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the methods *of* bioethics

AN ESSAY IN META-BIOETHICS

John McMillan

The Methods of Bioethics

ISSUES IN BIOMEDICAL ETHICS

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The late twentieth century has witnessed dramatic technological developments in biomedical science and the delivery of health care, and these developments have brought with them important social changes. All too often ethical analysis has lagged behind these changes. The purpose of this series is to provide lively, up-to-date, and authoritative studies for the increasingly large and diverse readership concerned with issues in biomedical ethics—not just health care trainees and professionals, but also philosophers, social scientists, lawyers, social workers, and legislators. The series features both single-author and multi-author books, short and accessible enough to be widely read, each of them focused on an issue of outstanding current importance and interest. Philosophers, doctors, and lawyers from a number of countries feature among the authors lined up for the series.

The Methods of Bioethics

An Essay in Meta-Bioethics

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Contents

Part III. The Methods of Bioethics

Acknowledgements

Over the course of several years Adrian Walsh and I have discussed the importance of argument for bioethics, and how there seems to be an overemphasis on theory, and a number of the names that I have given to parts of this book arose out of discussions I've had with Adrian. The idea that we should view the obstacles to good bioethics as 'spectres' is his, and it describes well the way in which a number of historical issues continue to haunt bioethics. It was his idea that we can think of the two broad classes of strategy used in ethical reasoning as 'speculation' and 'drawing distinctions', and this suggestion, as well as many others he has made, helped to shape this book into the form it now has. From my first interactions with bioethics I was aware that this is an area where a degree of humility is required: if you come from a philosophical, legal, or sociological background you should be aware of the expertise that others bring to ethics, especially in a clinical context. Adrian suggested that the best description for this concept is 'epistemic humility'; I have developed that idea, and it plays an important role in the argument of this book.

I'm indebted to Julie McMillan-Kearns, Bruce McMillan, and Thomasine Kushner for invaluable comments on drafts of this material. The two anonymous reviewers who read this book for Oxford University Press made a number of insightful comments and spotted gaps in the argument. This book is much improved as a result of their efforts. Others who have made particularly penetrating and insightful comments include: Tony Hope, Julian Savulescu, Tom Douglas, Mark Sheehan, Mikey Dunn, and Mike Parker.

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John McMillan

1

How to Find Your Footing in Bioethics

My introduction to bioethics was in the middle of the 1990s, and I started in this new area animated and filled with zeal because my philosophical studies were about to take a turn for the pragmatic. No longer would my efforts to grasp the meaning of difficult passages in Wittgenstein or Kant merely be about the pursuit of knowledge, I was about to embark upon an ocean of issues that really matter. So, I was puzzled when I ventured into the bioethics literature of that time, to find that the predominant issues were to do with theory. And not just any theory, moral principles! This did not sit at all well with the intellectual diet of possible-world semantics, functionalism, and moral nihilism that I had been nurtured on. This wasn't just a sense that this was a much more optimistic view about the prospects for moral theory than I had seen before, it was a sense of surprise that the exciting neon-lit dilemmas that I heard about were not taking up everyone's time. It was as if the attention of those working within bioethics had been directed at something that was not in the centre of the painting, creating the unsettling feeling that what should be central to our attention was being overlooked.

While bioethics has moved on, and much less effort is exerted arguing about whether there should be one, three, four, or seven principles for bioethics, the feeling that somehow bioethics has missed the ethical woods for the theoretical trees has not left me. Theory building is not as grand now, and there is less of it. Nonetheless, every year books appear that describe a new theoretical perspective

upon bioethics, along with edited collections tied together with the promise of a distinctive insight into the nature of ethical issues. The tendency for introductions to begin with summaries of the major moral theories, and then say something about principles, persists, and this book arose from the conviction that we've all missed an important point about how it is we do bioethics. That is the idea behind this being an essay in 'meta-bioethics': it involves taking a step back from bioethics and thinking about what we are really aiming to do, and how in fact we go about doing it well.

My second, and perhaps more important, motivation is that over a period of twenty years I have seen a series of newcomers to bioethics struggle to figure out what this enterprise really is, and how you go about doing it. Many of these people have come from medicine and other health professions, and I've often felt a source of frustration at watching them push very sensible clinical ethical thoughts through crude paraphrasing of what Mill, Kant, or Aristotle would say about that situation. That is not to say that those from non-philosophical backgrounds should be protected from history's great thinkers, just that setting moral theory up as something that is going to help get you started in bioethics often leads very clever people astray when there are much more useful things that could be said to help them.

These two motivating reasons mean that this book has been written for readers with two different needs: those new to bioethics and looking for the quickest way to get started, and those not so new to bioethics who are interested in its nature, purpose, and future.

Bioethics has made a mistake about what its methods are, and this has led not only to too much theorizing but also to fragmentation within bioethics. The unhelpful disputes between those who think bioethics needs to be more philosophical, more sociological, more clinical, or more empirical continue. While each of these claims will have *some* point, they obscure what should be common to all instances of bioethics. Moreover, they provide another phantom that can lead newcomers to bioethics down blind alleyways stalked by bristling sociologists and philosophers. The method common to all bioethics is bringing moral reason to bear upon ethical issues, and it is more

accurate and productive to clarify what this involves than to stake out a methodological patch that shows why one discipline is the most important. For those who are interested in these issues, Parts I, II, and III of this book present a characterization of what I take to be the nature of bioethics, a discussion of methodological spectres that are obstacles to bioethics being what it should, and then chapters discussing the methods of bioethics.

Those who have been asked to write their first essay in bioethics, or perhaps have been co-opted to write a paper on bioethics, can skip directly to Part III of this book. Chapter 7 is a good place to start if you want an introduction to how you begin in bioethics. From there on, Chapters 8, 9, and 10 add further strategies and methodological bells and whistles.

This book does not discuss empirical ethics in depth, nor other empirical methods that can be used in bioethics. That is not because I think they're unimportant—my view is that everyone who claims to have expertise in this area should have some familiarity with how such methods work and are important for good bioethics. My reason for not discussing them is because there are many other good books that introduce these methods well, and no books that I am aware of that discuss how it is that that you argue about bioethics, which is the basic and general methodological skill.

Part I of this book offers a characterization of what bioethics is. This is important for my central argument, as the conception of bioethics as an issue-driven area involves bringing moral reason to bear upon ethical issues, explains why the spectres described in Part II are problems, and is the argument for the methods described in Part III.

Moral reason is not so much a thing, comparable to a body of knowledge; it is an activity in which a variety of techniques are used to work toward the best justified normative position about an issue. Issue-driven moral reason is frustrated when bioethics overplays the significance of normative moral theory in reaching well-grounded ethical positions. That is not to say that normative moral theories have no point, nor even that they have no value for bioethics; but their

value is not what it is commonly taken to be in bioethics, and it would be much better to focus upon how we in fact argue.

Bioethics does not only require us to argue well; we must also engage with issues that matter and attempt to reach conclusions that are practically normative. This means that we must straddle the conceptual and the empirical. We must be philosophical in the Socratic sense of posing questions, imagining possibilities, and drawing distinctions, and empiricists in the sense that we either use empirical methods or find some way of grounding our analysis in the issues that matter. Armchair ethics can fail to engage with reality and be practically normative, while meaningful, issue-driven bioethics requires some sophistication in conceptual approaches.

The complexity of bioethics and the rapid development of technologies is a reason why epistemic humility is important: we must be rigorous and build the best case that we can for our ethical positions but, in doing so, be mindful that there is a good chance that we have missed something of importance—that what seems vital today might not be that way tomorrow, and most of all, that the issues we discuss can be deeply important for other people's lives.

The good news is that many powerful argumentative strategies are simple and close to the way that we reason every day. By grasping a few of these basic skills in argument, newcomers to this area can draw upon prior expertise and do good bioethics without mastery of normative moral theory.

PART I

Bioethics

2

What Is Bioethics?

The Origins of Bioethics

According to Dan Callahan, bioethics has its origins in the technological developments of the 1960s (Callahan 2004: 279). He describes how new medical techniques such as kidney dialysis, organ transplantation, prenatal testing, contraception, and intensive care created a need for the careful analysis of profound moral issues. Interestingly, he also thinks that these advances coincided with a renewed interest in normative and applied ethics within philosophy, feminism, and the civil rights movement. Plausibly, he describes how these events together led to an environment where a renewed emphasis upon self-determination and scholarly inquiry into the ethical issues presented by new technologies could flourish.

Another catalyst for the creation and prominence of bioethics is moral crisis. Legal wrangles over who (if anyone) could authorize the withdrawal of artificial nutrition and hydration from comatose patients in the 1970s and 1980s led to public interest and a need for ethical guidance for such cases (Powledge 1975). Whistle-blowing publications, such as Henry Beecher's brilliant and brave *Ethics and Clinical Research*, raised consciousness about the ethics of research, and cast a shadow over the assumption that physicians would always conduct research in an ethical fashion (Beecher 1966). Sentinel events such as the Tuskegee Syphilis Study—in which African American men with syphilis were not treated with penicillin, so that the natural progression of their illness could be followed (Reverby 2001)—led to the creation of safeguards for those taking part in research, and

to important statements such as the Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research 1978).

Moral crisis was also a catalyst for bioethics in Britain. While Beecher's revelations of unethical research ruffled feathers on one side of the Atlantic, Maurice Pappworth's discussion of many of the same research studies had less impact upon the British establishment, but was influential for those who helped bioethics in that country (Pappworth 1967; 1991). Several years later, the collection of infant bodies, hearts, and body parts at Liverpool's Alderhey Hospital led to an inquiry and to legislative changes (Royal Liverpool Children's Inquiry 2001). For the medical profession, especially pathology, this was an event that gave its leaders cause for soul-searching and reflection upon the persistence of paternalism (Hall 2001; Hunter 2001). It is best to view the events that bring ethics into public view as part of an ongoing process where issues are highlighted and some progress made. While Alderhey and other events around that time such as the Shipman inquiry (Dyer 2005) changed the ethical and legal landscape of that country, bioethics was already well established by that time. The Institute of Medical Ethics, which proved to be very influential upon British medical schools, British professional bodies, and in the creation of the *Journal of Medical Ethics*, was established in 1972, long before these events (Campbell 2000).

In New Zealand, the revelation that women had taken part in an unapproved research study that involved subjects, without their consent, undergoing unnecessary diagnostic procedures while not being actively treated for a cancer precursor, was a catalyst for calls to improve our understanding and teaching of ethics (Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital 1988). That recommendation spurred on interest and the development of bioethics in New Zealand. Bioethics is a global phenomenon, and it seems reasonable to suppose that a moral crisis, or perhaps just 'significant moral concerns' of

some kind, have played a role in the emergence of bioethics in all the countries where it is established.

Of course, interest in medical ethics and the ethical issues presented by technological advances occurred much earlier than the 1960s. The American Medical Association's first code of ethics was published in 1847 (American Medical Association 1847), and built on earlier work by figures such as Thomas Percival and John Gregory (Percival 1823; Fishman 2015). High-quality scholarship on medical law and ethics predated the creation of bioethics, and there is no better exemplar than the work of Cambridge lawyer Glanville Williams (Williams 1958).

Utopian and dystopian thinking about new technologies such as Assisted Donor Insemination (AID) predate and prefigure similar debates in bioethics (McMillan 2007). Some viewed the possibilities created by AID as an opportunity to work toward the betterment of humanity and revise our moral beliefs about the relationship between love and procreation (Muller 1936; Brewer 1935). Others viewed AID as a threat to vitally important social institutions, such as marriage and the immorality of infidelity (Archbishop of Canterbury's Commission on Artificial Insemination 1948).

What is distinctive about the late 1960s is that interest in ethical issues and rights reached a mass sufficient for the creation of a distinct interdisciplinary area of inquiry into ethics. The Hastings Center (of which Callahan is a co-founder) was from its beginnings an institution that integrated the insights of a number of cognate disciplines. While philosophy tends to view applied ethics as a subset of moral philosophy, bioethics is distinct in that it has always included lawyers, theologians, sociologists, anthropologists, and historians (Sugarman 2010).

While the 'bio' in bioethics doesn't capture the interdisciplinary nature of bioethics, its interdisciplinary nature, along with the amount of work conducted on ethical issues and the emergence of bioethics as a distinct area of inquiry, is what distinguishes it from applied ethics. What it has in common with applied ethics is an emphasis upon attempting to provide answers to practical moral questions.

My Definition of Bioethics and What It Needs to Do

An account of the methodology of any field must begin with an account of the field itself. A historian, mathematician, or physicist could not describe how their discipline is, and should be done, without an account of what it is, and when it is done well. However, every attempt to define a discipline is difficult and likely to alienate some.

It is difficult for a number of reasons, including that scholars, understandably, have a tendency to see their area as central, and also to view some other areas within a discipline as peripheral. While scholars can be very clear about what they do, it seems unlikely that any discipline could be defined using a set of necessary and sufficient conditions that implied when something is, or is not, history, mathematics, or physics in a non-arbitrary way.

Any attempt to define a discipline that leads to sharply defined boundaries that rule some activities in and some out is likely to cause annoyance because it is alienating: it is likely to imply that some who view themselves as working within a discipline are ruled out by the definition. On the flipside, there will also be those who find they have been categorized within a field, and object to that categorization.

An account of the methods of a discipline requires an account of that discipline, but it does not need to be a definition that demarcates all that falls within and outside it. What is required is an account that illuminates the central purposes, nature, and aims of an area. Such an account can explain more usefully why it is important, for example, that theoretical physicists can describe empirical events that would falsify or help corroborate their theory. So the following characterization of bioethics should not be read as an attempt to clearly demarcate bioethics from that which fails to be bioethics; rather, its aim is to elucidate the nature of bioethics in a manner similar to how the Oxford Professor of Jurisprudence Herbert Hart explained the nature of law in *The Concept of Law* (Hart 1961).

The Essence of Bioethics

It is unlikely that a definition of 'bioethics' with necessary and sufficient conditions could satisfy everyone. Instead, I will follow Hart's strategy in *The Concept of Law* (1961), and rather than offering a *de re* definition of bioethics that generates necessary and sufficient conditions, I'll articulate the *essential* aims, concerns, and features of bioethics. Hart claimed that the essence of law is the union of primary and secondary rules. By this he meant that the essence of law, or perhaps, the 'heart' of law, is that it is the conjunction of normative legal rules and rules that create, alter, or remove primary rules. The union of primary and secondary rules will not refer to every instance of what we consider law, but that is not the point of such a definition. Hart intends to illuminate the core or centre of what law really is, so as to illuminate its nature. That kind of account is sufficient for describing the methods of law, or another area. In the following sections, I will develop that kind of account of bioethics—an account that will help to articulate what the methods of bioethics are, and should be.

Battin's Trichotomy and Clinical Consultation

Margaret Battin is well placed to comment upon the nature and development of bioethics. Like Dan Callahan and Alastair Campbell, she is one of the foundational thinkers in bioethics and has been a leading figure since the 1970s. She has written extensively about core issues such as the end of life and the rationing of health care. In Battin's view, bioethics has tended to be dilemma-motivated: when a sharp moral issue is identified and causes interest and concern, then it becomes an issue for bioethics.[1] The emphasis upon addressing pertinent practical issues leads her to conclude that bioethics involves 'bringing moral reason to bear' upon pressing, practical ethical issues.

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[1] Tony Hope and I also argue that bioethics should be issue- or dilemma-driven in McMillan and Hope (2008: ch. 2).

The idea that part of the 'core' of bioethics is 'bringing moral reason to bear' seems correct, and I will defend and develop that idea. Within her observation that bioethics tends to react to practical and pressing issues is another clue to what seems to be core for bioethics, and is another aspect of bioethics I will defend and develop.

Battin observes that bioethics is characterized by three related but distinguishable activities, all of which involve bringing moral reason to bear upon practical issues and are driven by pressing issues:

theoretical reflection, grounded in philosophical inquiry; clinical consultation, stemming from the needs of medicine; and policy development, prodded by law—have been driven from the start by dilemmatic cases.

(Battin 2013: 2)

Especially in the United States, where clinical ethics consultation is common in hospitals, Battin thinks a core activity of bioethics is to provide advice about challenging ethical issues in clinical care. While being able to apply theoretical moral considerations to practical issues is likely to play a limited role in clinical ethics, it requires a set of additional skills, experiences, and attitudes. Clinical ethics consultation will usually involve discussing a complex clinical scenario with clinicians who are specialists in that area of health care. That implies a degree of humility and often playing more of a mediating role than acting as a moral expert. Clinical cases usually involve a complex and changing set of facts, and this too implies a different approach from a more philosophical reflection upon ethics. Clinical ethics consultation almost always occurs within a legal and professional context, and those norms are also relevant to reaching a sound and justified decision about what should happen.

While Battin chooses the term 'clinical consultation', it is clear that she has something broader in mind than just clinical ethics. She mentions research ethics as an important area of activity within bioethics, and while that is not obviously 'clinical consultation', it is a way in which bioethics helps to meet the needs of medicine. Public health ethics is a growing and important speciality within bioethics, and it too is a way of meeting the needs of medicine. I propose that a better term than clinical consultation is 'biomedical case consultation'.

That preserves her observation that there is an important difference between advising about the ethics of a specific case or issue and a scholarly exploration of that class of issue, typically in a scholarly publication.

Bioethics and Public Policy

Bioethics as policy development has its own set of extra attributes. As Battin observes, law is often ascendant in policy work because policy functions in a law-like way and has to generate rules that will work over a range of cases. Bringing moral reason to bear upon public policy requires its own skills and experience. Reasoning about the ethics of a policy issue involves contextual features such as the legal background; but it also should be sensitive to what is politically feasible, what is likely to work as a general policy recommendation, and what the public is likely to accept.

Dan Brock served on the President's Commission for the Study of Ethical Problems in Medicine, and he observed that it was necessary to temper how he would argue about an ethical problem (Brock 1987). As a philosopher, he would use evidence and argument in an attempt to reach the truth. However, he found, when arguing that there is no moral difference between killing and letting die, that when he succeeded in convincing policymakers of this position, it resulted in their starting to entertain policy that would have had harmful consequences. So, philosophers and bioethicists contributing to the shaping of public policy should also be what Brock calls 'moral consequentialists': they should be sensitive to the moral implications of an ethical view being enacted as a matter of policy.

Brock is right that policy work requires 'moral consequentialism', and this also implies being aware of where a policymaking body is located, its function and what it can realistically achieve. There are occasions where an ethical argument should be tailored so that it supports the best option that is likely to be supported or funded by a governmental agency.

Suppose that there is a method of screening for bowel cancer that would be the optimal method of screening, in that it is efficient at

detecting cancer at an early stage and it has few false positives, so minimizes harm to those who have invasive diagnostic tests when they do not have early bowel cancer. Suppose also that this programme is very expensive, and policymakers can reliably predict that the publicly funded health care system does not have sufficient funding to support it. There is a variant method of bowel screening that is effective at detecting early bowel cancer and will thereby generate similar health gains to those who are in the early stages of cancer. Suppose that this alternative method is cheaper and has a good chance of being funded if the bioethicist argues strongly in its favour. The drawback with the cheaper method is that it has a higher rate of false positives, which will mean that more people who do not have early cancer are given a colonoscopy (the preferred diagnostic technique for bowel cancer).[2]

The bioethicist might reason that the expensive and more accurate screening method is preferable, because fewer well people will be harmed, and that this is the option that they should support being funded. However, if they do so, it might be that neither programme is funded and bowel cancer is detected later in a large number of people. This is an example of moral consequentialism: although the bioethicist might have good moral reasons for arguing that the more expensive screening programme is more ethical, in so doing, she runs the risk of causing harm. In this kind of case, a bioethicist has to be knowledgeable about the role of the policy group of which she is a member, be well briefed about the practical realities of what is achievable, and be aware of the risks of arguing strongly for the best at the expense of the good.

