competent performer is thought of as a professional in rational thinking. It is not that the competent performer has no emotional reaction to a certain outcome, but at this stage, rational deliberation determines performance.

Proficiency: At the fourth stage, the executer of a skill does not so much focus on the rules or principles formerly learned, nor does she primarily decompose and individually assess the aspects of a given situation. The proficient performer has been involved in many difficult situations. Based on the richness of her experience, her perspective is characterized as a holistic capturing of the complex situation. The proficient performer, as described by Dreyfus and Dreyfus, simply "notices" or "is struck by" the aspects of the circumstances at hand, the goal, or a plan: "No longer is the spell of involvement broken by detached conscious planning."[20] However, although her grasp of the situation is immediate and independent of conscious deliberation, and although her intuition might instantly suggest a certain way of conduct, the actual decision as to how to act might still involve balancing intuition and rational analysis.

Expertise: The performer at the highest stage of skill acquisition has experienced numerous different situations that required a multitude of different ways of acting. The expert knows the possible subgroups of circumstances and the various ways of conduct they demand. Due to her holistic experience, she does not depend on deliberation for grasping and resolving critical situations. Also, due to her experience, emotion plays an implicit and constitutive part in forming the performer's perspective and choice of action. The expert does not solve problems in a traditionally rational way, he just does what works: "What must be done, simply is done."[21]

The Dreyfuses describe the development of skill acquisition as a continuous transition from blind application of general rules at the novice level, via a stage of competence governed by the paradigm of rational reasoning, to a stage of expertise characterized by smooth intuitional management of complex situations. Note that the greatest leap in skill acquisition takes place in moving from stage 3 to stage 4. In the first to third stages, the strategy for successful coping is determined by rational analysis and conduct. General rules and maxims operate as guidelines for successful coping. Of course, the progress from novice to competent performance aims at successfully mastering certain situations, yet rules and principles are considered the criteria for the assessment of a performance at these stages. The novice fully masters the first stage when he is able to follow the rules taught to him; the competent performer will justify his choice of action with reference to his rational analysis of the situation. Starting with the fourth level,

proficiency, the quality of performance changes in that rational thinking is increasingly suspended, and intuition becomes the operative mechanism of decisionmaking (or its equivalent) and conduct—that is, the means for successful coping switches to a *different kind*. If we might map this process in terms of Dewey's thought, the Dreyfus model describes the progress of skill acquisition as the shift from merely explicit know-that to the internalized, implicit know-how of problem solving. Yet the Dreyfus model goes further, in that it identifies rational deliberation with the minor stage 3 of skill acquisition.

An important feature of the Dreyfus model is its emphasis on the importance of context for skill acquisition. A defining characteristic of the novice in the first stage is the learner's dependence on rules that are detached from the specific context of the situation. Abstract principles form the basis of diagnosis and the choice of action. Yet, starting in stage 2, the multitude of information constituting a specific situation becomes a salient for the executer of a skill, and becomes overwhelming at the stage of competent performing. Context, in the Dreyfus model, is important because no two situations are likely to be exactly the same. Furthermore, real-life situations might be overly complex with reference to our capacity for rational deliberation: more than one rule of thumb or maxim might apply to a given situation—and such guidelines might suggest competing resolutions or courses of action. The Dreyfus model, through its use of the concept of intuition, suggests the possibility of smooth, successful coping—but this means a paradigmatic change of strategy. Starting with the proficiency level, involvement in a situation becomes the leading strategy for successful coping. Emotions can serve as a guide for involvement. Whereas emotional reactions are viewed as something hindering rational thought at the third stage, from stage 4 on, emotional reactions, the gut feelings they call intuitions, form the basis of perception and choice of action. Sensitivity to context, the very opposite of detachment, becomes the constitutive feature of the higher stages of performance.

