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**Author**

Evans, John H

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## POWER AND JURISDICTION

I thank Flamm and Kodish (henceforth FK) for their close reading of my article. The core misunderstanding or disagreement with FK concerns the nature of power. FK are opposed to the concept of professional jurisdiction applied to bioethics because “its advisory status conflicts with the traditional definition . . . of ‘jurisdiction’ as the power or right to exercise authority” (p.191). FK emphasize that they make no decisions, and thus do not have power, and state that “preserving stakeholders’ moral agency and responsibility for decision making remains crucial.” They do not have jurisdiction or power because “they are not the executives, judges, public officials, or legislators retaining authority to take or impel action” (p.191). In sum, for FK, power, and thus jurisdiction, requires the ability to make binding decisions.

This is the common sense, legal notion of power. The analogy is that the king has power because he makes the decisions. However, his is not the definition I use, and most social scientists would say that this definition disguises real power. To quote political scientist E.E. Schattschneider, “the definition of the alternatives is the supreme instrument of power”<sup>1</sup>. Let us call this agenda-setting power. In this view, the king’s advisors have the real power, because they decide which options are put before the king. I agree that bioethicists essentially never have power in the legal sense and I state that in my original article. Rather, they have the more important power, which is the ability to set the ethical agenda.

While disowning power, FK claim “influence.” They “acknowledge that the professional aim of bioethicists is to exert influence. Asked for advice or guidance on a matter that requesters perceive is ethically challenging, bioethicists’ responses are oriented toward influencing ethically supportable action” (p.191). I take “ethically supportable action” to be the limit of the

alternatives they are giving to the decision-maker, and thus the use of agenda-setting type of power.

Similarly, in the discussion of the IRBs, FK write that one component of decision-making is whether a study represents “good ethics” (p.191). Therefore, in the clinic and the IRB bioethicists seem to have an agenda setting sort of power where the ethics of the actual deciders is constrained to the decisions that are “ethically supportable” and reflective of “good ethics.” In fact, FK support my depiction of principles as ethical agenda-setting when they say “the four principles reflect domains or inquiries present in any clinical case regardless of what values the involved stakeholders actually espouse” (p.192). In sum, my theory is not dependent on king-like power, and FK do not attempt to show that it is, but confirm that bioethicists have the sort of power I ascribe to them.

#### THE CLAIM TO NOT REPRESENT THE PUBLIC’S ETHICS

FK write that “we disclaim that we represent the public’s ethics in our work” (P.190) and that they only facilitate the ethics of others by “preserving stakeholders’ moral agency” (P.191). I would ask where the principles that they say shape the discussion of ethics came from? FK write that the principles are “values that are inarguably notable in our modern, Western medical community.” (P.192)

I would say that the notable ethics of the modern Western medical community embodied in principlism is the public’s ethics, and thus FK are then promoting the public’s ethics. The history of principlism shows that doctors ceded control of their ethics to “the public” as represented through principlism <sup>2</sup>. If that is wrong and the ethical constraint upon the individual decision-makers is instead just that of the “modern Western medical community,” I would argue that the bioethics revolution of the late 1960s should finally complete its task and make those the

ethics of the public. In the IRB the public source of the ethics is even more clear, because the ethical principles to be used (autonomy, beneficence, justice) are forced on every IRB through public policy that was set by our elected representatives of the public. My point is that since bioethicists, including FK, are using what are portrayed as the public's ethics, would it not be useful to know that these are actually the public's ethics?

#### BIOETHICS IN ORGANIZATIONAL ETHICS

FK write that they cannot simply adopt the assumption that “the field of bioethics is intently expanding its role in organizational ethics” (p.192). But, my claim is not dependant on bioethics doing this “intently,” and they describe how the bioethicists at the Cleveland Clinic have non-intently but effectively moved into the boardroom as they use “bioethics tools . . . that influence organizational decision makers, and we use them with not only realism, but humility” (p.192). Humility is how bioethics influence or power works.

FK return to their legal conception of power to say that bioethicists' influence over organizational ethics is not possible, that the only way bioethicists could have “influence over organizational path and mission” is if they “rise to high levels of executive leadership over healthcare organizations” (p.192). But, that view is in opposition to how FK say that bioethicists have influence over decision-making in the clinic, where they are not the deciders. Their statement about organizational ethics is equivalent to saying they cannot have influence unless they are the doctor or patient in the clinic. Why couldn't bioethicists have the same agenda-setting power or influence they have in the boardroom that they so effectively use in the clinic?

#### THE USE OF SOCIAL SCIENCE IN BIOETHICS

Since they do not see themselves as using the public's ethics, they do not see the need for measuring them, and then do not agree with the social science task I describe. FK instead

describe how they use social science to better communicate with decision-makers and improving HCEC practices. I agree that these are good uses of social science, but this discussion is besides the point of my article. In fact, I think the comments of FK reinforce the need for empirical measurement of the public's values. What if I could show that the public is opposed to the values of the "Western medical community" that FK use? Should these values still be used to shape the conversation about ethical choices as FK advocate?

ENDNOTES

11.E.E. Schattschneider, "Intensity, Visability, Direction and Scope," *American Political Science Review* 51, no. 4 (1957): 937.

22.David J. Rothman, *Strangers by the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making* (New York: Basic Books, 1991).