It is worth noting that moral consequentialism is a feature of biomedical case consultation too, in that great sensitivity to the consequences that moral recommendations can have is important. That could be because a clinician ends up doing something that was contrary

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[2] Colonoscopy is an unpleasant, albeit very effective, technique that involves inserting a long flexible instrument with a camera into the bowel so the interior surfaces can be examined.

to their better judgement, or it could also be that a recommendation contradicts what other health care professionals think about that issue. For example, an obstetrician seeking clinical advice might have a different set of priorities from a midwife, and care needs to be taken about the moral consequences of advice that takes a negative view of another professional group.

Scholarly Bioethics

Theoretical reflection, grounded in philosophical inquiry is the most obviously philosophical of Battin's three core activities. While I agree that there is a third broad area of this kind, it is better to think of it as 'scholarly bioethics'. Bioethics publications are likely to be instances of scholarly bioethics, as are conference presentations and seminars. There are two reasons why this characterization of the more academic part of bioethics is better. The first is that philosophers can view themselves as the only people equipped to theorize and reason about ethics (this is a spectre discussed in Chapter 4). So, it is important when characterizing bioethics to do it in a way that does not lead to one discipline being dominant. A second spectre is what I call 'the ethical sausage machine', and it occurs when a theoretical perspective overdetermines a practical ethical recommendation. As I will explain, this happens when bioethics is driven by theory rather than by moral issues. While Battin thinks that all areas of bioethics tend to be issue-driven, it is important that the third area of bioethics is not identified with 'theoretical' reflection, because this is not what scholarly bioethics does, nor should do.

Scholarly bioethics has a less strict focus upon providing tentative moral conclusions to practical ethical issues. In addition to being less restricted in its moral recommendations, bioethics and scholarly inquiry can be much more speculative about the issues it considers. While biomedical case consultation usually involves finding a way forward with a case, and public policy usually involves guidance on policy questions, scholarly bioethics can speculate about our moral thinking on as yet undiscovered technologies.

The enhancement debate rehearses how we should approach new technologies that enable human beings to improve their cognitive and physical abilities beyond the normal range (Savulescu and Bostrom 2009; Persson and Savulescu 2012). Of course, questions can be asked about whether the amount of scholarship directed at hypothetical futures is excessive, but it can be defended in ways in which a similar degree of speculation could not in a clinical ethics or public policy-setting.

Moral Reason

Battin's observation that the core of bioethics involves 'bringing moral reason to bear' is important and needs further elaboration. Given that the term 'bioethics' literally means 'life or living' ethics, it has to involve the morality of life or living things. Her phrase 'bringing to bear' is well chosen because 'applying' might be taken to imply that it involves overlaying a pre-existing moral framework upon a set of issues. As I will demonstrate throughout the book, it is much better to view moral reason as a process whereby practical moral issues and relevant facts are teased out and then considered in a reflective, normative argument.

For now I will offer a preliminary description of moral reason that will be developed in this book. One aspect of moral reason is that it attempts to clarify the nature of the practical and moral considerations relevant to an issue. Then all relevant considerations are subjected to a critical process in which claims are tested for their truth and inferences for their validity. One way of doing this (which I will discuss at the beginning of Part III) is by creating syllogisms. While that process usually does not occur explicitly in bioethics, ordinarily it should be present implicitly within all the three main areas of activity. Although a case consultation is not a philosophy tutorial, carefully exploring the implications and assumed facts of a complex clinical scenario that is vexing a clinician can be a very effective way of helping them think through what should be done.

Medical Ethics versus Bioethics

The meaning of the term 'bioethics' and its relationship to 'medical ethics' has always been contested. Callahan's view of bioethics as arising primarily from developments in biomedicine is likely to reflect his experience in the establishment and development of the Hastings Center (Callahan 2004). That view is also a feature of the Kennedy Institute of Ethics, which was established in 1971. As Warren Reich explains,

The Georgetown model introduced a notion of bioethics that would deal with *concrete medical dilemmas* restricted to three issue-areas: (1) the rights and duties of patients and health professionals; (2) the rights and duties of research subjects and researchers; and (3) the formulation of public policy guidelines for clinical care and biomedical research.

(Reich 1995: 20)

On this view, bioethics appears to be little more than a more scholarly and systematic approach to medical ethics. However, Van Rensselaer Potter emphasized the 'bio' in bioethics, and argued that what we need is a new discipline that synthesizes value with biology (Potter 1970). For Potter, the greatest challenges to humanity arise from the way in which our natural environment and resources are being rapidly depleted, and the solution needs to be global and biologically informed. Whereas those who understood bioethics as being primarily a new version of medical ethics were motivated by a crisis within that area, Potter and those who followed him saw bioethics as the solution to environmental existential threats.

The idea that man's survival is a problem in economics and political science is a myth that assumes that man is free or could be free from the forces of nature. These disciplines help to tell us what men want, but it may require biology to tell what man can have, that is, what constraints operate in the relationship between mankind and the natural world. Bioethics would attempt to balance cultural appetites against physiological needs in terms of public policy.   (Potter 1970: 151)

These apparently contradictory accounts of bioethics are important for understanding its origins, and choices that have been made about

the issues that need to be addressed, but also about whether the approach to them should be national (as often tends to be the case with issues in medical ethics) or global, as undoubtedly was the intention with Potter's more biological conception.

While this debate is important historically and because it flags different points of emphasis, it is generally accepted that bioethics is much broader than medical ethics. According to the Kennedy Institute of Ethics library classification scheme (2017), bioethics includes topics such as animal experimentation and environmental ethics. That seems correct: it seems pointless and alienating to restrict the area to medical ethics when there are other important issues, and that seems reason enough for viewing bioethics in a broad and inclusive way.

Whether or not medical ethics or Potter's global, biologically grounded ethic should be at its core is an issue for debate, and not one that is material to the central argument of this book. Nonetheless, there are some important differences between medical ethics and bioethics. Medical ethics has to take into account the roles of health care providers and the contexts in which they are operating when considering ethical duties. Bioethics, in the expanded sense of the Kennedy classificatory scheme, is concerned more with public or common morality. For example, the duty to help those in need, when considered from the perspective of medical ethics, will take into account the expectation that physicians offer medical treatment in emergencies to those in need. We would expect any person to provide what aid they can to others they find in need; but the physician has additional duties and privileges in such a situation. Not only should they help, but they must also be careful to make sure that their treatment falls within an acceptable standard, given the constraints they are operating under. They are also permitted to do things, such as use a scalpel on someone else to treat them, even without consent in an emergency setting, while the common morality (in the sense of what applies to everyone outside of a professional role) view of a non-physician performing this act is very different: legally, it's a serious assault.

While there is an important difference between bioethics and medical ethics, little hangs on this for my present purposes, as my interest is in methods, and the strategies I defend in Part III apply just as well to medical ethics as they do to bioethics.

Bioethics as Distinct from Applied Ethics

It might be thought that viewing bioethics as 'bringing moral reason to bear' upon practical ethical issues means that it is more or less the same thing as applied ethics, as that too must involve bringing moral reason to bear on issues.

However, when characterizing applied ethics, David Archard and Kasper Lippert-Rasmussen say:

the borderline between normative and applied ethics (1) is fuzzy; (2) may be drawn in different ways, depending upon which normative theory is the right one; and (3) may not mark any deep divide, for instance in terms of the methods involved in these two branches of moral philosophy.

(Archard and Lippert-Rasmussen 2013: 14)

In discussing the distinction between normative theory and applied ethics, they assume that applied ethics is a branch of moral philosophy, which in turn is a branch of philosophy. Philosophy is free to describe applied ethics as an area within the broader discipline, but when the range of issues described by anthologies such as Hugh LaFollette's *Handbook of Practical Ethics* (LaFollette 2005) is very similar to what might be expected in a similar companion to bioethics, that suggests that the primary difference between 'practical ethics' and 'bioethics' is that the former is a branch of philosophy and 'owned' by that discipline, whereas bioethics is an area of inquiry where no discipline can plead that it is special and authoritative when it comes to these issues.

Philosophical Bioethics

There are those who would identify their work as falling within 'philosophical bioethics', which suggests that this is a subset of

bioethics. Matti Hayry claims that engaging in one of the following activities would mean engaging in philosophical bioethics:

- defining moral and political concepts and divisions (instead of choosing sides between them);
- reconstructing moral and political views (instead of choosing sides between them);
- clarifying moral and political judgements (instead of making them);
- presenting solutions with their background assumptions (instead of advocating them).

(Hayry 2015: 43)

My view is that these kinds of activities are, and should be, typical of bioethics in general. Although philosophers do tend to present solutions along with their background assumptions, that is not something that is unique to more philosophical bioethicists, nor even to bioethics itself. A qualitative health services researcher should present their findings in a way that specifies any background assumptions.

Philosophers do not have a monopoly on defining political or moral concepts; many other disciplines do this too. For example, someone from a legal background doing bioethics is just as likely to define their concepts as someone who is more philosophically trained. If Hayry wishes to say that they would thereby be doing philosophical bioethics, it can be described in this fashion, but it is a potentially confusing way to put things. Moreover, my view is that all bioethics should be characterized by moral reasoning, and the activities Hayry identifies are instances of moral reasoning.

Of course it might be reasonable to describe an instance of bioethics as 'more philosophical' when it relies more heavily upon philosophical argumentation, and 'less philosophical' when it includes more empirical work; but it seems neither fruitful nor accurate to say that there is such a thing as 'philosophical bioethics'. In any case, the methods that I defend in Part III are intended to help those who are conducting empirical bioethics, as well as those working at the more philosophical end of the spectrum.

Empirical Bioethics

Empirical methods, especially qualitative methodologies developed in disciplines such as sociology and social anthropology, are often used to ground bioethics more immediately in the issues that matter to those directly involved in ethical decisions. There is an edition of the *American Journal of Bioethics* devoted entirely to empirical bioethics, and there are a number of excellent introductions to the theory and practice of empirical bioethics (Ives et al. 2017).

Empirical bioethics can be a good way of identifying the concepts used by those impacted by significant decisions, when explaining their experience. This is particularly so for understanding areas such as psychiatry, where it is important to ground ethical reflection in the experiences and issues of those involved in the delivery of mental health treatment, as well as those being treated (Widdershoven et al. 2008).

Although there is no doubt that empirical ethics can be useful, like philosophical bioethics it should be viewed as a question of degree rather than something fundamentally different from other forms of bioethics. All bioethics should include some form of empirical connection, in that it should be issue-driven and about the world. Although some bioethics is less empirical and more philosophical, it should, along with empirical bioethics, be viewed as an instance of bioethics; and the methods I describe in Part III are equally valuable to those involved in more empirical forms of bioethics.

Empirical bioethics can occur within scholarly bioethics, bioethics, and public policy, and there is a large and growing literature on public policy informed by ethical analysis that has an empirical component.

Philosophical Bioethics versus Missionary Bioethics

Another spectrum in bioethics is between those who view their primary role as discovering wrongdoing and those who aim to follow moral reason and argument where it leads. Bioethicists who

understand their primary role in this first sense are like missionaries in that they seek to bring moral criticism to bear upon practices, institutions, or individuals. We might even go so far as to describe this emphasis as the missionary perspective or position.[3] Missionary bioethics has always been an important part of bioethics, and, as I have already noted, greater awareness of unethical research practices and novel therapies with ethically significant implications was a catalyst for the creation of bioethics. There is no better example of missionary bioethics than Henry Beecher's *Ethics and Clinical Research*, which is skilfully written and deliberately does not identify the unethical research that Beecher found in peer-reviewed medical journals. This meant that Beecher's message had maximum impact, while minimizing professional harms to him (Beecher 1966).

Missionary bioethics is most likely to occur within scholarly bioethics: journal articles, newspaper columns, and blogs are ways in which whistle-blowers typically bring issues to light.

We might describe bioethics as 'philosophical' or 'more philosophical' when it directly employs philosophical modes of argument so as to test and entertain ethical conclusions and its main objective is to follow moral reason and see where it leads. A good example of this is John Harris's classic *The Survival Lottery*, in which he considers the rationality of society being organized so that some of its members are randomly selected and their organs harvested in order to save the lives of others (Harris 1975). Some working in a more Socratic fashion, like Harris and Savulescu, will entertain moral positions that are justified by moral reason, but which are counterintuitive and provocative. In such cases it can be valuable to test commonly held moral beliefs in order to see how justified they really are. While bioethics at the philosophical end of this spectrum is more likely to occur within scholarly bioethics, it can be useful in case consultation and public policy to argue in a philosophical fashion. Often a complex case will have more than one defensible conclusion, and being open to consider the implications of alternative courses of action can be

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[3] I am grateful to Julian Savulescu for drawing this distinction.

valuable. Likewise for public policy, where there are usually a number of options and decisions that have to be worked through. Being able to argue in a counterfactual, 'what if this happened?' style that is typical of more philosophical methods of analysis can help to tease out which policy options are better.

Clearly, bioethics that is less missionary and more philosophical is likely to employ more fully the methods that I describe in Part III of this book. However, all forms of bioethics, be that empirical ethics or missionary ethics, should be characterized by bringing moral reason to bear upon issues. Even if that is simply a case of identifying appalling abuses in research, as Beecher did, that still can be considered to have a moral argument of sorts. In cases that identify appalling harms or wrongdoing, little work might need to be done to reach a conclusion about morality.

Ethics as Distinct from Law

While medical lawyers have always been involved in bioethics, and the analysis of law is fundamental for addressing ethical issues, ethical issues are distinct from legal issues. Bioethics and law have different sources or normativity: an ethical argument or claim has normativity in virtue of it embodying morally compelling considerations, whereas law is normative in virtue of it embodying a prescription of statute, common law, or some other non-moral consideration.

However, it is important to recognize that there is a complex and often interdependent relationship between bioethics and law. As Sheila McLean notes, there continues to be argument among legal scholars about the extent to which legal norms do and should embody ethical norms (McLean 2007). Perhaps the most influential debate about this issue was between Patrick Devlin and Hart. Devlin claimed that there were some issues, such as homosexuality, that were such a threat to the moral fabric of society that the law was justified in making them illegal (Devlin 1965). Hart invoked Mill's harm principle in an attempt to show that it was only when physical harm would be caused to another party that we could restrict

liberty, and the protection of a moral prohibition was insufficient warrant (Hart 1963).

Informed consent and confidentiality are two important examples of the way that legal norms can become subtly intertwined with ethical duties. Confidentiality is, in most Western countries, viewed as a legal and an ethical requirement. The law usually has rules about when a breach of confidentiality might be warranted, and this provides protection and guidance for professionals who think they might have an ethical obligation to breach confidentiality. Someone who has committed a serious offence is likely to know that this is the kind of information that is not ordinarily protected by medical confidentiality, so in the event that a clinician determines they need to disclose this information to an appropriate authority, not only is that clinician legally protected, but they also (so long as they acted upon other relevant considerations) should not be criticized for acting unethically.

A legal standard for the information that patients need to be given in order that their consent to medical treatment be considered 'informed' can create an ethical obligation. A clinician who only says 'I will treat this now', and offers no information about the proposed treatment, options, and likely outcomes, has not only failed to conform to a legal standard, but has acted unethically. This is an example where the content of an ethical duty has been filled by the law: informed consent is an ethical and legal obligation, but the standard of information required is set by the law.

Bringing moral reason to bear upon practical ethical issues involves arguing about the ethically normative features of an issue, and reaching an ethically normative conclusion about what should happen. Merely bringing legal reasoning, or legal duties, to bear upon a practical ethical issue will fail to yield an ethically normative conclusion, and therefore fail to be an instance of bioethics. But in saying that, it is important to be mindful of the significance of legal and professional duties when reaching a recommendation about what should be done. Moreover, there are many ethical duties that depend upon legal prescriptions for them having the structure and content that they do.

Conclusions

The main topic of this book is methodology and bioethics, and unpacking wat 'bringing moral reason to bear' means is one of my central tasks. The core aims and features of bioethics are that it involves bringing moral reason via three central activities to morally pressing issues. I have insisted that this characterization of bioethics is one that includes an important spectrum from more philosophical bioethics to more empirical bioethics, and also includes those who favour a more missionary perspective. With this characterization in place, Chapter 3 will consider what makes good bioethics good.

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3

'Good' Bioethics

Thus far I have suggested that bioethics is an interdisciplinary inquiry into ethical issues in the life sciences and biomedicine. I've also claimed, *pace* Battin, that bioethics involves bringing moral reason to bear on such issues. To further characterize bioethics and work toward an account of its methods, I will consider accounts of what makes for 'good' bioethics.

The Hastings Center and the Kennedy Institute for Ethics played a crucial part in the emergence of bioethics. The *Hastings Center Report* began in 1971, a time when similar moves were afoot in the United Kingdom. *The Institute for Medical Ethics* was founded in 1972, and pushed the field forward with the creation of the *Journal of Medical Ethics* (*JME*) in 1975. In 2015 *JME* published a collection of articles by scholars who had played a formative role in the area's emergence and development. The collection focused upon the question of what it is to do bioethics well, and contains a number of claims that are relevant to my characterization of bioethics.

John Harris and Art Caplan claim that good bioethics aims at 'doing good' via bioethics. For Caplan, doing good via bioethics seems close to a necessary condition for it being good bioethics.

There are many ways to do good bioethics. One crucial way is to do good by doing bioethics.   (Caplan 2015: 27)

'Crucial' might reasonably be taken to imply that unless bioethics does good, it should not be considered an instance of good bioethics. Perhaps 'doing good' is close to the 'first virtue' of bioethics in the same way that John Rawls claimed that justice is the first virtue of social institutions (Rawls 1972): in cases where we find that bioethics fails to do good, that undermines its rationale and is something we should not ignore.

Harris has similar thoughts:

> Doing good bioethics involves, at the very least, acceptance of some responsibility to make the world a better place, to ensure that life on Earth flourishes and to think, I believe, about these grand objectives when building and researching 'our little research craft'.   (Harris 2015: 39)

This claim seems equivalent to Caplan's: without some attempt to work toward the good, bioethics cannot be considered good. While this appears to be a claim that is uncontroversial, at least two objections can be made to it.

The first is to say that, while true, it is not a sufficiently strong nor specific claim. Given that the concept of bioethics has normative implications, in that it literally suggests something normative with respective to life and living things, it is not saying very much to observe that it succeeds when it directs us what to do. It also seems a vague claim, in that research in all disciplines is likely to see itself as promoting a good of some kind. An engineer whose research is on lithium-based battery sources is highly likely to explain why their work matters in terms of its utility to human beings. A historian who is driven to describe as accurately as she can the details of a specific period in history is likely to have an explanation of why it matters to us to have a good account of that period.

The pursuit of truth is fundamental for all scholarly endeavours, so a second worry is that prioritizing 'doing good' in this way might undermine the importance of truth for bioethics. While Rawls is right to consider justice fundamental for social institutions, it might be that there are some examples of good bioethics that do not produce, nor promote, 'the good'. Suppose that a bioethicist who took the missionary perspective seriously became concerned about research conducted

upon a vulnerable population, and investigated instances where research participants had been harmed. Suppose also that researchers covered up these harms and buried the results. The bioethicist might choose to pursue this cover-up and bring the ethical failings of researchers to light. It's possible that once these failures come to light, research results that would have benefited members of that vulnerable population are not produced, and a significant amount of good that would otherwise have been produced, is not. Such a case seems like one where the bioethicist could have conducted 'good missionary' bioethics, yet this has resulted in the world being worse than it otherwise would have been.