Although the examples they give are often of mechanical skills, the Dreyfuses are quite willing to apply their learning model to an account of how we gain ethical knowledge, that is, how ethical comportment can be taken to the stage of ethical expertise. This transference, the Dreyfuses say, is based on a conditional: "*If* the skill model we have proposed is correct, then, in so far as ethical comportment is a form of expertise, we should expect it to exhibit a developmental structure similar to that which we have described above."[22] The Dreyfus model does not, per se, neglect the importance of ethical deliberation. Yet they aim at producing an alternative to supplement the traditional model in which conscious rational deliberation plays a dominant role in ethics.

The way we learn ethical comportment in the sense of this model can be demonstrated by the example of a child learning to use the moral rule that one should never lie.[23] At first, the child might learn the rule and follow it. But faced with a moral dilemma, in which telling the truth would cause serious harm to others (think of the famous examples proposed by Kant or Singer), the child might learn that telling the truth, in certain situations, can be morally wrong. Of course, the child will also experience more often that not following the rule is the wrong thing to do. Finally, after having experienced many situations, the child will normally apply the rule and make exceptions only when morality itself demands it.

Transferring the learning model to ethics raises two difficult questions:

"(1) What is *ethical* expertise? and (2) how does one learn it?"[24] The skills of driving a car or playing chess provide clear criteria for expertise; the expert driver won't crash his car, and the expert chess player will (mostly) win his games. But what are the criteria for expertise in ethics? Referring to Aristotle, the Dreyfuses propose that ethical expertise is exemplified in the performance of those who are already accepted as ethical experts: "What is best is not evident except to the good man."[25] To become an ethical expert, one has to learn to respond to ethically relevant situations the same way acknowledged experts respond to them. The reply to the aforementioned questions, hence, entails a circular structure. This might be deemed as insufficient reasoning. A Kantian or utilitarian might accuse the Dreyfuses of producing a circular argument (in philosophical terms, a petitio principii), because the definition of ethical expertise presupposes the very concept of ethical expertise. To be more precise, here ethical expertise is *justified* by reference to a notion of ethical expertise.

But this is only a disadvantage if the concept is somehow interpreted in terms of a linear model, in which ethical knowledge is merely understood as knowing-that, but the knowing-how component of ethical thinking and conduct is ignored. The model of experiential learning represents a paradigm shift from that linear model and contrasts with much of traditional Western philosophy, which defines moral maturity in terms of rational argumentation. According to the Dreyfuses, even Dewey, who introduced the concept of know-how to his moral philosophy, falls short of acknowledging this when he claims that a considered moral expert has to rely on rational deliberation when facing a complex ethical situation.[26] Instead, the smooth, effortless performance of the Dreyfuses' ethical expert is made possible by his experience-based intuition even in problematic yet somehow familiar situations: "Indeed, phenomenological description suggests that the greater the experience, the *rarer* the need for deliberation."[27] It holds true, though, that a performer has to "fall back"[28] on principle-based deliberation when facing exceptional, and thus unfamiliar, "life-boat situations"—and the results of deliberation then will necessarily be crude.[29] They will, in the sense of the model, be less mature. However, according to the Dreyfuses, that is not how *expert* deliberation works: "[I]n familiar but problematic situations, rather than standing back and applying abstract principles, the expert deliberates about the appropriateness of his intuitions."[30]

The Dreyfus model of skill acquisition, when transferred to ethics, proposes nothing less than a fundamental change of the perspective on ethical thinking and conduct. Defining moral maturity or expertise primarily in terms of practical reason means—at least to some extent—putting the cart before the horse:

> [T]he mistaken idea that when the situation becomes complex an agent must deliberate—articulate his or her principles and draw conclusions as to how to act—only becomes dangerous when the philosopher reads the structure of deliberation back into the spontaneous response. This intellectualizes the phenomenon. One will then assume that intentional content—what John Searle calls an intention in action, and Kant calls the maxim of the act—underlies all moral comportment.[31]

The Dreyfuses do not deny the importance of practical reasoning in ethics. Many situations we experience demand explicit rational analysis. Yet neither does all moral comportment originate

from ethical deliberation, nor would it be adequate to declare practical reason the sole or highest institution of ethical maturity. Hence, moral expertise cannot solely be defined by criteria of morality proposed by traditional ethical theories. The most worthwhile aspects in ethics, so the Dreyfus account suggests, are not the results (the judgments) of detached rational analysis derived from abstract ethical principles but the intuition-based, smooth, effortless coping of an expert involved in ethically relevant real-life situations.