While this is a somewhat contrived situation, it does imply that caution is required when characterizing the nature of the value that good bioethics promotes. In this case it seems that truth, or perhaps justice, can count as a valuable end for bioethics. In any case, more needs to be said in order to characterize what makes good bioethics good.

Alastair Campbell was the founding editor of *JME*, and his aims for the journal shed light on the development of bioethics. He describes two principles that he thinks characterize good bioethics, which were reflected in the editorial policies of the journal. The first is a principle of 'no special pleading', which means that no philosophical or theological perspective should view itself as having a privileged position when it comes to making pronouncements about ethical matters. His second principle is what I will call 'engagement with experience', which is the idea that bioethics should be attuned to, or engage with, health care practitioners, patients, and health policymakers.

No Special Pleading

The first editors of *JME* were concerned that bioethics might be captured by a specific approach to ethics, be that theology or consequentialism. There were probably a number of reasons for this concern. One would have been that prior to the creation of bioethics, theologians were the default source of advice about pressing ethical questions. The creation of a specialist journal would have been an

opportunity to make a statement about how this new field should develop. It might also have been that it was important for the credibility of the journal that no one could say it was merely a publication created by a special interest group to push their own agenda. While being seen as the domain of theology would have been a problem for the journal, it would also have been important to ensure that utilitarianism was not promoted as the only philosophical approach to medical ethics. Peter Singer's *Affluence and Morality* and *All Animals are Equal*, published in the early 1970s, were especially significant early works in bioethics (Singer 1972; 1974). I will say more about theory-driven bioethics in my discussion of the 'ethical sausage machine' in the next chapter, but for now it is enough to note that the way in which Singer attempts to drive bioethics by theory meant that it could have been considered by some to be 'the' theory for bioethics.

Given that Campbell describes these as editorial principles, it is reasonable to suppose that he had in mind scholarly bioethics as the main area of activity where they were relevant. It should apply to public policy bioethics and case consultation too, as they are activities for which a range of perspectives is likely to be helpful.

A related idea is that bioethics (and presumably medical ethics) should be interdisciplinary. The Hastings Center is usually viewed as the first bioethics centre, and has influenced the development of this field significantly. When writing about his approach to bioethics, Hastings Center co-founder Dan Callahan remarked that bioethics

should be open to a full range of influence, in style and substance, of literature, history and the social sciences. It should take in the full range of human life, individual and social.   (Callahan 2015: 68)

The Hastings Center has always formed interdisciplinary teams for its research projects, and has thereby promoted the presumption that bioethics should be conducted in an interdisciplinary fashion. One way to ensure that this is to have a firm commitment to not privileging any specific theoretical or theological approach.

As well as being a commitment of the founding bioethics journals, 'no special pleading' plays a role in the objectives of the most important

professional body for bioethics. In his presidential address to the 1999 Tokyo IAB conference, Alastair Campbell explained why it is important that bioethics does not privilege a perspective:

The fourth objective of the Association is 'To uphold the value of free, open and reasoned discussion of issues in Bioethics', and one of the ways this is to be implemented is by 'providing support for scholars whose freedom to discuss questions of Bioethics has been restricted or is under threat'. In some countries these restrictions and threats are all too obvious, emerging as they do from an insistence on religious, social or political conformity: but the threats are also there in ostensibly liberal countries, as the murderous activities of the extreme anti-abortionist lobby have demonstrated yet again in the USA. In this context, the position of the IAB is unequivocal: We oppose all such dogmatisms. We welcome the whole range of ethical arguments and viewpoints. As an organisation we take no position on any of the substantive issues of debate in Bioethics. We have a single moral position, that to be genuinely ethical, discussion of any issue must be 'free, open and reasoned'.   (Campbell 1999: 185)

This is perhaps the most important argument for 'no special pleading'. It is a principle that can help to ensure that no approach can dominate and silence rival approaches to ethical issues. For global ethics, 'no special pleading' takes on greater significance, because of the way in which vested interests often are oppressive.

The objectives of the International Association of Bioethics (IAB) were formulated and enacted by its founding members, and Peter Singer played an especially important role in this. So although some would argue that utilitarianism is too dominant in bioethics, it too is an approach that some would try to silence; and although utilitarians tend to think that they have the correct theory about the nature of morality, that does not imply that they are not open to other ways of arguing about ethics.

The Strength of 'No Special Pleading'

There are, or course, medical ethicists and bioethicists who nail their theoretical colours to the mast. Raanan Gillon is arguably the strongest advocate for the 'four principles' approach, stronger even than

Beauchamp and Childress, the architects of the four (Gillon 2015). Does Gillon claim that the four principles are the best approach to medical ethics, and thereby should be in a 'dominant' position?

In one sense, he clearly does. The first edition of *The Principles of Health Care Ethics* included ninety chapters, all of which were about the four principles, in an attempt to demonstrate how they could accommodate every issue in health care ethics (Gillon 1994b). However, in doing so Gillon was trying to show how the principles could be interpreted in different ways and be consistent with most moral and theological traditions. The theoretical neutrality of the four principles is what leads Gillon to claim:

> whatever our personal philosophy, politics, religion, moral theory, or life stance, we will find no difficulty in committing ourselves to four prima facie moral principles plus a reflective concern about their scope of application. Moreover, these four principles, plus attention to their scope of application, encompass most of the moral issues that arise in health care.
>
> (Gillon 1994a: 184)

That seems to imply that the four principles, if universally adopted, would not imply that medical ethics had been captured by a particular perspective. Moreover, Gillon clearly thinks that they are not oppressive toward other views, can accommodate many views, and might even be consistent with the contribution of other disciplines. So, does it follow that the four principles approach attempts to carve out a niche as the dominant approach, yet does not imply 'special pleading'? My view is that the atheoretical nature of the principles slips around most of the worries about special pleading, but there is scope for disagreement on this point.

There are ethicists such as Justin Oakley and Rosalind Hursthouse who write from within a virtue ethic tradition (Oakley and Cocking 2001; Hursthouse 2011). They will often introduce the ethical analysis of an issue by stating they are about to 'give a virtue ethics' reading of that issue. Does this tendency of virtue theorists and other ethicists arguing from within a particular tradition amount to special pleading? It would if they claimed that their account was the only one that

made sense, and was capable of doing justice to the moral phenomena of a complex situation. However, virtue theorists often claim that they are providing an account of a moral issue that is richer and more nuanced than some other moral theories. In such cases they are not attempting to capture or dominate ethical argument, but to enrich it. In Chapter 8 of this book I will say more about how qualifying an ethical argument by saying you are about to give an account based upon a particular moral theory unnecessarily limits the scope of your argument, and is an open invitation for someone who is unsympathetic to virtue theory to cease reading; but it does not appear to be a case of 'special pleading'.

Trickier cases arise when appeals are made to religious positions. Leon Kass is unusual in bioethics in that he overtly refers to God's wishes or conception of nature when arguing about the limits of biotechnology and his defence of the sanctity of life doctrine.

We can learn from thinking about Genesis what it means that the earth's most godlike creature is a concretion combining ruddy earth and rosying breath; why it is not good for a man to be alone; why the remedy for man's aloneness is a sexual counterpart, not a dialectic partner (Eve, not Socrates); why in the shame-filled awareness of sexual nakedness is humanity's first awe-filled awareness of the divine; and why respect for a being created in God's image means respecting *everything* about him, not just his freedom or his reason but also his blood.   (Kass 2002: 21)

While bioethics is usually secular, Kass is unafraid to lead with his religious commitments in an attempt to enrich and deepen the moral resources at our disposal when grappling with profound issues. His argumentative strategy seems somewhat different to that of others in bioethics who have religious commitments, in that while he might argue that he too is trying to give a fuller account of moral phenomena than is offered by secular moral theories, he appeals to considerations that many will clearly not agree with, and uses these considerations to reach conclusions about what all people should do. It seems implicit within Kass's account that those who do not agree that technologies such as in vitro fertilization are an affront to God's conception of our reproductive nature are ignorant about the moral

facts of the situation. When evaluated from the perspective of 'no special pleading', Kass's use of theory seems oppressive in that it claims priority over other arguments and perspectives and gives an account of the moral phenomena that emphasizes some moral features at the expense of others.

Campbell, Callahan, and the IAB are right that bioethics is, and should be, an area where there is no dominant theoretical approach. Their reasons for believing this are sound, but there is a deeper methodological reason why no theoretical approach should be dominant. That's because the importance of normative moral theories tends to be overstated, and normative theories are a misleading way to describe how bioethics is usually done.

Engagement with Experience

The idea that good bioethics should in some way be working toward the good seems plausible, although not specific enough. Campbell and Callahan defend what can be described as an 'engagement with experience' requirement for good bioethics. Rather than being a purely academic enterprise, bioethics should be genuinely normative in that it engages with the issues that are relevant to those making and impacted by difficult ethical choices.

Bioethics requires getting into the minds, emotion and culture of those who will actually have to make hard treatment decisions with individual patients, and doing the same with legislators and government officials, whose decisions can matter enormously for healthcare systems and thousands of people. (Callahan 2015: 70)

Callahan embellishes Battin's three areas of activity for bioethics. For Callahan, bringing moral reason to bear isn't just a case of reasoning in an analytic fashion about an issue. For him, it is critical that bioethics uses the full resources of an array of disciplines, so that the nature of difficult decisions is understood. While Battin gives a plausible account of what bioethics is, Callahan describes a vision of what's required to make it good.

The idea that bioethics has to connect with the experiences of those impacted by, and making, decisions in health care is shared by Campbell. When reflecting upon the founding aims of *JME*, he remarked:

good medical ethics can be achieved only when the theorising stays closely in touch with the realities of healthcare. This entails talking to and working with doctors and other healthcare providers. It means engaging with the experiences of the recipients of healthcare and with the policy makers who set the framework for success and failure in healthcare delivery. (Campbell 2015)

When it began, *JME* connected with clinicians by including the analysis of a clinical case in each issue. Those involved in medical education or clinical practice will know that clinical cases are a common currency in medical education, and this made sense as a way of fostering interest in a scholarly approach to medical ethics. While *JME* no longer includes case commentaries, Campbell suggests that empirical approaches to ethics are also a way in which bioethics can engage with the experiences of those involved in and affected by health care.[1]

If ethicists focus their analysis upon what a new technology is likely to mean for those accessing, providing, and framing policy about it, then perhaps bioethics will speak to what is significant and not merely legitimate. Take for example Non Invasive Prenatal Testing (NIPT), which makes it possible to detect foetal DNA in maternal blood, thereby enabling the prenatal diagnosis of more conditions without invasive diagnostic procedures (Snelling et al. 2016). A superficial ethical analysis might point out that this is no different in principle from what we already can do in the area of prenatal testing, and that there are procreative liberty interests which mean NIPT should be permitted. However, an analysis of that kind on its own runs the risk of giving the stamp of ethical approval to a technology that has a number of subtle effects, and is likely to change the nature of prenatal testing. These tests require only a blood sample, and NIPT can be provided via mail from companies in faraway parts of the world, who

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[1] See McMillan and Hope (2008) for examples of how this can be done.

may not help people interpret the complex information that such tests produce. Policymakers can be placed in an invidious situation in that they might not think that there is strong enough evidence of benefit, but move to recommending access under a national health service in order to control the quality of NIPT. Offshore companies are using social media to advertise their NIPT services directly to pregnant women, which might be seen as consistent with autonomy, but could also be criticized as predatory (Snelling et al. 2016). Campbell and Callahan are right that genuine engagement with experience is a way in which bioethics can focus upon the issues that need attention and not become a superficial exercise.

'Engagement with experience' is a prima facie plausible view, and it is hard to imagine many working within bioethics arguing that it is isn't correct for many paradigm cases of bioethics, nor conceding that their work failed to do this. However, it is potentially quite a radical view when you think of some famous examples of medical ethics that this condition is likely to pick out.

In Chapter 2, I showed how bioethics can range over a spectrum, from bioethics that is 'more empirical' to bioethics that is 'more philosophical'. Bioethics that is 'more empirical' and qualitative is likely to engage with the experience of those centrally involved in and impacted by a decision. Being more empirical itself is not sufficient for connecting better with experience: quantitative methods might show a statistical trend in relation to views about a moral issue within a group, but this might not engage with the experiences of those involved. Likewise, bioethics that is more toward the philosophical end of the spectrum can still engage with the experiences of those involved in decisions, especially if it is phenomenologically oriented approach.

Nonetheless, there are examples of what we might consider to be good bioethics that do not obviously connect with the experience of those involved.

In Part III of this book I will discuss the argumentative strategies used by Judith Jarvis Thomson in her article defending the permissibility of abortion. She develops her argument around two thought experiments that are designed to isolate and test issues critical to the

abortion debate (Thomson 1971). In the 'famous violin player' case, the reader is asked what their intuitions would be if she found herself connected to a violin player in such a way that staying connected for nine months is essential for the violin player's survival. The argument goes, that although it would be morally admirable of the reader to stay connected to the violin player, she should not be compelled to do so. So, the thought experiment is a counterexample to the claim that abortion should be illegal because the foetus has the moral status of a person.

The problem is that one reaction to Thomson's thought experiments is to point out that this is a very contrived situation; it is hard to know what one would actually think if in such a predicament. The difficulty of placing oneself in such a situation suggests that this thought experiment does not 'engage with experience'. It is certainly a situation that seems quite removed from and in many respects different from the experience that a woman contemplating the termination of her pregnancy would have.

James Rachels' 'Active and Passive Euthanasia' (Rachels 1975) is one of the most highly cited articles in medical ethics, and another example that I will consider in more depth in Part III. He too constructs a thought experiment that is designed to tease out a particular point about the euthanasia debate. He asks his reader to consider two uncles, Smith and Jones, both of whom have equally wicked intent, the only difference being that one actively drowns his nephew in the bath whereas the other fails to save his nephew when he easily could, and passively watches him drown. Rachels claims that we should view Smith and Jones as being equally wicked, and that it is therefore not the case that there is always a moral difference between bringing death about actively, as opposed to passively.

Physicians and medical students often object that this scenario is so far away from the clinical realities surrounding the end of life that it cannot inform what should happen in a clinical context. Whatever is made of that point, it does seem that this is a thought experiment that does not engage with the experience of those treating patients toward the end of their lives.

Does 'engagement with reality' mean that Jarvis Thomson and Rachels have failed to produce good bioethics? Taken literally, that seems correct: philosophical thought experiments are usually designed to test the logical extent of concepts, so they are often idealized and at least one step removed from reality.

This suggests that a modification of 'engagement with experience' is needed. I will say more about the nature of thought experiments and how they can be particularly useful methods for bioethics, but here will simply refine what it is to 'engage with experience'.

Caplan and Harris think good bioethics should promote the good, and while that seems too vague, it does suggest an argument for why engaging with experience matters. Merely making bioethics true to the experience of central players in ethical issues isn't important simply for reasons of getting it right. It's because bioethics is much more likely to be useful when it applies to the experience of central players. In the case of thought experiments, they can be invaluable ways of stimulating critical reflection upon assumptions and distinctions that are central in important ethical issues.

In cases such as these, where methods such as thought experiments are removed to some degree from experience, but succeed at making useful contributions to the critical understanding of assumptions or distinctions, good bioethics can indirectly engage with the experience of key players in ethical issues by being of indirect practical importance. 'Indirectly' because thought experiments can make us think critically about our assumptions and moral concepts, and when these are used in actual situations they are of very significant practical importance, but indirectly so.

A better term than 'engagement with experience' is 'practically normative', and my view is that an essential feature of good bioethics is that it connects and makes a contribution to the understanding or resolution of ethical issues in one of the three domains Battin identifies.

Jarvis Thomson's article is good bioethics because it aims to open up new ways of thinking about the abortion debate: it invites us to frame the issue in terms of what someone should be permitted to do, rather than morally obliged to do. It also requires people to question a

central assumption that they often make about the abortion debate: that the moral status of the foetus is the central issue. While it might not directly engage with the experiences of key players in decisions about termination of pregnancy, it does engage with the critical legal and ethical issue, and thereby is 'practically normative'.

Likewise, Rachels pushes those who habitually defend the withdrawal and withholding of life-sustaining treatment on the basis that it is passive and not active, to think critically about the assumptions they are making. So although the Smith and Jones case is very different from the experiences of key players in decisions about the end of life, the crucial moral concepts that are central to these decisions are delineated and criticized. So although this might 'fail to engage with experience', it certainly engages with what's relevant practically about law and medical association's statements on care toward the end of life.

So, 'engagement with experience' should be interpreted broadly so as to include ethical analyses that are practically normative, in the sense of attempting to improve some aspect of the world.

Good Bioethics Always Involves Sound Reason

I've shown that moral reason is central to bioethics. An implication of that view is that if instances of any of the three activities that typify bioethics—scholarly bioethics, case consultation, and public policy—fail to even implicitly involve moral reason, they fail to be bioethics. This is important because bioethics borrows empirical methods from other disciplines, and without moral reason being considered essential, there would be no difference between bioethics and disciplines such as medical sociology or law.

Nonetheless, there can be insufficient, weak, unsound, or false moral reason. Someone who makes a moral argument that is clearly invalid or includes false statements might have engaged in moral reason, it's just that they have done it badly. Likewise, someone who makes an attempt at moral reason, but offers a weak and insufficient

analysis that does not support the conclusions reached, has engaged in poor bioethics. Therefore, in addition to moral reason being a necessary condition for an activity being bioethics, moral reason is one important way in which bioethics can be good or bad.

The *JME* special issue includes articles by the Oxford Professor of Practical Ethics, Julian Savulescu, who thinks philosophy should have a greater role in bioethics than it does.

> The trouble with medical ethics is that there is not enough original, good philosophy [. . .] good ethics requires good philosophy.
>
> (Savulescu 2015: 32)

Savulescu claims that philosophical insights such as Parfit's non-identity problem have advanced our understanding of important issues in bioethics surrounding the creation of life and our obligations to those not yet born. I'm not convinced that the non-identity problem has advanced our understanding of such issues (McMillan 2013), but Savulescu offers other plausible examples where important ethical concepts, such as coercion and exploitation, that have been clarified and theorized in political philosophy have helped bioethics progress.[2]

Dan Brock made a similar point in his reflective piece on what makes good bioethics good.

> Training in careful, rigorous argument, whether from philosophy or else-where is necessary for good bioethics and unfortunately too much bioethics displays both its importance and its absence.   (Brock 2015: 33)

Brock, correctly in my view, points out that philosophers cannot claim to be the only people who can argue, nor do they have a monopoly on training students to argue. Most disciplines will claim they teach critical thinking, which admittedly might be partly due to expectations that the humanities disciplines make some attempt to demonstrate their utility. Nonetheless, it undoubtedly is true that teaching students how to argue is part of teaching them to write

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[2] See McMillan (2014; 2011) for illustrations of how these concepts can stimulate further debate.

essays in most disciplines, and some disciplines such as law focus upon argument in a way similar to philosophy.

Examples of published, but weak, bioethics are often characterized by poor structure, and by a failure to ensure that the considerations given in favour of a conclusion do in fact support the conclusion reached. Some of the most compelling examples of bioethics, both empirical and more philosophical, are cogent because they skilfully make a case for a moral conclusion, so in addition to moral reason being an essential feature of bioethics, it is also a factor that can contribute to good bioethics being good, and it being done badly.

Conclusions

Following the reflections of some of the founding figures of bioethics, I have suggested that good bioethics is typified by two features. I've argued that Harris and Caplan are right to point to the good-promoting feature, but have shown that the kind of value that bio-ethics promotes can be put more precisely. Callahan and Campbell are right that in cases where part of the point of an instance of bioethics is to directly relate to the experiences of the key actors involved, then 'engagement with experience' seems a good-making property. I have refined this principle and shown how a broader concept of 'practical normativity' is a way of capturing this dimension of value so that it includes bioethics that is more philosophical. Finally, I have shown how the central place I gave to moral reason as an element of bioethics can also be something that, when done well or poorly, contributes value or disvalue to bioethics.

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The Spectres of Bioethics

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Four Spectres of Bioethics

Spectres haunt and persist beyond their proper time. While we might know and be capable of reciting the reasons why we should not believe in a ghostly apparition that frustrates us, they have a tendency to keep doing so until they have been brought into daylight and exposed as the phantoms that they are. Bioethics, as a practice and a body of literature, has a tendency to labour unnecessarily hard under the shadow of some habits and commitments that it would benefit from being freed from. This part of the book describes five spectres that continue to haunt bioethics, the dispelling of which would refocus intellectual endeavour upon reaching provisional solutions to practical moral problems.

The Moral Mantra Mistake and the Tedious Theory Tendency

[. . .] as I came to write about many different kinds of ethical issues over the years, many of a complicated kind, no ethical theory seemed to fit well for any of them; and I gradually moved away from an interest in ethical theory itself, a major preoccupation in the early years of bioethics. How could bioethics as a new discipline be credible if it was not grounded in a theory, as is science?

(Callahan 2015: 68)

Callahan's observation is important and one of the motivating thoughts behind this book. The tendency for a new scholarly enterprise to look for theory is reasonable, and something that might be true of all disciplines when they develop and mature. His suggestion that moral theory—in the

sense of normative moral theories that provide a justification for ethical claims at a high level of abstraction—turns out to be not as useful as you might expect is one of the central ideas of this book.

It is not that moral theories are unimportant: reflection upon the normative basis of morality is a crucial issue, but it is one that falls more neatly within moral philosophy than bioethics. It's not that justificatory moral theories should play no role in bioethics and need to be banished. My aims are modest; I think that their utility when bringing moral reason to bear upon pressing moral issues is overstated. It is not that insights from philosophy and the theoretical explication of concepts such as coercion, exploitation, and personhood are not important to bioethics: this kind of philosophical contribution has been invaluable and does involve philosophical theory or theorizing of a kind. My concern is with the priority given to normative moral theories and the way in which they can obstruct rather than facilitate good bioethics.

As Callahan notes, the early years of bioethics were preoccupied with the search for theory and it might be objected that revisiting the 'four principles' debate is returning to historical issues and a debate that has had its time. There are two reasons why this chapter begins with a discussion of principlism. The first is that, although this is a debate that is well past its peak, it is important because of the way in which it shaped bioethics, and the four principles continue to be the most widely known and accepted normative theory for bioethics, at least for those who think normative theory has a core role. The second is that, although debate has moved on from the four principles, there is a plethora of new bioethical theories. I have mentioned examples such as virtue theory, empirical ethics, and philosophical bioethics, and there are many other recent examples such as 'naturalized bioethics', 'feminist bioethics', and 'narrative ethics'. Not all of these versions of bioethics would see themselves as being normative theories like the four principles, but insofar as they are, I am as concerned about them as I am about the principles: the value of normative moral theory as a way of going about bioethics has been oversold, and it has a vexing tendency to obstruct rather than enable good bioethics.

Four Principles and the Search for Theory

Tom Beauchamp explains how he and James Childress began work on the principles of biomedical ethics in the 1970s. He says that they were motivated by the concern that bioethics lacked a unifying theory or principles, and also because the ethical considerations in play were primarily beneficence-based (Beauchamp 2007). So, part of the interest in theories and principles is explained by the wish to ensure that the normative framework for bioethics reflected considerations such as social justice and respect for autonomy. The 1970s and 1980s were times when much still needed to be done to improve patient involvement in decision- making and to encourage medicine to acknowledge the ethical dimensions of clinical practice. When viewed from that perspective, Beauchamp and Childress defended a moral framework that highlighted the importance of justice and autonomy, while also retaining an emphasis upon core aspects of medical morality in the principles of beneficence and non-maleficence.

I mentioned in Chapter 2 that unethical research was the catalyst for the Belmont Report and for recognition of the need for clear guidance about the ethical conduct of human participant research. A principles-based approach was a sensible and helpful way for bioethics to progress with this important example of public policy bioethics.

Others have objected to the idea that values from 'common morality' need to be imported into medicine for medical ethics to progress. Pellegrino and Thomasma (1988) claim that the commitment of medicine to work toward the patient's good is sufficient, when properly understood, to drive medicine toward a better respect for patient autonomy, justice, and other values that the profession needs to adopt.

There is merit in both of these positions, and arbitrating between them is not crucial for my purposes here. The important point is that there were a number of reasons why it was useful to have a normative theory that provided a common framework of justification and could be used for highlighting ethical duties that needed to be promoted.

Even so, it would be an overstatement to claim that ethical debate was all at sea and had no way to progress before the formulation of the four principles. There was ethical debate, and much of it of a very high quality, long before the first edition of *The Principles of Biomedical Ethics*. Many of Peter Singer's landmark works on animal rights and famine appeared before then (Singer 1972; 1974).

For the most part, Beauchamp and Childress are clear that they seek to provide a framework for ethical justification that is grounded in common morality. Moreover, they are also clear that they do not think that the principles can and should be used in a deductive way, so as to 'drive' bioethics. However, there are places where they suggest they can play a more substantive methodological role.

In *The Principles of Health Care Ethics*, Beauchamp suggests that the principles can be more than a justificatory framework:

> it could even be claimed that principles gave the embryonic field of bioethics a shared 'method' for attacking its problems, and this gave some minimal coherence and uniformity to bioethics.   (Beauchamp 2007: 3)

He is undoubtedly correct; and for many attempting to engage with bioethics after the discovery of the four principles, bringing moral reason to bear on practical issues involved dropping issues into pigeonholes labelled 'autonomy', 'beneficence', 'non-maleficence', and 'justice'.

Of course, Beauchamp and Childress were careful to emphasize that they thought the principles should not be used in a deductive way; but in the context of health care and health care education that was hoping for quite a lot. It was never likely that clinicians and students would grasp a philosophical distinction between justification and deduction, and they were always likely to use the principles in a deductive manner. Medical students and doctors are, on the whole, very bright and efficient at collecting theories from a multitude of sources so as to help them make headway with clinical issues. From their standpoint, theories are valuable because they are action-guiding and help tell them what they should do in a given situation. While philosophers are likely to see the importance of justification and

how moral principles differ from other more prescriptive principles, that distinction is likely to be lost on, or perhaps not relevant, to people who are synthesizing a large amount of information from different sources.

While the stultifying effect of the four principles upon the moral deliberation of newcomers to ethics was not something that Beauchamp and Childress intended, and in many places they are clear is not the way in which the principles should be used, its effect is such that the phenomenon merited a name: the Georgetown Mantra (Takala 2001). The idea is that, instead of thinking reflectively and carefully about the ethical issues in a situation, and then formulating a way of organizing and working through these issues so as to reach a view about what should be done, newcomers to bioethics end up selectively labelling some of the issues as falling within under headings of 'autonomy', 'non-maleficence', 'beneficence', and 'justice', after which they take a potshot at saying autonomy should trump for reasons that are not given. That is a debasement of what Beauchamp and Childress intended, but the phenomenon is real, to the extent that it is possible for a health care professional to write about the Georgetown Mantra as a method for ethics without the slightest hint of irony (Camden 2009).

Rather than establish a canonical set of principles for bioethics, *The Principles of Biomedical Ethics* spawned rival theoretical approaches to ethics such as virtues-based approaches (Oakley and Cocking 2001), feminist approaches (Leach-Scully et al. 2010), and narrative ethics (Lindemann 2001). Then there were those who agreed with a principlist approach, but thought that their ethical principles were better. Robert Veatch describes how these ranged all the way from one-principle beneficence-based accounts (Pellegrino and Thomasma 1988), through to a ten-rule-based theory (Gert et al. 1997) (Veatch 2007). Given that the four principles approach alone seems to hinder bringing moral reason to bear upon practical issues, it is hard to see how this plethora of justificatory theories can make things better. John Arras wryly remarked when discussing the current popularity of reflective equilibrium:

In the world of bioethics, the air is abuzz with reflective equilibrium. Not too long ago, this same air echoed the din of clashing moral methodologies. Casuists, feminists, narrativists, and pragmativists had been collectively engaged in a tag team debunking exercise at the expense of the embattled defenders of principlism, the heretofore dominant method in the field of practical ethics.   (Arras 2009)

Arras provides a number of sound arguments for why reflective equilibrium is unlikely to be the magic key that unifies all of these theories into a method. He shows that there is an underexplored question in the debate about how these theories could constitute a method, in the strong sense of telling us how to proceed; but while he flirts with this issue, he doesn't follow through with the implications of that thought. That is to question whether any of them in fact are adequate methods for bioethics. My view is that bioethics has gone astray in its attempt to ground its methods in what are primarily justificatory principles and theories. What is needed is serious analysis of what makes good bioethics work. There is a need for careful reflection upon what the methods of bioethics really are, instead of being distracted by philosophical concerns about how to justify moral beliefs.

Sidgwick has a reputation for being a careful philosopher, and remarks in *The Methods of Ethics* that he will conduct

an examination, at once expository and critical, of the different methods of obtaining reasoned convictions as to what ought to be done which are to be found—either explicit or implicit—in the moral consciousness of mankind generally [. . .]   (Sidgwick 1907)

As James Childress says, Sidgwick sets himself the task of reflecting upon the ways in which human beings should deliberate about morality and arrive at a course of action. But Sidgwick also points out that a reflective inquiry of this kind should look at how people reach reasoned convictions and, after critical evaluation, use this as a basis for an account of how one should reason. I agree wholeheartedly with Sidgwick, and this thought is at the heart of how I characterize bioethics and its methods.

However, in his account of *Methods in Bioethics*, Childress does not proceed to analyse and recommend ways in which we tend to and

can work toward moral courses of action. Instead, he does what the vast majority of bioethicists do when called upon to consider methodology, and gives a brief overview of a range of moral theories. He clearly thinks the methods of bioethics are the

major types of principle based methods, (consequentialist, deontological and pluralist principle methods), case based methods, virtue ethics, ethics of care, and communitarian perspectives, along with some critical points from feminist ethics and rule based ethics.   (Childress 2009: 16)

This is a mistake; none of these 'methods' alone is a method whereby reasoned convictions about moral problems can be reached.

This error is all-pervasive in bioethics, and even bioethicists of the ability of John Arras don't appear to see it clearly enough. With his typical sophistication and elegance in *The Way We Reason Now*, Arras identifies a number of serious problems that would result from evading the deductive method of using principles, by borrowing Rawls's account of reflective equilibrium to work toward consistency between our intuitions and judgments (Arras 2009). This is a solution to a philosophical problem, but not a way in which those new to bioethics or those working within health care can efficiently bring moral reason to bear on practical ethical issues.

Sidgwick's suggestion—that if we wish to understand the nature of morality, then what we must do is understand and critically analyse how it is we reach reasoned convictions—implies that a critical analysis of how it is that good bioethics applies moral reason to practical ethical issues is the route whereby an account of method in bioethics can be grounded.

The Ethics Sausage Machine

> Laws, like sausages, cease to inspire respect in proportion as we know how they were made.
>
> (Saxe 1869)

John Godfrey Saxe, in a remark often misattributed to Bismarck, alludes to the political machinations, compromises, and sleights of

hand that are often integral to the development of law. As he observes, the less we know about this, the more likely we are to respect the law.

No one could criticize a utilitarian, or any theoretically driven, approach to bioethics for a lack of clarity about how it reaches ethical conclusions. If anything, theoretically driven approaches to ethics are so clear about how they reach normative conclusions that what they will say about an ethical issue can be readily predicted. In the same way that a sausage machine will convert a variety of substances into a series of similar small goods, a theoretically driven approach to bioethics will mince a variety of background considerations and issues into a familiar ethical recommendation that is so systematic that, unless we buy the whole machine, we will not want to eat the sausage.

While consistency (as I will argue in Part III) is a virtue of argument in bioethics, along with clarity, there is a tendency for overly theoretical approaches to assume or gloss over considerations that make a material difference to the ethical conclusions we should reach.

Theory-driven approaches are in tension with what I have argued is Battin's accurate observation that bioethics is issue- or dilemma-driven. While those arguing for a theory-driven approach might be open to the views of other perspectives, it is hard to see how those with a theory-driven approach can avoid the implication that they think the account of an issue that follows from their pet theory is the authoritative account of that issue. As I showed in Chapter 2, Alastair Campbell's principle of no special pleading is important so that bioethics can offer the most nuanced accounts of ethical issues it can, retain its interdisciplinary nature, and protect freedom of expression in oppressive contexts. When viewed from this perspective, theory-driven approaches do seem inconsistent with no special pleading.

Along with Dan Wikler, Peter Singer founded the International Association of Bioethics and was its first president (Campbell 2000). He and Helga Kuhse founded the Centre for Human Bioethics at

Monash University in 1980 and the journal *Bioethics*. It is hard to think of anyone who has had a greater influence over the creation and direction of bioethics, and he is also famous for his utilitarian approach to bioethics. I mentioned in Chapter 2 Potter's conception of bioethics as a global, biologically grounded ethic, with environmental issues at its core (Potter 1970). Peter Singer's early essay *Famine, Affluence and Morality* is not only consistent with Potter's vision, but prescient in that we can view it as a prototypical example of global bioethics (Singer, 1972). In *Famine, Affluence and Morality* he analyses our failure to do what we should to aid those starving in parts of the world that are remote from us. It is a particularly clear example of how Singer's theoretical commitments feed into his method for bioethics and a good example of how the overdetermination of bioethics by theory can weaken the strength and cogency of moral claims.

He describes the famine that held Bengal in its grip and how countries such as the United Kingdom, Australia, and the United States spent much more on projects other than saving the lives of starving Bengalis.

He claims:

if it is in our power to prevent something bad from happening, without thereby sacrificing anything of comparable moral importance, we ought, morally, to do it.   (Singer 1972: 231)

Given the awful suffering caused by famine, there is much to admire about Singer insisting that we should, and could, do much more to prevent and remedy such tragedies. As he observes, most would be inclined to agree that in such cases there is a beneficence-based duty to provide aid to those in need. However, a note of caution should be sounded: whenever such compelling cases are discussed, it is tempting to accept the principle without thinking carefully enough about what else we are accepting. While it is hard to imagine anyone arguing that we do not have a beneficence-based obligation to provide aid, it is another question whether we should accept that we have a moral obligation to prevent harm whenever we can, and when it does not involve sacrificing anything of comparable moral importance.

Suppose that a farmer's large combine harvester is out of control and headed toward a barn that is housing 100 pigs. He has just had it serviced and knows that its harvesting blades are in pristine condition and will wreak havoc in the barn, with it being overwhelmingly likely that most of the pigs will die. Suppose also that the only way the farmer has of shutting down his machine is by shoving his son, who is standing in the doorway of the harvester, so that he falls into the machinery of the harvester and stalls it before it reaches the barn.

This is a case where it is within the power of the farmer to prevent something bad from happening by sacrificing something Singer will view as of less importance: the death of his son is less important morally, when compared to the lives of 100 pigs. Most of us will part company with Singer in both the idea that bringing a death about is equivalent to saving a life and that pig lives should be considered on a par with human lives. This problem arises because of Singer's theory-driven approach to bioethics. While this application of Singer's rule conceals implications of the rule we would not want, the reason he has chosen that rule is because of his theory-driven approach to bioethics. There are many other rules that could be grounded in an analysis of what is happening, why it is wrong, and why we should provide aid: something such as 'When the costs to us are not significant, we should do more to aid those who are starving.' A better way to reason through obligations about such issues is to look to the issues, and not push the issue through a set of assumptions that are theoretically motivated.

It is also worth noting that this is only a prima facie beneficence-based duty; Singer has not discussed competing moral obligations, which is another problem with theory-driven bioethics. If we approach the same issue with a view to thinking carefully about the ethical considerations, then the importance of aid will be on the table, but so will other issues such as whether anyone can be identified as responsible for the famine. If people are starving because of financial subsidies to farmers in other countries, making it unprofitable to farm in the famished country, then we should direct our attention to whom the duty to aid falls upon most clearly. If the famine is the result of an

insurrection that has destroyed crops and made it difficult for the government to ensure food production, and that insurrection was supported by a superpower with the aim of destabilizing the government, then we should also argue that the superpower has a duty to aid the famished country. This is not simply because it will give us someone to blame; being able to show that a person or institution was materially involved in a group of people being harmed generates not only a duty for them to aid but a well-specified right that those are suffering can claim against (Pogge 2007).[1]

Singer justifies his duty of beneficence by the following argument.

If we accept any principle of impartiality, universalizability, equality, or whatever, we cannot discriminate against someone merely because he is far away from us (or we are far away from him).   (Singer 1972: 232)

Taken at face value, this is a strong claim: that all principles of impartiality, universalizability or equality imply that the mere fact someone is a long way away from us is not a grounds for discrimination. However, intuitively this seems right: while we do tend to discriminate against those who are geographically remote, it is hard to defend that in a principled way. When considering the inequality that exists between countries, Singer grants the following:

Admittedly, it is possible that we are in a better position to judge what needs to be done to help a person near to us than one far away, and perhaps also to provide the assistance we judge to be necessary [...] From the moral point of view, the development of the world into a 'global village' has made an important, though still unrecognized, difference to our moral situation. Expert observers and supervisors, sent out by famine relief organizations or permanently stationed in famine-prone areas, can direct our aid to refugees in Bengal almost as effectively as we could get it to someone in our own block.   (Singer 1972: 232)

Singer's claim about how, historically, we focused upon those closer to us because we knew about their suffering, and how this has now

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[1] This is Thomas Pogge's suggestion for how we can utilize human rights in an account of global justice (2007).

been superseded by the development of the global village and our global knowledge, is controversial for at least two reasons.

First, even if it's true that the only justification for partiality is epistemic, Singer is incorrect that the 'global' village has enabled us to know how to alleviate the suffering of those far away as efficiently as the suffering of those nearby. The effect of foreign aid has been shown to be mildly effective at best (Bourguignon and Sundberg 2007: 316), and that suggests we can still do more good by providing aid to those nearby, where we are better informed about what will improve the conditions of their lives.

Secondly, Singer's concession to partiality doesn't capture what those who think there are agent-relative duties, such as virtue theorists and deontologists, take to be important when thinking about our duties to others. Agent-relative duties are the obligations that persons have in virtue of their standing in a particular kind of relation to another person. So, your physician has agent-relative obligations to you when you are seeing them for a medical examination. They do not have those obligations to a starving Bengali, as they are not in a doctor–patient relationship with that person. Friendship is another kind of relationship that entails agent-relative duties: a friend can reasonably expect that you will and won't do some things in virtue of you being their friend.

Singer is correct that the mere fact a starving Bengali is on the other side of the world is not a reason to discriminate against her and favour the nine-year-old girl in the same house as you. However, if the nine-year-old girl in the same house as you is your daughter, then that is a good reason to discriminate against the starving Bengali. That is not to say that we should not do much more to aid those in poverty in other parts of the world, but to point out that no one, apart from someone whose approach to ethics is driven by a theory that does not take into account the moral significance of our important relationships, would think that our obligations to those we do not and never will know are the same as those to our nearest and dearest.