The Dreyfus learning model that we here have introduced as part of the theory that underlies the formation and function of our ethics liaison service is not uncontroversial. It has been applied to various fields of skill acquisition and has been widely discussed and criticized, both in terms of its model and in terms of its applicability to specific areas. Pena[32] questions whether it is a good idea for the novice to "memorize rules"[33] and asks whether the expert really ignores principles instead of deliberating about the appropriateness of his intuitions when facing a problematic situation; furthermore, he questions whether the model aptly represents clinical skill acquisition and methods of clinical problem solving.[34] With reference to ethics, Musschenga appreciates the Dreyfuses' emphasis on the role of moral intuition but has been critical in saying that they fall short of doing justice to the importance of reasoning skills.[35] We agree with this criticism insofar as we note that shared decision-making cannot be based solely on the implicit know-how of expert intuition but also demands that those involved be able to communicate their convictions and participate in a rational explicit discourse—and indeed, that the ability and willingness of ethics consultants to so participate constitutes their main pedagogical strength in clinical ethics contexts. However, in spite of possible criticisms, we believe that the Dreyfus model can make a significant contribution to medical ethics in that it challenges the common ethical perspective implicit in what we have termed the linear model.

Conclusion

We initially noted a general gap between bioethical theory and clinical practice. We suggested that this distance can be minimized if ethics consultation starts with the assumption that clinicians ought to be seen as ethically competent decisionmakers, and educated to this end. This requires rethinking the concept of ethical knowledge and the meaning of education in ethics consultation. We interpreted common models of ethics consultation as linear models, characterized by a propositional-deductive understanding of ethical knowledge, and argued that the task of ethics education of clinicians is misrepresented in these models. Whereas common designs suggest detached analysis, we underscore the fundamental importance of sensitivity to context in resolving clinical-ethical issues on the ward. Our ethics liaison service is designed with this assumption. It is important to note that current clinical-ethical issues necessarily occur within a setting of everyday ward procedures; hence, the way ethical problems are perceived—and managed—is influenced and shaped by the structures of this setting. Ethics consultation ought to respond to the clinical necessity of real-time decisionmaking, or to the dynamics of patient preferences and/or medical indications in the course of a case, and so forth. This context is constitutive for ethical-clinical decisionmaking on the ward. Getting hold of ethical issues as they arise in the clinical setting requires a theoretical approach to ethical knowledge that is more comprehensive than

propositional-deductive thinking alone. We think that the Dreyfus account, in elaborating the distinction between explicit knowing-that and implicit knowing-how, allows for rethinking further important aspects of ethics consultation.

It is our experience, gained during ethics rounds at Marburg University Medical Center, that a lot of ethical issues on the ward do indeed present complex yet familiar problems. They can be represented by, and integrated into, routine ward procedures, the common know-how of (ethical) problem solving on the ward. By partaking in regular ward rounds, the ethicist is able to continuously educate clinicians by facilitating resolution of current ethical conflicts and encouraging shared decisionmaking. The ethical expert, when appropriate, can provide adequate professional ethical information—as represented in ethical theory and precedent cases—but also encourages clinicians, as Dreyfuses' theory demands, to *habitually* see and evaluate cases from an ethical point of view, for example, by considering questions such as the following: What is the patient's will? What is her or his social situation? What means of diagnosis or therapy does she or he consent to? What is medically indicated? These are common (simple or complex) yet crucial procedures in grasping the ethical dimension of a case. Thus, educating the ethical intuition of clinicians toward expertise serves to bridge the gap between professional ethics and medicine. Both ethicists and clinicians contribute to an ideally smooth course of making ethically relevant medical decisions on the ward.