Agent neutrality is the flipside of agent relativity, and is the view that our duties to others do not depend upon the relations in which

we stand to them, so your child and any other child deserve the same moral consideration.

'Famine, Affluence and Morality' is an important article; it will have done much to further this cause, and Singer's conclusions are ones that most of us will be inclined to accept: we really should do more to aid those in need. However, his theory-driven approach means that the machinations of his sausage machine include ingredients that will not be palatable to most.

The impartiality assumption and emphasizing beneficence as a master principle are two defining features of utilitarianism and its application to bioethics. Singer's argument in 'Famine, Affluence and Morality' takes the following form, which is common to many utilitarian arguments in bioethics and to a number of Singer's other classic works such as 'All Animals are Equal' (Singer 1974).

1. Moral action β would decrease suffering more than moral actions α or ϙ.
2. We choose to perform α or ϙ at the expense of β.
3. There is no relevant moral difference between α, ϙ, and β.
4. So we have a moral obligation to β.

Premise (3) in this instance relies heavily upon the impartiality assumption, which as I have already mentioned is controversial. Premises (1) and (3) are, as I have noted, questionable on epistemic grounds.

The shortcomings of Singer's arguments are important to note, but what is more relevant to bioethics is the way in which this form of argument can be re-applied to different issues, so as to produce a claim about what we should do. All that is needed is to provide some reason in favour of premise (1), and a moral conclusion is said to follow.

None of this should be taken to imply that all utilitarians have a theory-driven approach to bioethics. Singer clearly does, and is upfront about that, but other utilitarians such as Jonathan Glover do engage in issue-driven bioethics (Glover 1977). In Part III of this book I will discuss useful methods for bioethics, and one of them is to

minimize theoretical assumptions. Singer does not do this, but it is clear that his accounts are theory-driven and he does not hide the assumptions within his positions. As I will show in Part III, Glover tries to develop the strongest arguments he can; and while there is no doubt that he is a utilitarian, he also aims to argue in a way that will convince as many as he can, and not just those who share his views about the correct normative moral theory.

There are variants of the ethics sausage machine. In 'All Animals Are Equal', Singer explains how racism and sexism were ridiculed when first proposed, but have come to become viewed as serious wrongs that involve unjustifiable discrimination on the basis of skin colour or gender (Singer 1972). As is the case with his views in 'Famine, Affluence and Morality', he appeals to a principle of equality that encapsulates the impartiality assumption, and endorses Bentham's and Sidgwick's impartiality principles.

In Chapter 2 I discussed Alastair Campbell's commitment to there being 'no special pleading' about the correct theory and perspective for bioethics, and how he seemed to have in mind theological approaches to bioethics and utilitarianism. Clearly he did not want any theory or perspective to stake a claim as the only method for bioethics, but utilitarianism and theological ethics can be approaches that are especially theory-driven. My second ethics sausage machine is a theological approach that is doctrinal and drives the ethical analysis of issues such as contraception, abortion, and euthanasia. As is the case with utilitarianism, it does not follow from the fact that someone has theological views about the nature of morality that they will have a theory-driven approach to bioethics. In saying that, there are a few examples of theory-driven theological approaches.

Perhaps the most influential Catholic pronouncement that has implications for bioethics is Pope Paul VI's *Humanae Vitae*. This is a statement that clarifies and reiterates the Church's position on the place of procreation in marriage, and how the value of human life is integral to this. It attempts to ground a view of the central role that procreation and sexual activity play within the institution of marriage in an account of human nature. Catholic theologians claim that they

base moral requirements in the way the world is, or in other words the 'natural law'. One reason why this is important is because it provides an answer of sorts to the Euthyphro dilemma. Finding a foundation for moral requirements in an account of the natural order means that moral claims can be justified by appealing to how things naturally are. So, in the case of the moral duties between husband and wife, they can be justified by pointing to an account of the nature of that relationship, its value, and how contraception, procreation, and sexuality fit within it. While God is central to this picture, the natural law tradition can insist that it is nature that plays the key role in justification.

Nonetheless, the natural law, or the way things naturally are and should be, according to the natural law theologian, is the result of God's will. When discussing why sexuality must be essentially procreative, and contraception is thereby impermissible, the Pope both refers to the nature of things and emphasizes that these are God-given.

This doctrine [that every marital act must remain oriented in itself to procreation], often expounded by the Church's magisterium, is based on the indissoluble connection—established by God and not rightly severable by human volition—between the two inherent meanings of marital intercourse: unitive and procreative.   (Paul 1968: section 12)

Clearly human beings are able to distinguish between the two purposes that marital intercourse can serve; the claim is that if they do so they are not correct to do so, because this is a connection that God has built into nature. Finnis explains the underlying argument:

To make a choice against the procreativeness of any sex act is one way to guarantee that it is not a marital act and therefore, in the Christian understanding of human reasonableness, is not a morally suitable act for anyone.
(Finnis 2011)

So, the principle that actually underpins the prohibition on contraception is that it renders marital sexual acts that are only for love, not marital acts, and therefore not actions that anyone should engage in. Sexual activity is only permissible within marriage and when it is

procreative, as permissibility requires the union of procreation and love to be essential to its purpose.

Assume, for argument's sake, that there are different reasons in favour of a prohibition on contraception—suppose there is evidence that the availability of contraception in fact increases HIV/Aids infection rates. These considerations do not need to enter into the Church's deliberations, as they already have determined in a deductive fashion that contraception should not be permitted. The theory-driven way in which the Church approaches this weakens its position by making its claims contingent upon theoretical assumptions, which are hard to see anyone who is not Catholic granting. This also has the effect of making their position unconvincing to others, even when there is a consideration that would be relevant to the same conclusion.

Other Ethics Sausage Makers

I've discussed examples of theory-driven bioethics that are utilitarian and theological. As I have noted, it does not follow from subscribing to a normative moral theory that one will drive bioethics with that theory. Nonetheless, there are examples of theory-driven bioethics from other moral traditions. While neo-Kantians such as Christine Korsgaard are not absolutists about duties such as lying (Korsgaard 1996), it is clear that Kant thinks there are maxims that we should never act upon, and one of them is to lie from an altruistic motive (Kant 1949). Absolutist duties such as this are instances of theory-driven ethics and, insofar as they imply duties that are relevant to bioethics, are theory-driven approaches to bioethics. A Kantian who agrees with Kant on this point is just as likely as Singer and the Pope to bite the bullet and reply that this is just the way it is.

There are theoretically driven approaches to bioethics in which assumptions and commitments are imposed upon ethical issues in a different way from normative moral theory. As Mark Sheehan and Mike Dunn (2013) note, medical sociologists will often work from within a tradition that observes and theorizes social phenomena

through a particular lens. For example, a sociologist from a feminist or Foucauldian perspective will tend to observe and theorize about issues that make sense and can be explained from that perspective. Given that bioethics is and should be issue-driven, this creates an epistemic challenge for sociologists. They should be overt about their commitments, and show why those from other disciplines and perspectives should view their claims as good bioethics, and not merely observations from within a perspective. Sheehan and Dunn are correct that this means sociologists need to argue out why their observations are sufficiently issue-driven to be taken as practically normative.

While those who have moral commitments that overdetermine what they will say about an ethical issue are free to follow their convictions, there are a number of consequences. Campbell is correct that bioethics should involve no special pleading, and theory-driven bioethics assumes that the theory referred to is correct and trumps all other considerations, and thus does place itself in a privileged position. As I will show in Part III, when I discuss the importance of minimizing theoretical assumptions, it weakens the strength of any resulting claim, so that someone who does not believe that moral theory to be true can simply disregard the claim made about that issue, as it relies upon a premise they do not wish to grant or think is false.

In one way, it is a shame that Singer's revisionary and insightful work is theory-driven, as it provides a way for those who do not think utilitarianism is true to disregard his conclusions, many of which are important.

Philosopher Kings and Other Queens of the Sciences

'Unless,' said I, 'either philosophers become king in our states or those whom we now call our kings and rulers take to the pursuit of philosophy seriously and adequately, and there is a conjunction of these two things, political power and philosophic intelligence, while the motley horde of the natures who at present

> pursue either apart from the other are compulsorily excluded, there can be no cessation of troubles.'
>
> (Plato 1993: 473d)

It would be overstating things to claim that philosophy views the troubles of bioethics as being due to a 'motley horde of natures'. Nonetheless, there are those who think bioethics is not philosophical enough, and would make greater progress if it included more philosophy. As noted in Chapter 3, Julian Savulescu claims that bioethics needs more good philosophy, and by that he doesn't just mean better arguments, but insights that derive from philosophical theorizing (Savulescu 2015). I have defended the view that a grounding in philosophy is one important way of learning how to 'bring moral reason to bear' upon issues, but it is not the only discipline that can do this, and the usefulness of philosophical insights such as normative moral theory tends to be overstated. However, the Socratic tradition in philosophy fits the conception of moral reason that I have developed thus far, so in that sense, all who engage in bioethics are or should be philosophers. Nonetheless the tendency of a number of disciplines to see themselves as being the magic key that makes bioethics good is a methodological spectre that obstructs, rather than promotes, good bioethics.

The Snooty Specialist Spectre

At times, the turf wars of bioethics have descended into snootiness which has done little to promote interdisciplinarity, and that on its own is a methodological spectre. It is also fair to say that there is a degree of condescension from some philosophers toward those who are described as 'bioethicists' or 'medical ethicists'. In *Life's Dominion*, a book which can reasonably be considered as canonical in bioethics, Ronald Dworkin remarks:

Would legally sanctioned killing make the community as a whole more callous about death? Would it have as great or greater an effect, in that direction, as capital punishment does? These and similar questions are now much discussed in newspapers, medical journals, and symposia of what

are called 'medical ethicists'. But there are also philosophical and moral questions to consider, and these are even more important and difficult.

(Dworkin 1993: 182)

Philosophers are by no means alone in this tendency; sociologists of medicine sometimes see their discipline as having already carved out niches that bioethicists then think they have discovered. Adam Hedgecoe claims that 'empirical ethics' is redundant as it cannot do anything that good medical sociology does not already do (Hedgecoe 2007). He misses the point, well made by Sheehan and Dunn, that although medical sociology has its own tradition of critical normativity, that is not the same thing as practical normativity, and this is what is distinctive about empirical ethics (Sheehan and Dunn 2013; Ives et al. 2017).

Such tensions between bioethics and sociology have always been a feature of this intellectual landscape. Samuel Gorovitz (1986) details the ways in which bioethics was 'baited' by a number of disciplines barely ten years after its creation. He also mentions criticism of some of his own work by Renee Fox and Judith Swazey.

They also quote a passage of mine on personal autonomy as illustrative of why bioethics is 'an impoverished and skewed expression of our society's cultural tradition.'   (Gorowitz 1986: 359)

There is some irony in the fact that the founding figures of bioethics such as Campbell and Callahan sought to create an area of inquiry where all cognate disciplines could contribute, but it has been criticized as an enterprise that attempts to infiltrate or is subservient to vested interests. When reviewing two books critical of bioethics, Albert Jonsen remarked:

Stevens tells a story of bioethics in which the bioethicists have become pusillanimous opportunists, subservient apologists for the powerful medical establishment. Smith's bioethicists, on the other hand, are insidious infiltrators of the ancient ethics of medicine, sapping its moral strength and injecting the poison of utilitarianism.   (Jonsen 2001: 40)

There are some tit-for-tat persnicketies from bioethicists such as Carl Elliott, who takes pot shots at philosophy: he thinks of it as a dying

discipline that should be grateful to bioethics for injecting it with a new lease of life.

> To eavesdrop on the on many conversations about the state of contemporary philosophy is like listening to a group of homeless disaster victims remembering the calamity that made them homeless and, still wondering where to go next.   (Elliott 1999: xx)

Needless to say, none of this is helpful or furthers the task of working toward practical normativity about important moral issues. What is perhaps more problematic (and another form of the snooty specialist spectre) is the tendency of a number of disciplines to view themselves as offering a unique or privileged perspective upon bioethics.

Other Queens of the Sciences

Disciplines such as philosophy are free to view and define themselves in whichever way they choose. However, the traditional view that philosophy has had of itself as 'the queen of the sciences' (Cooper 2009) is a view that implies a healthy sense of self-worth and confidence in one's place in the order of things.

Curiously, there is more than one queen of the sciences. Mathematics has a tradition of viewing itself as scientific royalty (Bell 1931), as does physics (Bunge and Shea 1979). Scientists might be surprised to find out that they should be kissing the ring of theologians, some of whom think they are best placed to rule the sciences (DiDonato 2015).

None of this fits with Campbell's principle of no special pleading, and given his knowledge of theology and philosophy, it is easy to see why he thought it important to make a statement about it.

But within bioethics, some disciplines continue to stake a claim as the overarching critic of bioethics. While some philosophers view themselves as uniquely qualified to do bioethics, sociologists of medicine have staked out a claim as the meta-discipline of bioethics, with sociologist Raymond De Vries claiming that we need a sociology 'of' bioethics as well as sociology 'in' bioethics (Vries 2004).

Sociology 'of' Bioethics

Sociology has always been one of the disciplinary perspectives within bioethics. Insofar as sociologists work on the same kind of issues as lawyers or philosophers, we might describe this as sociology 'in' bioethics. The idea that sociologists should look at bioethics as a social artefact—investigating what leads it to consider the issues it does, which institutions predominate, and how they influence bioethics—is what could be called sociology 'of' bioethics.

Bioethics is an important social phenomenon and one that is worthy of the attention of sociology. However, the more radical suggestion is that the sociology 'of' bioethics should be considered part of bioethics, and a form of research activity within bioethics.

It might be thought that little hangs on broadening the scope of bioethics so as to include a reflexive socially critical sub-speciality. However, if sociology 'of' bioethics becomes part of bioethics, then that implies it should be published in bioethics journals, be funded as bioethics research, and be a component of courses in bioethics. It would also mean that discussions of methodology in bioethics should consider how one goes about doing sociology 'of' bioethics, and that seems just as unrealistic as expecting mastery of law or philosophy to include bioethics. There are several problems with this suggestion.

First, for other scholarly inquiries that involve looking at progress or change within a discipline, it would be odd to think that the reflective or critical exercise becomes part of that discipline. The Sociology of Scientific Knowledge (SSK) is an approach to the social history of science that involves paying attention to the actual structures and events that lead to change in science (Ashmore 1989). It was formed as a way of generating deeper and more accurate accounts of why scientific theories go into crisis and are replaced than was given by Kuhn in *The Structure of Scientific Revolutions* (Kuhn 1996). It is odd to think that a SSK analysis of the events that brought the Hadron particle collider into being would mean we should view SSK as a subdiscipline of theoretical physics. It is likewise odd to think that an instance of sociology of bioethics would become part of bioethics.

Second, bioethics essentially involves bringing moral reason to bear upon ethical issues, and should aim to be practically normative. Medical sociology in bioethics will not involve bringing moral reason to bear upon ethical issues; and because it will only offer critical, reflexive analysis of bioethics, it cannot, as Sheehan and Dunn (2013) point out, generate practically normative guidance about what should be done about important ethical issues.

Third, sociology in bioethics is a category mistake. This book is an exercise in meta-bioethics, in that it is a reflection upon the meaning and nature of bioethics that aims at furthering methodology in bioethics. It therefore tracks and furthers the aim of bioethics to provide practical normative guidance about ethical issues. However, it is a category mistake to think that all reflexive or meta-level investigations about bioethics *are* bioethics. There is no reason why a lawyer, historian, or philosopher should not engage in meta-level research about bioethics, but to then think that this qualifies as bioethics is to mistake one kind of analysis for another. Sociology of bioethics is a legitimate and important critical project, but it should not be an exercise in bioethics, and those who suggest it should display a lack of awareness about what bioethics is, and how it can progress.

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5

The Fact/Value Spectre

Tis not contrary to reason for me to prefer the destruction of the whole world to the scratching of my finger. Tis not contrary to reason for me to chuse my total ruin, to prevent the least uneasiness of an Indian, or person wholly unknown to me.

(Hume 1739)

The roots of the fact/value spectre are to be found in Hume, whose commitment to empiricism, in conjunction with his sceptical rigour, led him to draw a sharp distinction between facts and values. For Hume, all knowledge comes via the senses and, at least in the early Hume of *A Treatise Concerning Human Understanding*, it was hard to see how the passions could be factual. The early Hume claimed that preferences, values, and the passions were not amenable to reason; and once he had seized upon that thought, ethics was in trouble.

The opening lines of Wittgenstein's *Tractatus* are 'The world is everything that is the case. The world is the totality of facts, not of things 1.1' (Wittgenstein 1922). While the *Tractatus* is challenging to read, to the extent that someone as clever as Bertrand Russell completely missed the point of it in his introduction, it was highly regarded by the logical positivists and taken to lay out the logical groundwork for verificationism. Put simply, verificationism is the idea that the only meaningful statements are those that can be verified

empirically (Ayer 1946). So, we know the meaning of 'a yellow rose is in the vase' by verifying empirically that there is a rose in a vase, and that the rose is yellow. While that initially appears plausible, it immediately creates a difficult for ethics. If we said 'the research participant has been treated immorally', we might be able to verify that there is a research participant, but we cannot determine the truth or falsity of 'immorally' empirically, so the statement is meaningless. Ethics, aesthetics, and all areas where we speak of things that are not capable of being empirically verified are meaningless.

Logical positivism is now considered a relic of the twentieth century: next to no one will admit to believing that the ability of a statement to be verified determines whether or not it is mean-ingful. Nonetheless, the legacy of positivism continues to bedevil bioethics, and it influences approaches to the area in a variety of unhelpful ways.

While the verificationism of the logical positivists is no longer considered seriously in philosophical circles, those from scientific or empirical disciplines can view ethics as being mere talk or a matter of opinion, and not an area amenable to serious intellectual inquiry. For those of an empiricist leaning, that which pertains to ethics is not empirical and is therefore fluff at best, nonsense or subjective if they're being impolite.

Philosophers have not always been as sceptical as Hume about values. Platonists thought 'the just' and 'the beautiful' were formal and knowable through the structure of our experiences about justice and beauty (Plato 1993). Likewise, rationalists such as Kant think that morality has its foundations in the nature of our rationality, and that this is the only kind of foundation that could explain the phenom-enon of morality (Kant 1998).

Nonetheless, the view made popular by the eighteenth-century British moralists is one that many take for granted; they implicitly believe that values are mere feelings, and are not grounded in the fabric of the world, like facts.

One of the most quoted passages in Hume, and the one that many will identify with the fact/value distinction, is from the *Treatise* where

he describes the logical problem of deriving a normative conclusion from purely factual premises.

In every system of morality, which I have hitherto met with, I have always remarked, that the author proceeds for some time in the ordinary ways of reasoning, and establishes the being of a God, or makes observations concerning human affairs; when all of a sudden I am surprised to find, that instead of the usual copulations of propositions, *is*, and *is not*, I meet with no proposition that is not connected with an *ought*, or an *ought not*. This change is imperceptible; but is however, of the last consequence. For as this *ought*, or *ought not*, expresses some new relation or affirmation [. . .]

(Hume 1739: 177–8)

This passage is often taken to express scepticism about all normative claims. But Hume can also be interpreted as observing how many of his contemporaries are careless in the way they move from describing how something is, to how it should be (1989, Pigden). If that's all he means here, then it is a helpful reminder to all involved in bioethics that they should check the ethical premises that they're using to see whether they imply the normative conclusions that have been drawn. There will be cases within bioethics where normative claims are inferred too hastily from an empirical study, and where a normative premise should have been stated clearly; and when read in this way this passage is a useful reminder to check the validity of ethical inferences from empirical studies (McMillan 2017).

The reason why some have interpreted this as a radically sceptical statement about grounding claims is because that does seem to be implied by Hume's empiricism, and by what he says elsewhere. His claim that it is not contrary to reason to 'wish one's ruin' or to 'prefer the destruction of the entire world to scratching one's finger' is a deeply sceptical pronouncement about the rationality of all values, including morality.

'The naturalistic fallacy' is the name G. E. Moore gives to the idea that there is something essentially irreducible about a class of statements, including moral judgements, that is not 'naturally' located in the world (Moore 1993 [1903]). Moore should be read as making a

point about the meaning of moral terms and how they cannot be captured completely in descriptions of how things are in the world. For example, the research subject who has been treated immorally can be identified in the world as 'a person', and there is no 'naturalistic fallacy' there. We might also point to things that have happened to the research subject, such as not having given consent and having been caused pain, to back up our claim about the subject being 'wronged', and these things too could be features of the world. However, at that point Moore might object that there is still a question about whether the absence of consent and pain are the same as 'wrong'. While he might concede that these things are reasons for thinking that someone 'wrong' had occurred, that's a judgement that is not reducible to a natural feature of the world.

Irrespective of what we make of Moore's open-question argument, it is important to note that discussion of the fact/value distinction can run together a number of different philosophical points.

Putnam and the Fact/Value Distinction

There is a large literature on the fact/value distinction, and it would be a mistake to claim that the matter is completely settled. It is the nature of philosophy that important distinctions continue to be discussed and refined so as to accommodate problems. These technical discussions are beyond my scope here, but it is important to give an account of some of the problems the fact/value distinction is commonly thought to have, so as to help understand why it is a problem for bioethics.

In *The Collapse of the Fact/Value Distinction*, Hilary Putnam describes how a series of problems in epistemology and the philosophy of science led philosophers to see that it was impossible to give an account of knowledge, and of scientific knowledge, that did not include values.

[. . .] judgements of coherence, simplicity (which is itself a whole bunch of different values, not just one 'parameter'), beauty, naturalness, and so on, are presupposed by physical science, likewise many today who refer to values as

purely 'subjective' and science as 'objective' continue to shut their eyes to this same fact. Yet coherence and simplicity and the like are values.

(Putnam 2002: 31)

Putnam is not saying that the epistemic values of science are as readily grounded as moral or religious values. It is reasonable to suppose that these three kinds of value have different epistemic justification and will, or will not, be capable of being grounded in different kinds of ways. His point is that just because something doesn't appear to be directly observable in the way that the 'wrong' done to the research subject isn't, it does not follow that it is not objective, or is incapable of being included within our realm of knowledge. The coherence and simplicity of Newtonian mechanics are scientific virtues, and we do not think they are unjustified.

Metaethicists such as John McDowell, Philippa Foot, and David Wiggins have discussed the apparent factual, or objective, nature of so-called 'thick ethical concepts'. These are concepts that we would undoubtedly view as being evaluative, but for which we do not appear to be making some kind of error to view them as truth-apt:

If someone asks me what kind of person my child's teacher is, and I say, 'he is very cruel', I have both criticized him as a teacher and criticized him as a man. I do not have to add, 'He is not a good teacher,' or, 'He is not a good man.' [. . .] 'Cruel' simply ignores the supposed fact/value dichotomy and cheerfully allows itself to be used sometimes for a normative purpose and sometimes as a descriptive term.   (Putnam 2002: 34–5)

The point here is that there are moral values that share many of the same features as facts, and we do not bat an eyelid about whether or not such claims are epistemically warranted. In the context of bioethics, there are many thick ethical concepts that we use without needing to be concerned about whether we're making some kind of epistemic mistake. For example, if we see a psychiatrist, attempting to calm a psychotic patient, say something that is untrue but that will put that patient at ease, we might say that this psychiatrist had been both 'untruthful' and 'paternalistic', but that she was justified in doing so. Concepts such as these are the bedrock upon which bioethics is built. They are also concepts that appear to be factual and

evaluative: there are factual features of the psychiatrist's behaviour that will make these attributions true or false, yet at the same time these are evaluative and ethical concepts.

It might be objected that thick ethical concepts are ambiguous in that when they're being used in a factual sense, they're not clearly normative, and when they're being used in a normative sense, they're not straightforwardly factual. There's something to this worry, but because the fact/value distinction tends to be presented as a dichotomy, thick ethical concepts create a significant grey area between fact and value. Furthermore, even if someone is using 'coercion' in a descriptive sense (i.e. someone did something because of a threat), this is a sense that, although not normative insofar as it entails that this should not occur, could not be considered morally neutral.

If Not Empirical, Then Nonsense or Subjective (Positivism)

The fact/value spectre can influence the way in which some, especially within the domain of public policy, approach bioethics. A good example of this is the way that the Human Fertilisation and Embryology Authority (HFEA) appeared to use public opinion surveys so as to reach a public policy position on whether they should permit sex selection for social, as opposed to non-medical, reasons (Leather 2005; Human Fertilisation and Embryology Authority 2003).

Under the guidance of former head of the HFEA Suzi Leather, the HFEA conducted public opinion surveys on a number of policy-related issues. The way in which the HFEA appeared to use public opinion about sex selection for normative social policy created a wave of criticism and debate (Harris 2005a; Baldwin 2005; Harris 2005b). A number of arguments were in play during this debate, but the one relevant to the fact/value spectre is John Harris's claim that the fact public opinion was against sex selection for 'social' reasons amounts to nothing more than 'prejudice' and should not be used uncritically in support of policy. Harris was a particularly vehement critic of the way in which public policy appeared to follow directly from public opinion.

In the report, the opinions emerging from the consultation exercise, which, unsupported by evidence or valid arguments are impossible to distinguish from prejudices, are given formal approval and proposed regulation by a government appointed body set up with the responsibility to provide expert leadership [. . .] while undoubtedly informed, it is informed largely by the results of a public consultation, the 'hostility' of which to sex selection is manifest and even explicitly acknowledged in those terms by the HFEA, and is accepted at face value.   (Harris 2005b: 292)

The objection is not that the HFEA gauged public opinion and took it into account when creating policy: one of the regulatory purposes of the HFEA is to maintain public confidence in new reproductive technologies (Leather 2005), so knowing and reacting to public opinion is an important part of its remit. Moreover, 'moral consequentialism' is an important requirement of bioethics as public policy, so gauging public opinion is a useful way of investigating some of the consequences of policy options.

Harris might easily have cited Hume and his famous observation that it is logically invalid to move from a description of a state of affairs to a statement about what should be the case. Nonetheless, his point is clear enough: there is no reason to think that just because a group of people express a view about what should be the case, it really should be the case.

It might be that the HFEA's report did not include arguments and moral premises that were implicit in their reasoning. It could also be that the HFEA thought that, given its statutory role in maintaining public confidence, hostile public opinion was sufficient for it to adopt a conservative policy position. However, it could also be that its approach to bioethics as public policy was motivated by positivism about ethics. If ethics is merely a matter of how individuals feel about an issue, or simply a matter of what individuals subjectively believe about a moral issue, then surveying public opinion would make sense as a way of doing bioethics.

Belief in a naïve version of the fact/value distinction could imply that the only way to do bioethics is by measuring, as accurately as one can, how people feel about an issue. Given that ethics is not amenable

to reason, there is no point in rigorous, evidence-based argument about ethical issues.

Bioethics as public policy is particularly challenging in the way that considerations such as public opinion and political implications will apply to policy that is about a number of cases, as opposed to case consultation, which usually concerns one particular instance. Nonetheless, these are reasons why public policy bioethics should be just as attentive to argumentative strategies and evidence as are case consultation and scholarly bioethics, and the positivism implied by adherence to a naïve version of the fact/value distinction is a significant obstacle to good public policy bioethics.

Bioethics Research Positivism

Empirical bioethics, as a movement within bioethics, is admirable for a number of reasons. For clinical specialities such as psychiatry, rich with complex ethical issues, it is an important way that bioethicists can engage with the experience of those at the coalface, it is a way that we can check evidence that plays an important role in an ethical position, and it is a way that we can ground the ethical concepts that we analyse and use in moral argument (McMillan and Hope 2008).

However, given the prevalence of the belief that there is a fundamental distinction between facts and values, there is a risk that bioethics research that is empirical will be viewed as research, whereas rigorously argued scholarly bioethics, that has no empirical component, will be viewed as mere opinion and not real research. If research involves the investigation of facts, and ethics falls on the value side of this distinction, then it follows that ethics that does not involve the investigation of facts is not research.

This is of concern for those required to, or who wish to, gain research funding, as adherents of the fact/value distinction are likely to judge conceptual bioethics proposals as being less credible as research, and thereby deserving to be given a lower priority or viewed as not fundable. This can—and has—resulted in some bioethics researchers including an empirical component in what would have

otherwise been perfectly reasonable conceptual research project, in order to satisfy funding panel members with this prejudice.

Another place where the implicit adherence to the fact/value distinction reveals itself is in the way in which bioethics articles are categorized. There will be exceptions, but in general 'original research articles' in medical journals are those in which researchers report biomedical research that has been conducted in an accordance with the scientific method. Bioethics research articles, if they do not involve empirical data collected in a scientific way, are likely to be published in sections such as 'Head to Head' in the *British Medical Journal*, or 'Medicine and Society' in *The New England Journal of Medicine*. While it is good that bioethics research is published in medical journals more frequently than it used to be, there are knock-on effects from the categorization of these articles in a way that implies they are a less significant contribution to knowledge.

Evidence Based Medicine

The assumption that research articles report facts and lesser kinds of article discuss values has a corollary in the Evidence-Based Medicine (EBM) movement. The impact of EBM on clinical care over the last thirty years should not be underestimated. Patients have benefited from clinicians being encouraged to ground their clinical decision-making in guidelines that summarize the best available evidence, as opposed to just their clinical experience. David Sackett and other architects of EBM are clear that clinicians should use it to inform their decision, but not at the expense of good clinical judgement and experience being brought to bear upon individual cases (Sackett 1997).

Nonetheless, for someone who believes in a naïve version of the fact/value distinction, EBM is research about the factual basis of medicine, and that implies that what is left over is of less value or not amenable to rigorous, critical investigation. Just as moral theories run the risk of overdetermining moral issues and are often thought to play a more significant role than they are capable of, EBM, in

conjunction with the fact/value distinction, can overdetermine what's important clinically and encourage an uncritical, anti-intellectual, and subjectivist approach to bioethics.

Values Based Medicine

Bill Fulford created a method for discussing values in medicine that he intended to be the values counterpart to EBM (Fulford 2011, 2004; Petrova et al. 2006). Values-based medicine (VBM) is supposed to supplement evidence-based medicine (EBM) by filling in the values base missed by the critical appraisal of evidence.

The aims of both EBM and VBM are worthy, and mesh research activity with clinical practice. So VBM emphasizes, as does EBM, the importance of particular kinds of research activity. In addition to supplementing EBM, it's also clear that Fulford thinks VBM is an antidote to ways of approaching bioethics that he finds lacking. He says that VBM is 'a skills based counterpart to the currently dominant quasi-legal form of clinical bioethics' (Fulford 2004: 205). He explains this point as follows.

Values based medicine, then, aims to resolve differences, not by consensus but by what I have called elsewhere 'dissensus' [. . .] that is, by processes that support effective action through a balance of legitimately different value perspectives. It is worth looking at this notion of dissensus in a little more detail, since it is at the heart of the practice of VBM. Thus, in the quasi-legal model of bioethics, differences of values are resolved, in principle, by reference to a rule (embodied in a code or guideline and often supported by law), which has been settled in advance by consensus. Differences of interpretation may arise, of course, but these are settled, again in principle, by reference to a regulatory body with executive decision-making powers.

(Fulford 2004: 216)

In the footnote to this claim, Fulford mentions by way of illustration the UK's Human Fertilisation and Embryology and Authority (HFEA), which does operate in a quasi-legal way, principally because it is a body given a mandate by an Act of Parliament. Even so, it seems unfair to the HFEA to criticize it for failing to acknowledge 'dissensus'

and reaching consensus by applying rules. In fact, as I have just shown, the HFEA has been criticized for giving too much weight to the views of the public.

In any case, there is a more substantial problem with Fulford's view, because the problems he claims to address are straw men. Theory-driven bioethics is problematic because it overdetermines ethical issues and produces obligations that are contingent upon that theory. But even in those cases, it's not true that disagreements about value are resolved by reference to a rule: disagreements that don't fit with what follows from *Humanae Vitae* or utilitarianism are taken to be incorrect. What's much more common, and is illustrated particularly ably by Jonathan Glover in his chapter on the scope and limits of moral argument in *Causing Death and Saving Lives* (Glover 1977), is that values should tested for their scope, consistency, and consequences in moral argument (points that I will return to and elaborate upon in Part III). It is hard to think of any example of a decent published bioethical argument that reaches consensus between values via the adjudication of a pre-accepted rule.

It is vitally important in bioethics to argue carefully about the scope, consistency, and consequences of values because, contra Fulford, not all values are legitimate. He claims that 'human values are not, merely, different but *legitimately* different' (Fulford 2004: 215). The assumption behind this belief is the view that serious inquiry into the nature of values and attempts to ground values is fundamentally mistaken. This becomes apparent in the endnote attached to this claim, where he describes in more depth what he means by 'values'.

That our values are not only different but legitimately different follows analytically from the logical separation of fact and value (or, more exactly, of description and evaluation) insisted on by 'nondescriptivism' in philosophical value theory. The eighteenth-century British Empiricist philosopher David Hume is generally credited with the first explicit account of the claim that no description of a state of affairs in the world can ever, in itself, add up to a value judgement of that state of affairs: 'no ought from an is' is how Hume's 'law' is often summarized.   (Fulford 2004: 229)

There's a practical worry about viewing all values in the context of mental health (or in any context, for that matter) as legitimate. Forensic psychiatry often requires clinicians to help clients who have problems with violent or sexual offending. On many occasions, those who abuse women and children will attempt to rationalize this via a different set of values. Some paedophiles will collude with each other and attempt to justify what they have done via a set of values about their offending not really harming children and it being part of their sexual education. Likewise, men who abuse women might collude with other abusers and attempt to justify what they do by agreeing about the relative worth and role of women. There are paedophiles who think that the moral prohibition on sexual relationships with young children is merely a social construct, or reflects societally endorsed values, and that their value set is just as valid.

Overcoming collusion with such immoral values is a central therapeutic challenge for psychologists and psychiatrists attempting to prevent harmful behaviour. Fulford's attempt to place all values on the same footing, and to view them as not only different but 'legitimately different', is false because some values are not legitimate, and there are therapeutic (and not only ethical) problems with viewing values in this way.

Conclusions

The subjectivism about ethics that the fact/value distinction implies, and the positivism it implies about empirical approaches to ethics, continue to be a methodological spectre. The distinction itself is questionable, and the ways in which we all treat values, especially thick ethical concepts, as being grounded in the world, mean that none of us actually believes the fact/value distinction in its naïve sense. Perhaps the most worrying implication of the fact/value distinction is that it implies a view of bioethics that does an injustice to how important, sound, and difficult well-argued bioethics can be. The main thrust of this book is that the key to doing bioethics well, in all three areas of activity, is to argue well; and the irrationalism implied by the fact/value distinction is an impediment in working toward that goal.

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The Methods of Bioethics

6

Empirical, Socratic Bioethics

The standard view of moral philosophy is that it can be distinguished as three areas of interest and inquiry: metaethics, normative ethics, and applied ethics (Kagan 1998). All three of these areas of moral philosophy are potentially relevant to bioethics, and can play a role in bringing moral reason to bear on issues.

Metaethics is concerned with the meaning, nature, and status of morality. Moral relativism can be defined in a number of ways, but the most useful sense for bioethics is that it is the view that the truth conditions of moral judgements depend upon a specific cultural context. Defenders of the Nazi physicians who conducted inhumane experiments upon concentration camp prisoners claimed that these experiments were permissible within Germany. Those tasked with judging the war crimes of the Nazi physicians created the Nuremberg Code as a universal code of ethics for human experimentation, thereby attempting to circumvent that defence (Annas and Grodin 1992). If moral relativism is true, it implies that those outside a specific cultural context, Nazi Germany for example, are unable to criticize behaviours that are viewed as ethical from within that cultural context. This matters for bioethics because there are practices that occur in a minority of countries, such as female circumcision, which those of us who do not live in those countries should view as unethical (Lane and Rubenstein 1996). However, if moral relativism is true, then our different cultural context seems to rule out saying that what happens in other contexts is immoral.

There are two other meta-ethical views that play an implicit role within bioethics. Emotivism is the view that moral judgements are

not propositions, and are therefore incapable of being true or false. Instead, they are merely expressions of emotion, which could be action-influencing but do not have any truth conditions and are mere feeling. Simple subjectivism is the view that moral judgements can have truth conditions, but they are true in virtue of whether or not we have a corresponding feeling. In the previous chapter, when I discussed the fact/value spectre, I showed how it leads to irrationalism about ethics, and these meta-ethical positions are also a legacy of the fact/value spectre. For example, a simple subjectivist reading of the claim that bioengineering is bad is that it is true if and only if the person making that claim feels that bioengineering is bad. Meta-ethical views sometimes play an unstated role in bioethics: emotivism or simple subjectivism are implicit within the claims of some who argue for positivism about ethics.

Normative ethics aims at generating or explaining moral truths. Classic moral theories such as Bentham's and Mill's utilitarianism and Kant's deontology are examples of normative ethical theories. Too many books on bioethics are filled with truncated versions of moral theory, and I am not going to do the same here; but it is relevant to explain another reason why it is a mistake to think that moral theories can produce a method for bioethics.

Moral theories differ in how revisionary or critical they are of conventional morality. Utilitarianism, especially direct-act utilitarianism, is a highly revisionary or critical moral theory. If we had compelling evidence that a lottery, such as that described by John Harris (1975), where a citizen was selected at random and their organs harvested so as to save a number of other people would create more happiness, then that would be the right thing to do. It would be the right thing to do even though it is contrary to our 'conventional' morality and what most people would think is ethically acceptable.

Direct-act utilitarianism is just one moral theory, and other versions of utilitarianism are much less revisionary. A classic statement of direct-act utilitarianism can be found in Bentham:

By the principle of utility is meant that principle which approves or disapproves of every action whatsoever, according to the tendency which it

appears to have to augment or diminish the happiness of the party whose interest is in question [. . .] (Bentham 1907: 3)

This is 'act' utilitarianism because whether or not a course of action is correct depends upon whether that act in this situation will lead to the greatest happiness. It is 'direct'-act utilitarianism because Bentham thinks we should apply the principle of utility *directly* when deciding what to do.

A less revisionary utilitarian is Mill, who, arguably, should be considered an act utilitarian (Crisp 2002), but one that thinks we should apply the principle 'indirectly'. Mill claims that we should follow the requirements of conventional morality, and that it is only in those cases where conventional morality does not tell us what we should do that we should consult the principle of utility directly. He claims that our conventional morality has tended to track that which promotes happiness, and ordinarily it is an important guide.