This proactive quality of the ethics liaison service supports the goal of prevention in medical ethics. Instead of engaging in ethics consultation only after an ethically problematic situation has occurred, continuous ethics education of clinicians aims at ensuring early recognition of ethical issues. Ideally, ethical competence—as characterized in the Dreyfus account—ought to enable clinical staff to anticipate ethical problems in current patient care, forestalling the kind of impasse that might lead to the need for a more complex consultation.

However, we do not necessarily agree with the Dreyfuses' claim that rational deliberation equals falling back to a minor level of performance. That is, we do not agree that what they call intuition is universally superior to and can always replace rationality or reason. Propositional-deductive reasoning does form an indispensable aspect of ethical coping. The process of shared decisionmaking central to the ethics liaison service calls for participants to articulate and rationally support their convictions and perspectives. But we do think that the Dreyfus account methodologically opens up an important alternative perspective on ethical expertise in such practical contexts as the clinical setting. In underscoring the importance of intuition, the Dreyfuses epistemologically qualify the implicit know-how component of ethical knowledge as relevant to ethical coping in real-life situations. Their account explains that when ethical theory is taken into practice, the means of ethical coping switch to a different modality. Routine ward procedures are significant in ethics in medicine.

But even more important, in challenging the traditional assumption that deductive reasoning is the mark of moral maturity, the Dreyfuses' account allows for rethinking the aim of consultation and education in clinical ethics. It is unlikely that the ultimate goal of reducing the number of ethics consultations will be considered if the ethics consultant or committee members are viewed as the exclusive possessors of ethical expertise and authority. Instead, as the Dreyfuses' account suggests,

moral maturity is represented not only in the results of professional rational deliberation but also in the smooth course of competent ethical coping in patient care within the clinical setting: "What must be done, simply is done." This alternative perspective on ethical expertise serves to bridge the gap between clinical-ethical theory and practice in that it allows for understanding and instructing clinicians themselves as ethically competent decisionmakers—as ethical experts within a specific field. It helps us to understand how we can come close to the ultimate goal of ethics consultation when ethical knowledge is taken into practice.