Nobody argues that the art of navigation is not founded on astronomy, because sailors cannot wait to calculate the National Almanac. Being rational creatures, they go to sea with it already calculated; and all rational creatures go out upon the sea of life with their minds made up on the common questions of right and wrong, as well as on many of the far more difficult questions of wise and foolish. (Mill 1998: 2.24)

Most moral philosophers will argue in favour of their pet moral theory by showing how it is consistent with, and helps to justify, important moral beliefs. Shelly Kagan explains well the distinction between the foundational aspects of a moral theory and its prescriptive components (Kagan 1998; 1992). A moral theory can give an account of why an obligation is an obligation; for example, a Kantian, when asked why we should aid the poor, might explain this by showing how the maxim for this action is one that we would will to be universalized in a world where all act upon this maxim. In doing so, they would be justifying and explaining normativity, and thereby spell out foundational elements of their moral theory. A Kantian, when faced with someone poor and in need, should say that he or she has a duty to aid that person. This is an instance of the prescriptive components of a moral theory.

Contemporary moral theories differ significantly in the foundational parts of their theories: a contractarian will give a very different explanation for a specific moral requirement from a virtue theorist or rule utilitarian. However, they can do so while discussing the same moral obligation, for example to aid the poor. This matters for bioethics, because it should be in the business of bringing moral reason to bear upon practical ethical considerations. If contemporary moral theories (those that are not revisionist) tend to converge in their prescriptions, then which moral theory is correct is not fundamentally important to reaching a normative practical conclusion.

Arguing about the foundations of moral theory is one of the central tasks of normative ethics, however; it is not a task for applied ethics or bioethics. It is common for those theorizing about method in bioethics to view normative moral theories as being a method for bioethics. This is a mistake, and obfuscates what method in bioethics in fact is.

Some see applied ethics as being the area of moral philosophy where normative theories are applied to practical issues, thereby providing answers to applied moral questions. This is the same approach implied by Beauchamp, Childress, and Arras in the case of bioethics. As Archard and Lippert-Rasmussen (2013) point out, viewing applied ethics as the application of normative theory is misleading. When discussing applied philosophy, they remark that applied philosophy (and applied ethics) are on a spectrum of sorts in the extent that they apply philosophical theory.

On the question of what it is that one applies when one applies philosophy, we suspect that works of applied philosophy range from works that primarily apply methods of analysis and argumentation to a particular object of study to works that apply certain substantive philosophical principles to it.

(Archard and Lippert-Rasmussen 2013: 6)

Archard and Lippert-Rasmussen claim that applied ethics tends not to work by deducing moral obligations from principles and principles are usually not where the discussion of an issue in applied ethics begins. Instead, the starting point is usually a set of claims and justifications

that are given for a position in applied ethics. For example, if someone claims that we should ban greyhound racing, the analysis of this is likely to begin by looking at the reasons that person gives for that claim. It might be that principles end up playing some kind of role in the argument, for example a principle that puts animal suffering on a par with that of human beings. Nonetheless, most debates in applied ethics begin with a claim and an assessment of the reasons for that claim.

The main difference between applied ethics and bioethics is that the former is viewed as a subset of moral philosophy, and is primarily conducted by philosophers. There is no sharp distinction between applied ethics and bioethics in terms of their content or issues, and there is no obvious reason why they should be different in method either: both of them involve bringing moral reason to bear upon practical ethical issues.

Philosophical Forefathers

Given that the main difference between applied ethics and bioethics is who it is that's involved, it might be expected that the founding figures of bioethics were from a range of disciplines and not just philosophers. Most of the influential bioethicists mentioned thus far have some claim to being philosophers, and it does seem that the bioethicists most interested in generating theory for bioethics are philosophers. While it is the case that most of the founding figures in bioethics were philosophers or philosophically trained, not all of them would have viewed themselves primarily as philosophers.

Although figures such as Daniel Callahan, James Childress, and Alastair Campbell (Campbell 2013; 2009) have a background in theology, and could be described as 'philosophical theologians', they write about bioethics in a secular way. There are exceptions to this, as I noted in Chapter 3, Leon Kass is a philosophical theologian who overtly refers to God in some of his writing about bioethics and this weakens the strength of his claims, when compared to his more secular arguments (Kass 2002).

Socratic Reasoning: Speculative Reason and Drawing Distinctions

Philosophical methodology is contested, and no less controversial than bioethics. However, it is possible to distinguish a number of aspects of philosophical methodology that are uncontroversial. The Socratic tradition is characterized by speculative reason and what I will call 'drawing distinctions'. While Socrates, Aristotle, and Plato are the philosophers who might come to mind first when thinking about Socratic reason, Descartes played an important role in the development of modern philosophy and its methods.

In the *Meditations*, Descartes sets himself the target of finding a foundation for knowledge. He employs radical scepticism and doubts all that he possibly can, in order to arrive at that which cannot be doubted, and must therefore be knowledge (Descartes 2008). He famously arrives at the conclusion that the only thing he cannot doubt is that he thinks, and that his essence is therefore that of a thinking thing. The tradition of employing radical scepticism in order to strip away assumptions, prejudices, and that which is without foundation continues to be the norm in analytic philosophy.

One broad class of sceptical technique is to reason in a speculative and a creative way. In the *Meditations*, Descartes speculates that it is possible an evil demon is confusing him about what his senses are telling him. While we might think it unlikely, Descartes points out that it is possible that what we think we hear and see is in fact just part of an elaborate hoax, and we therefore should not trust our senses as an infallible route to knowledge. While speculative reason, or asking 'what if?', ordinarily does not need to consider possibilities as unlikely as Descartes's evil demon, speculating about possibilities is an important activity within practical normative reason that I will develop in this section of the book. While this is a common class of argumentative strategy in philosophy, it is not unique to that discipline, and other disciplines such as law and economics will speculate about possibilities, so as to tease out the implications and limits of positions.

'Drawing distinctions' is a better description for my second category of methods than 'conceptual analysis', partly because the latter term comes with intellectual baggage, and also because it is an activity that is particularly important as a method for bioethics, but is not something that only philosophers do. 'Drawing distinctions' is a fundamental method for law, sociology, and any discipline that relies upon distinguishing between concepts and being clear about those that play an important role. As I will show, a number of argumentative strategies can be described as 'drawing distinctions', and they include clarifying the meaning of a concept by offering a theoretical account of it, introducing a new concept that can play a significant role, testing the implications of a concept, and seeing whether distinctions that people think are important are in fact what they really think is important.

Bioethics Should Be Rigorous and Systematic

Bioethics aims at bringing moral reason to bear upon practical ethical issues, and being practically normative. While the radical scepticism of Descartes's *Meditations* continues to be a characterizing feature of method in analytic philosophy, it would be counterproductive for bioethics, where there is an imperative to generate tentative solutions to moral issues. The interdisciplinary nature of bioethics also means some give-and-take is required in order for those from different disciplines to work productively together; for example, it would be just as unreasonable for a sociologist to be very critical of a philosopher involved in bioethics for not knowing an important claim of Talcott Parsons as it would for a philosopher to generate a farfetched possible-worlds counterexample[1] to a sociologist's claim about bioethics.

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[1] Surveying possible world counterexamples and evaluating them in turns of how far-fetched they are is an interesting project in its own right. I have in mind counterexamples such as Davidson's 'swamp man' (Davidson 1987). We are asked to imagine a case where Davidson is walking in a swamp and is killed by a bolt of lightning. At the same time, a lightning bolt strikes in another part of the swamp and spontaneously creates a being who is identical to Davidson down to the last molecule.

Nonetheless, it is important that bioethics is as systematic and rigorous as it can be. Bioethics has more than its fair share of critics, and the best response to this is to ensure that bioethics is as good as it can be.

Empirical and Socratic

Like philosophy, bioethics is and should be engaged in the speculative, and should draw distinctions. However, a clear difference between traditional philosophical problems and the issues of bioethics is that philosophical issues such as free will and the nature of morality have been debated for over two millennia, whereas the issues of bioethics tend to be contemporary and rapidly changing. That difference alone is sufficient to warrant a more empirical approach to bioethics, in the limited sense of awareness of current issues and development.

That is not to say that philosophy is not attentive to scientific or social developments; the philosophy of biology is a prime example of where philosophers should be 'empiricists', in the sense of being aware of recent scientific developments. The point is that it is possible to do high-quality philosophy, in areas such as metaphysics and epistemology, with no reference to social or empirical work. Bioethics, on the other hand, loses its rationale if it fails to be practically normative, as it involves bringing moral reason to bear upon practical ethical issues. Without empirical engagement of some sort, it is hard to see how bioethics can deliberate about practical ethical issues; I illustrated the importance of this with the example of non-invasive prenatal testing (NIPT) in Chapter 3. But bioethics also involves the speculative, so I will return briefly to NIPT before exploring the role of speculative reason in the debate that occurred over the dead-donor rule and anencephalic newborns.

While this thought experiment is supposed to show that swamp man would not really be Davidson, even if everyone thought he was, it is a staggeringly unlikely event, and would be out of place in discussions about bioethics.

Non-invasive Prenatal Testing

Non-invasive prenatal testing (NIPT) is a new method of prenatal diagnosis in which free-floating DNA from the foetus can be detected in the pregnant mother's blood (Allyse et al. 2015). This makes it possible for foetal blood to be tested in a much less invasive way than is the case for other methods of detecting foetal anomaly, such as amniocentesis, which can carry up to 1 per cent risk of spontaneous miscarriage. While we have for some time had methods of determining a range of genetic features prenatally, including the sex of the foetus (McMillan 2014), the cost and non-invasive nature of NIPT mean that it is likely that many more pregnant women will find out whether their foetus is going to born with chromosomal anomalies such as Down syndrome. That raises a range of ethical questions about how liberty and access to new technology should be balanced against the possibility that harmful stereotypes about the value of those with disabilities might be reinforced (Farrimond and Kelly 2013). In response to this worry, those counselling women who are considering a prenatal test have been encouraged to be 'non-directive' in what they suggest, which creates an ethical tightrope of sorts for those working in this area (Caplan 2015).

Clearly NIPT is an example where bioethics has to be empirically engaged, make distinctions, and be speculative. Knowledge that this technology exists, and about what it is, is essential for understanding the possibilities it creates, and for framing the relevant moral questions. Accurate information about the conditions that can be tested for, the companies offering this, the false positive rates, and so on are important for a practical normative analysis of NIPT. More detailed empirical engagement with how information about NIPT and disability is discussed with women thinking about opting for NIPT is also important for framing ethical questions about whether it is liberty-enhancing.

Speculative reason is important too. Working toward an ethical position on NIPT will involve weighing up the objections to it against the interests, including liberty interests, that it promotes. That cannot

be done well without speculative argument about how strong coun-
terarguments would have to be to clearly outweigh liberty and other
interests, in being able to access NIPT. Speculative reason about the
nature of this liberty interest, and how it compares with other liberties
that are fundamental and those that we might view as trivial, is
likewise a way in which reason would further ethical deliberation
about NIPT. For example, we might speculate that enabling us to
have this much choice over the children that are born will lead to
more technology, and an even greater degree of control. If we specu-
late about a possible future where technology has advanced to the
point that it is routine to select from a shopping of list of traits for
your future child, then that might give us an argument for restricting
this liberty, so as to avoid this future.

Distinguishing between the different forms of freedom that are
relevant to NIPT is an important part of the picture. The freedom of
pregnant women to access technologies such as NIPT needs to be
distinguished from the freedom to be in a society where the negative
features of disability are minimized, and the freedom to raise a child
in a society where their disability does not count against them.
Another important distinction is between screening and diagnosis.
At present, NIPT does not meet the standards required for the
diagnosis of foetal abnormality (although it is likely that as it develops
it will), but should instead be considered a 'screening' test (Snelling
et al. 2016), so making a distinction between 'diagnosis' and 'screen-
ing' is important for practically normative bioethics about NIPT.

Anencephalic Babies and the Dead-Donor Rule

As an example of how bioethics is, and should be, practically norma-
tive, speculative, and should draw distinctions, I will revisit the main
arguments developed during the 1990s debate about harvesting
organs from very disabled infants. Anencephaly is a condition
where babies are born without large portions of their skull, cranial
vault, scalp, and cerebral hemispheres. It's a condition so severe that

infants are offered comfort care only, and they die soon after birth (Moore 2010).

While anencephalic infants lack essential parts of their brain and skull, the rest of their organs are not affected, and could be used to save the lives of other babies who need organ transplantation. However, that raises a difficult ethical issue about whether organs should be harvested from infants who not only cannot consent but will never develop the ability to consent.

This is further complicated by the fact that harvested organs will be much healthier if they are removed from a donor while the donor's heart is still beating and receiving a normal blood flow. However, that involves stopping the heart of the anencephalic, which would appear to violate two important ethical considerations: the sanctity-of-life doctrine and the dead-donor rule (the idea that life-sustaining organs should only be harvested from a donor who has been declared dead). Both of these ethical concepts have to be defined carefully, and then tested, as they play an important role in whether harvesting organs from anencephalic babies can be justified.

As Shinnar and Arras observe, a solution that would enable organs to be harvested, and for the dead-donor rule to remain intact, is to reconsider how we define death (Shinnar and Arras 1989). Anencephalic infants lack almost all higher brain areas, but have an intact brain stem. So, if the concept of brain death is defined so as to cover the permanent cessation, or absence, of higher brain activity, then anencephalic infants would already be considered dead, despite the beating of their heart and respiration. Their organs could then be harvested without violating the dead-donor rule. However, a major drawback in redefining brain death in such a way is that brain death would become even more different from our ordinary concept of death. While we might argue that an anencephalic infant does not and will not have 'a life', it's clear that when they are born alive, they are alive and not dead.

For the purposes of understanding the methodology of bioethics, this is an example of what I refer to as 'drawing distinctions'.

Redefining brain death as the permanent cessation of brain stem activity, as opposed to whole brain death, is an example of redefining a concept for the purposes of furthering an ethical argument. A more subtle form of 'drawing distinctions' is the way in which stipulating brain death to be cortical death might end up causing the concept of brain death to part company with features that we think essential to our ordinary concept of being 'alive' as opposed to 'having a life'. That particular distinction has played a pivotal role in important arguments advanced by Jonathon Glover and Ronald Dworkin (Glover 1977; Dworkin 1993).

In 1987, Loma Linda Medical Centre introduced a protocol where anencephalic infants were kept alive and monitored with the intent of determining whether whole-brain death had occurred, at which point their organs could be used for transplantation (Willis 1990). Twelve infants were entered into the protocol, six of whom were actively treated for a week, after which further resuscitation was not performed. Five of these infants died soon after active treatment ceased, but one lived on for several weeks (Shinnar and Arras 1989). The other children were not given active treatment and were monitored until brain death occurred. The Loma Linda protocol did not result in any donor organs being harvested. Autopsies revealed that the infants who had been actively resuscitated had organs that were potentially salvageable, but the infants who had been allowed to die from birth had damaged organs.

This raises another ethical issue about what it is permissible to do to a very disabled infant so that its organs are in a better state to save another infant. If the whole-brain-death criterion results in resuscitation being inflicted upon a disabled infant which is not for that infant's benefit, it would be less harmful and more honest to simply consider them dead and not attempt resuscitation. The Loma Linda experience showed that the whole-brain-death rule made the harvesting of organs from anencephalic infants unfeasible (Goldsmith 1988). It is also a good illustration of the importance of epistemic humility in bioethics: even when we think there are sound reasons for a course of action being correct, it is often difficult to know until it has happened;

it is also a reason for acknowledging the epistemic advantage of actors in the situation.

Developments in biomedicine were a catalyst for the creation of bioethics, and this is also true of our understanding of death. The ethical complexities of harvesting organs led to the development of the whole-brain account of death, as defined by an expert committee of Harvard Medical School (1968). The committee proposed four conditions for whole-brain death that had to be assessed by a clinician: lack of receptivity and responsivity to all external stimuli; no movements or breathing (including within three minutes of being removed from a respirator); no reflexes; and a flat electroencephalogram (EEG).

As Fost (2004) notes, the Harvard criteria have been criticized on multiple grounds, including the observation that the criteria do not establish the cessation of all brain activity (hypothalamic activity can continue undetected) and that clinical staff tend to view anencephalic infants and other patients in a persistent vegetative state as being brain-dead (Fost, 2004).

If clinical staff view some patients as brain-dead who are not whole-brain-dead, that suggests either that clinical staff are recommending some as organ donors who should not be organ donors or that the whole-brain death definition might be an incorrect account of brain death, or that it might acceptable to harvest organs from patients who are not brain-dead.

The Harvard criteria identifies whole-brain death with the death of the patient, partly for legal reasons: physicians are able to declare a person legally dead, and once a patient is legally dead, the patient cannot be killed. However, there are reasons for doubting that brain death is the same concept as the death of the person. It seems plausible to suppose that when a person is rendered brain-dead after a traumatic head injury, their life is, in an important sense, over. They will not think, plan, experience, value, or love ever again. However, it is plausible to describe a person whose life is over as still being alive, in a case where their heart continues to beat and they continue to breathe. Defenders of the sanctity-of-life doctrine insist that merely

being alive is sufficient for the obligation to not kill an innocent to be invoked (Keown 1997). So, for Keown, distinguishing sanctity of life from quality of life in this way plays a critical role in his view about organ harvesting from anencephalic infants.

Another strategy that aims at retaining the dead-donor rule and permitting anencephalic infants to be harvested is what Sytsma (1996) calls the 'inapplicability' argument. In essence this is the argument that because the anencephalic never had, and never will have, a functioning brain, the concept of whole-brain death doesn't apply, as they did not have a whole brain to die off. Something that has never been cannot cease to exist, so it is impossible for the whole brain of an anencephalic infant to be considered dead. This can be considered a speculative form of argument, as it poses a speculative 'what if' to generate an analogy that can be used as a point of comparison.

Nonetheless, Sytsma thinks this argument is spurious because anencephalic infants have a brain stem, which means there is neurological activity that would be detected by an EEG, along with reflexes, movement, and some degree of receptivity, so they clearly do not meet the criteria for whole-brain death. This is another instance of 'drawing distinctions': it is an argument that considers the properties essential to a concept and then argues about whether or not they are present.

It might be that the 'inapplicability' argument could be bolstered in another way, perhaps by adding a scope condition to whole-brain death: these criteria only apply in cases where there was, or could be, a functioning whole brain. Stipulating a scope restriction such as this would imply that the concept of whole-brain death does not apply, and an anencephalic infant can simply be considered not alive. This kind of argumentative strategy is another way in which we can 'draw distinctions' in moral argument. Instead of arguing about the meaning of a concept, we can argue about its scope of application.

It might be objected that this kind of scope restriction will not work, as the relevant thing should be whether or not a patient has some of the properties thought to rule out whole-brain death, and it is

ad hoc to rule out a specific instance where a concept appears to apply. This objection could be countered by 'speculative reason'. Suppose that it is true that the presence of one or more features of the whole-brain-death account establishes that a brain is not dead. That implies that when one or more of the whole-brain-death properties are present that something is alive: something is either alive or dead. Frogs have reflexes, they move, are receptive to the environment, and presumably would have some neural activity that could be measured by an EEG. It follows from Sytsma's account that frogs are not brain-dead and that we, presumably, should not harvest their organs. This is an example of speculative reason, because it involves imagining an example that follows from an account that leads to absurdity. I will say more in later chapters about the forms of speculative reason that are useful in bioethics, but for now it is important to note that this is a Socratic mode of argumentation and one that is powerful and central to bioethics.

Slippery-slope arguments are common in bioethics and they were a feature of the debate about changes to the dead-donor rule. Willis expresses the worry that changing the scope of the dead-donor rule or the whole-brain-death criteria will lead us to using adults who have not consented to being an organ donor and retain brain stem activity (Willis 1990). In a later chapter I will say more about different forms of slippery-slope argument and evaluate their strengths and weaknesses.