Notes

1. Cf. Richter G. Greater patient, family and surrogate involvement in clinical ethics consultation: The model of clinical ethics liaison service as a measure for preventative ethics. *HEC Forum* 2007;19;327–40; Richter G. Clinical ethics liaison service: Concepts and experiences in collaboration with operative medicine. *Cambridge Quarterly of Healthcare Ethics* 2009; 18:1–11. See also Quante M. Prinzipienlose Medizinethik? In: Düwell M, Neumann JN, eds. *Wie viel Ethik verträgt die Medizin?* Paderborn: Mentis; 2005:74–7.
2. Cf. Neitzke G. Aufgaben und Modelle von Klinischer Ethikberatung. In: Dörries A, Neitzke G, Simon A, Vollmann J, eds. *Klinische Ethikberatung: Ein Praxisbuch*. Stuttgart: Kohlhammer; 2008:59.
3. See note 2, Neitzke 2008, at 62–71. Berkowitz KA, Dubler NN. Approaches to ethics consultation. In: Post LF, Blustein J, Dubler NN. *Handbook for Healthcare Ethics Committees*. Baltimore, MD: John Hopkins University Press; 2007:140–2.
4. Compare the discussions of common models of ethics consultation by Neitzke and Berkowitz and Dubler. See note 2, Neitzke 2008, at 62–71; see note 3, Berkowitz, Dubler 2007, at 140–2.
5. See note 2, Neitzke 2008, at 64.
6. See note 2, Neitzke 2008, at 62–71. See note 3, Berkowitz, Dubler 2007, at 140–2.
7. An elaborated account and analysis of a linear model of bioethics is given by Krones T. *Kontextsensitive Bioethik: Wissenschaftstheorie und Medizin als Praxis*. Frankfurt/New York: Campus; 2008, at 72–192, 307–12.
8. A detailed account is given by Richter. See note 1, Richter 2007 and Richter 2009.
9. Society for Health and Human Values–Society for Bioethics Consultation, Task Force on Standards for Bioethics Consultation. *Core Competencies for Health Care Ethics Consultation: The Report of the American Society for Bioethics and Humanities*. Glenview, IL: American Society of Bioethics and Humanities; 1998, at 6–7.
10. See note 1, Richter 2007 and Richter 2009; Richter G. Klinischer Ethiker—der Ethik-Liaisondienst als Modell präventiver klinischer Ethikberatung. In: Baumann-Hölzle R, Arn C, eds. *Ethiktransfer in Organisationen: Handbuch Ethik im Gesundheitswesen Bd.3*. Basel: Schwabe, EMH; 2009:157–63.
11. Dewey J. *Human Nature and Conduct: An Introduction to Social Psychology*. New York: H. Holt; 1922, at 177–8.
12. Miller FG, Fins JJ, Bacchetta MD. Clinical pragmatism: John Dewey and clinical ethics. In: Miller FG, ed. *Frontiers in Bioethics: Essays Dedicated to John C. Fletcher*. Hagerstown, MD: University Publishing Group; 2000:87–9.
13. Dewey J. *How We Think*. Boston, MA: D.C. Heath; 1910, at 72; cited in Miller et al. 2000, at 87, see note 12.
14. See note 12, Miller et al. 2000, at 87.
15. See note 12, Miller et al. 2000, at 95.
16. See note 12, Miller et al. 2000, at 94.
17. See Dreyfus HL, Dreyfus SE. Towards a phenomenology of ethical expertise. *Human Studies* 1991;15:229–50.
18. See note 17, Dreyfus, Dreyfus 1991, at 232–6. In Dreyfus HL. *On the Internet*. 2nd ed. London: Routledge; 2009, at 25–48, the author introduces a six-stage learning model (including the mastery level). In McPherson I. Reflexive learning: Stages towards wisdom with Dreyfus. *Educational Philosophy and Theory* 2005;37:705–18, McPherson discusses Hubert Dreyfus's 2001 seven-stage account (including the level of practical wisdom). However, for our purposes we restrict ourselves to the more common five-stage learning model.
19. See note 17, Dreyfus, Dreyfus 1991, at 233–4.
20. See note 17, Dreyfus, Dreyfus 1991, at 234.
21. See note 17, Dreyfus, Dreyfus 1991, at 235.
22. See note 17, Dreyfus, Dreyfus 1991, at 236 (emphasis in the original).
23. See note 17, Dreyfus, Dreyfus 1991, at 237.
24. See note 17, Dreyfus, Dreyfus 1991, at 237 (emphasis in the original).
25. Aristotle. *The Nichomachean Ethics*. Book II, 4. Ross D, trans. New York: Oxford University Press; 1980; cited in Dreyfus, Dreyfus 1991, at 237, see note 17.
26. See note 17, Dreyfus, Dreyfus 1991, at 238.

27. See note 17, Dreyfus, Dreyfus 1991, at 238 (emphasis in the original).
28. See note 17, Dreyfus, Dreyfus 1991, at 241.
29. See note 17, Dreyfus, Dreyfus 1991, at 241.
30. See note 17, Dreyfus, Dreyfus 1991, at 241.
31. See note 17, Dreyfus, Dreyfus 1991, at 238.
32. Pena A. The Dreyfus model of clinical problem-solving skills acquisition: A critical perspective. *Medical Education Online* 2010;15:10.3402/meo.v15i0.4846; available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2887319 (last accessed 9 Nov 2010).
33. See note 32, Pena 2010.
34. See note 32, Pena 2010; Carraccio CL, Benson BJ, Nixon LJ, Derstine PL. From the educational bench to the clinical bedside: Translating the Dreyfus developmental model to the learning of clinical skills. *Academic Medicine* 2008;83:761–7.
35. Musschenga AW. Moral intuitions, moral expertise and moral reasoning. *Journal of Philosophy of Education* 2009;43:597–613.
36. See note 17, Dreyfus, Dreyfus 1991, at 235.