Arguments about the relevance and limits of parental autonomy were also a feature of this debate. Koenig describes the case of anencephalic Baby Theresa, whose parents wanted her to be an organ donor after she was born anencephalic (Koenig 1992–3).[2] Baby Theresa was able to breathe on her own, and with a small woollen cap that concealed the fact that her skull contained only a brain stem, she appeared much like any other sleeping infant. Koenig observes that all parents of children with disabilities are required to

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[2] This case is also discussed by Rachels (2006).

make greater effort than is usually the case for a child without a disability. The judgement that Baby Theresa is a non-person and therefore the kind of entity that could be killed, without this constituting the crime of homicide or infanticide, is a radical change to the way in which parents ordinarily view their offspring. Admitting that the strong and important duties that a parent has to its child can be defeated is a radical departure from an important set of duties, and could result in other disabled children likewise being dismissed as non-persons. There is more to this argument than merely being another slippery slope; it includes within it conceptual analysis of the moral duties that are implied by one agent to another in virtue of the relationship in which they stand. While virtue ethicists, the ethic of care, and other moral perspectives that emphasize the importance of relationships for ethics tend to be sensitive to that kind of consideration, more extensive use of this kind of argument would enrich bioethics. A problem with theoretically driven approaches to bioethics such as utilitarianism is that they can deflate the importance of agent-relative considerations such as this. A greater emphasis upon arguments of this kind would enrich bioethics and lead to more nuanced and fuller analysis for many issues.

Note that we can analyse the nature of the obligations that a parent usually has to a child without making reference to any moral theory. The strength of this kind of argument does not rely upon it being justified by a moral theory or principle. Whether or not we accept the implications of this argument depends upon whether we think the parents of Baby Theresa are departing from parental duties in a justifiable way. We could engage in speculative reason and consider what we would say about a case where, instead of appearing like any other baby, but wearing a woollen cap, they had an unnamed mass of living cells which was self-sustaining and appeared more like an organ. In a scenario such as that, would parents be judged as unjustifiably departing from usual parental duties if they decided the mass of cells should be used for some good?

The debate over NIPT demands that bioethics be empirically informed, make distinctions, and engage in speculative reason when

bringing moral reason to bear upon NIPT. The complex and vital moral questions that are features of the debate about harvesting organs from anencephalic infants were addressed by a range of argumentative strategies that are instances of speculative reason and drawing distinctions. Drawing distinctions, such as considering whether a concept can be redefined so as to avoid an implication, as well as fully explicating what is involved in a moral concept, are powerful and useful argumentative tools. Speculative reason played a crucial role in exploring the implications of proposed solutions. The anencephalic donor debate illustrated vividly how empirical engagement is critical for good bioethics: without understanding factors such as the nature of a condition, the clinical course that a condition might take, or possible treatments, there is a grave risk that bioethics could argue for conclusions that are incorrect because they rely upon false information, or, more benignly, end up being irrelevant because they do not understand and engage with the relevant moral issue. Another striking empirical feature of this issue is that it was created by new developments in biomedicine, was an issue that demanded serious ethical analysis, but ultimately became much less of an ethical issue within a few years as the result of further developments in prenatal testing.

The way in which moral reason interacts with complex empirical issues has implications for how bioethics should proceed and the way in which bioethicists should view any conclusions they reach.

The complex interplay between moral reason and the empirical suggests that conclusions in bioethics should be tentative. That is not to say that bioethics shouldn't aim at ethical recommendations about what should be done; I am strongly of the view that bioethics essentially is about, and should aim at generating, solutions to practical ethical issues. However, the complexity, fallibility, and possibility that there is more than one defensible solution to a moral problem mean that bioethics should be conducted with epistemic humility. While the problems of bioethics should be taken seriously, epistemic humility is crucial for bioethics and all conclusions should be viewed as fallible.

Epistemic Humility and Philosophy

Earlier in this chapter, I introduced an important element of the Cartesian tradition: the radical scepticism used by Descartes as a means of working toward a foundation for knowledge (Descartes 2008). The degree of rigour that such scepticism implies could be taken as a reason for attaching confidence to philosophical positions that survive such philosophical interrogation. Of course, that's exactly what Descartes intended: he hoped to have found certainty. However, even the very basic truths that Descartes thought he identified have been questioned, and it is generally conceded that all philosophical positions should be argued for rigorously, but held with a degree of epistemic humility.

It is the nature of philosophical positions that anything worth saying or arguing for is likely to be controversial. The history of philosophy is replete with examples where what was taken to be ontological or epistemic bedrock has eventually be shown to be problematic or false. There is no better example than the brilliant David Hume, who developed, via penetrating and rigorous argument, the full implications of eighteenth-century British Empiricism. But even a philosopher of Hume's genius tripped up on the major assumption of his day: that all knowledge arises via the senses (Hume 1946). This is why, while philosophy is rigorous, all philosophical positions should be treated as provisional, and with a degree of humility.

In her defence of Kant's account of humility, Jeanine Grenberg describes it as

> that meta-attitude which constitutes the moral agent's proper perspective on herself as a dependent and corrupt but capable and dignified rational agent.
> (Grenberg 2005: 133)

Kant and Grenberg are concerned with humility in the context of rationality and ethics, so the idea that we are 'dependent' and 'corrupt' refers to the way in which we all fail to act consistently upon law-like considerations (Kant 1998a). Humility, on this account, involves an acknowledgement of the likelihood that we will fail to do what

we should, but also the claim that we can and should aspire to do the right thing.

Epistemic humility is a similar concept, in that we should be aware of our fallibilities with respect to knowledge and our methods for reaching it. However, epistemic humility does not imply that we should not strive rigorously toward knowledge; it is the obligation to be aware of the possibility that even very well-justified views often turn out to be false. Philosophical rigour should therefore not be confused with intellectual hubris: it is possible and desirable to pursue philosophical inquiry with great rigour and defend views as if they are true, even though it has to be conceded that they very well might be false.

Epistemic Humility and Moral Theory

Within philosophy, moral theory has some particular features that mean humility is appropriate. For the classic problems of metaphysics, epistemology, or logic, the methods available are often different from moral theory.

A logical proof can be shown to be valid or invalid. A metaphysical theory about time could be shown to lead to an absurdity. An epistemic theory about knowledge can be shown to be false via a Gettier case counterexample (Gettier 1963).

While these kinds of methods do occur in moral theory, it usually grounds arguments in accounts of how we reason about morality. For example Mill's proof of the principle of utility (Mill 1998) claims that happiness is the ultimate end of action, which is in effect a claim about our moral psychology. He attempts to use that claim to argue for rightness consisting in the greatest happiness. What's relevant methodologically is that this is an argument that attempts to gain justification from how our actions ordinarily are.

Kant's methodology in the *Groundwork* is similar in that he attempts to isolate via transcendental argument (an argumentative strategy that I will return to in Chapter 10) to isolate the preconditions of morality (Kant 1998b). Some of the moral conclusions Kant reaches are ones that

many would disagree with, for example his absolutism about not lying (Kant 1949). However, his method is what is relevant for my present purposes, and he takes himself to be defining concepts that we would have to act upon were we to be moral. In other words, what does our ability to make promises require to make promise-keeping possible? His answer is that it presumes promises will always be kept—otherwise it simply doesn't make sense to make or agree to promises. While Kant is not appealing to our moral psychology in the straightforward way that Mill does, whether or not his moral theory is correct depends upon his giving the correct account of what makes morality possible.

I explained G. E. Moore's open-question argument when discussing the fact/value spectre (Moore 1903). At first sight, Moore's insistence that whenever someone attempts to identify a property such as beauty with something naturally in the world, such as the paint strokes on a portrait, there is an open question about whether the paint strokes are in fact beautiful, and that appears to be a straightforward example of defining what a concept means. That is, when we try to define beauty as the paint strokes of the portrait, we fail. However, even in this case, the open-question argument works by an appeal to how we ordinarily use non-natural (including moral) terms, which is similar to Kant and Mill trying to ground morality in an analysis of what we do.

The relevant point to grasp is that the methodology of normative moral theory usually builds upon our moral psychology, or the moral concepts we use. Our knowledge of our moral psychology is fallible, as is the analysis of our moral concepts; so that implies that all normative theories should be adopted, if adopted at all, with a healthy degree of epistemic humility.

Epistemic Humility and the Additional Complications of Bioethics

The scope for dependence and corruption within bioethics is even broader than it is for philosophy.

There is the additional complication that one way to distinguish bioethics from applied ethics is that the former tends to involve a number of disciplines. That alone means that the different emphases of disciplines result in the potential to talk past each other and squabble over theoretical approaches. This is another reason why bioethics should view moral reason and argument as the method for bioethics, and not fall into the habit of reverting to discipline specific theory. An emphasis upon speculative reason and drawing distinctions can enable bioethics to bridge disciplines.

Perhaps even more significant than theoretical differences are disputes about which issues bioethics should focus upon. As Battin (2013) noted, the ethics of clinical cases is one of the bread and butter areas of activity for bioethics. Some sociologists have criticized this as an area of activity that fails to acknowledge, or be sensitive to, the social and institutional structures that influence and create a role for clinical ethics case analysis (Chambliss 1996).

Others have criticized more philosophical bioethics for being much too reactive about the issues it considers. Rather than seeking out the issues that require attention, bioethics tends to focus upon the issues that it is invited to comment upon, without being cognisant of its reason for being asked to do so (Vries 2004).

A feature of the debate about using anencephalic infants as organ donors is the importance of biomedical information for understanding the nature of the ethical issues. This meant not only that the debate involved detailed knowledge of relevant facts, but also that its subject was something worthy of debate, contingent upon the circumstances that led to this being thought a possibility. Once difficulties were discovered at Loma Linda, including the impact organ harvesting had upon parents and the decrease in the number of anencephalic infants being born, it ceased to be an issue that justified as much attention. The contingency of the issues discussed by bioethics is another reason why epistemic humility is important.

The development of bioethics and an increased prominence of medical law has changed the nature of medical decision-making, so that what was once solely up to a clinician, and private, is now much

more public. The changes in the United States are such that David Rothman claimed that physicians are now 'strangers at the bedside' (Rothman 2003). Academic lawyers such as Ian Kennedy (1988) argued forcefully that physicians have no special expertise in ethical matters and should no longer describe what are clearly moral matters as medical decisions. However, when bioethicists are involved in clinical issues—or for that matter, in any issue where there are experts—the ability of bioethics to be morally authoritative is severely constrained. Charlotte Paul has objected to the way in which the traditional internal morality of medicine was viewed as unsalvageable, and in some contexts replaced with a morality 'external' to the practice of medicine (Paul 2000). Whatever is made of that debate, there is no doubt that complex domains like medicine involve expertise that someone 'external' to that domain will find hard to grasp. This is another reason why epistemic humility is important to bioethics.

In summary, epistemic humility is critical for good bioethics. The reasons for this are many and varied and they include: that bioethics is interdisciplinary, that it discusses issues that require detailed and accurate information, and that it enters into domains where others have special expertise. In the final section of this chapter I will, following Kant, explain why it is that I think bioethics must involve the conceptual and the empirical.

A Kantian Argument for Why Bioethics Must Involve Concepts and the Empirical

In *The Critique of Pure Reason*, Kant claims:

Our nature is so constituted that intuition with us never can be other than sensuous, that is, it contains only the mode in which we are affected by objects. On the other hand, the faculty of thinking the object of sensuous intuition is the understanding. Neither of these faculties has a preference over the other. Without the sensuous faculty no object would be given to us, and without the understanding no object would be thought. Thoughts without content are void; intuitions without conceptions, blind.

(Kant 1998a: A51/B76)

Kant makes two important points here. First, that without reference to the empirical, rationality that consists only in the manipulation of concepts will fail to be about experience. So when he describes thoughts without content as 'void', he means that without perceptual interaction or some kind of content, our thoughts would be empty.

Second, without concepts we cannot have meaningful perceptions or thoughts. So, it is impossible for us to perceive beauty in the portrait without a concept of beauty that enables us to see what is in the painting. Likewise, it is impossible for me to have thoughts about the grey cat sleeping on my bed without having the conceptual apparatus to think of my cat as 'a grey cat' and the bed in my room as 'my bed'.

When this extended to the moral domain it implies two important things about ethics. First, that armchair ethics, or ethical argument that does not engage with experience or fails to be practically norma- tive, is less contentful than ethical argument that is grounded in the world. So whether it is empirical ethics or some other way of ensuring that bioethics is well grounded in the issues it seeks to address, it is important that it connects with reality so as to be as meaningful as it can. I've already argued for the view that good bioethics is practically normative; Kant's observation about the relationship between mean- ingful perception, concepts, and the world is a more theoretical argument for why this should be the case.

Secondly, meaningful, issue-driven bioethics requires sophisticated conceptual approaches. So, it is never enough to simply engage empirically or normatively with an ethical issue in order to under- stand it in a nuanced and a sophisticated way; it is also necessary that the moral concepts informing experience should be sophisticated, apt for the issue, and well described.

What follows from this is a conception of Socratic reason in bioethics that necessarily involves the conceptual and the empirical. In the remaining chapters of this book, I will describe a set of argumentative techniques that can enable bioethics to bring moral reason to bear on ethical issues in this full, conceptually sophisticated, and grounded way.

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7

What Is an Ethical Argument?

There are reasons for a degree of scepticism about the utility of expressing arguments about bioethics in the form of a syllogism (a formal way of expressing the premises and conclusion of an argument). One is that basic syllogisms are usually constructed so that they are logically valid arguments: the truth of the conclusion follows from the truth of the premises. Valid arguments are rare in bioethics, and even when they are formulated they tend to be trivially true. A second reason is that it is more realistic to view 'cogency'—the idea that an argument includes relevant considerations that give us reason for thinking that the conclusion is likely to follow—as more relevant to bioethics than validity.

Nonetheless, syllogisms can have pedagogical value for bioethics as a way of explaining different argumentative strategies, and given that this is what the next four chapters of this book will be devoted to, it's useful to begin with a discussion of syllogisms and bioethics.

Perhaps the most well-used syllogism in first year philosophy classes is the following.

Syllogism 1
1. All men are mortal.
2. Socrates is a man.
3. Therefore Socrates is mortal.

A premise is simply a consideration or piece of evidence that supports a conclusion, while the conclusion of an argument is what the premises show. In this syllogism, (1) and (2) are the premises and (3) is the conclusion. It is a valid argument because if (1) and (2) are true, then

it follows that (3) is true. If an argument is valid and has true premises, then we can describe that argument as being 'sound'.

It is worth noting a difference between premises (1) and (2). Premise (1) is a general statement about a feature that all men have: they are mortal and will die. It is such a general statement because it includes what is often called a 'universal quantifier': the term 'all' means that this claim should be true in every instance. Logically this implies that there cannot be one instance of a man being immortal anywhere, or at any time. If an immortal man is discovered, then premise one is false.

When constructing arguments in bioethics, or critically engaging with the arguments in bioethics, it is always prudent to be alert to scope of quantifiers such as 'all', 'any', or 'every'. If the evidence supports such a strong assertion, then it should be made, but their strength is such that it only requires one contrary case to make the claim false. In the next chapter I will explain the argumentative strategy of 'counterexampling'. This is, quite simply, attempting to find an example that runs counter to a general claim that has been made.

Premise (2) is a factual statement about a specific person. In this syllogism it might appear close to trivially true, and we are likely to just concede it. However, it is not necessarily true, in that it is possible that Socrates is not in fact a man, but a god, or a ghost. A stronger objection is to point out that, strictly speaking, Socrates is not a man, as he has been dead for over 2,000 years. He was a man, but he isn't any more. I will return to the importance of subjecting what appear to be straightforwardly true factual statements to rigorous criticism, as it is a particularly useful strategy for those coming to bioethics with expertise in science. When scientists identify the factual premises in an ethical argument, and then subject that to critical appraisal, they can make original and important contributions to bioethics.

I mentioned that simple, valid syllogisms are uncommon in bioethics, and they often appear trivially true. Nonetheless, they can be constructed; consider the following ethical syllogism.

Syllogism 2
1. Clinical research cannot be ethical without the informed consent of research participants.
2. Children under the age of about 12 are incapable of giving informed consent.
3. So, clinical research on children under the age of about 12 is unethical.

This is a valid argument: if (1) and (2) are true, then it follows that clinical research on children under the age of 12 is unethical.

However, there are compelling objections to both of the premises that mean that although the argument is valid, it is not sound because the premises are controversial. There are some who would claim that premise (1) is true: we really should not conduct clinical research upon people who have not given consent. Given the potential harmfulness of some clinical research, and the consequences for people when clinical research goes awry or is unethical, it is reasonable to think there should always be consent. Nonetheless, not allowing exceptions to this general rule would result in a number of harmful effects. First, it would mean that we would treat children and other patient groups that cannot consent, such as those who have had a stroke, without having evidence about the side-effects or benefits, if any, of pharmaceuticals. For reasons such as these, exceptions are made to this rule and the World Medical Association (WMA) has produced guidance for when this is acceptable (World Medical Association 2013).

In Chapter 5 I emphasized the importance of Hume's point about it always being necessary to have a moral premise in order to reach a moral conclusion. Premise (1) makes a claim about what is unethical, and that is what enables this argument to have a valid, normative conclusion.

Premise (3) is controversial as well. Children under the age of 12, particularly those who have been living with a chronic illness for most of their lives, often have a sophisticated understanding of treatment options, and are capable of making an informed (albeit with parental support) decision about participation in a clinical trial.

Exceptions of this kind are common in bioethics, due to the complexity of the issues that we discuss. Consider the following, which is a weaker variant of syllogism 2.

Syllogism 3
1. Ordinarily, clinical research cannot be ethical without the informed consent of research participants.
2. Children under the age of about 12 are less likely to be capable of giving informed consent.
3. Some clinical research is consistent with therapeutic obligations to children.
4. So, there is a case for some clinical research being conducted on children under the age of about 12.

The premises are (1), (2), (3), and the conclusion, (4). Premise (1) states a presumption that it is only in special cases that research can be conducted upon people without their consent. That implies that there needs to be an additional, adequate justification in order for this to occur.

Premise (2) is a modified version of, and more likely to be true than, premise (2) in the earlier version of the syllogism. It says that in general we should be cautious about the ability of children below the age of 12 to be capable of consenting to a clinical trial, but that it is not something that should be completely ruled out.

Premise (3) is, in effect, a qualifying condition that specifies the kind of consideration that would be a justifiable exception under premise (1).

The conclusion does not necessarily follow from the truth of the three premises, so this is not a valid argument and cannot be considered sound. However, the premises seem plausible and offer support for the conclusion. The term usually used for an argument in which the premises seem true and provide support for the conclusion falling short of validity is 'cogency'. Often in bioethics the best that we can do is produce cogent arguments—ones that provide evidence for the truth of a normative conclusion.

Building a Case

For those starting out in bioethics, it can be hard to know how to go about writing the first essay or article. A helpful way to begin is to think about how articles work in other disciplines, including the sciences. Scientific papers will often include a null hypothesis (the idea that there is no relationship between experimental phenomena) and then proceed by using evidence established in an empirical study of some sort, in an attempt to disapprove the null hypothesis. While this appears very different from how bioethics should work, it is in fact not so different.

A scientific article attempts to disturb the null hypothesis by building a case that is based upon a well-designed and conducted experiment. While bioethics ordinarily doesn't involve experiments, the core idea of mustering the best available evidence you can in favour of a claim is common to all scholarly endeavours. The nature of the claims, and the best way of making a case for them, varies depending upon the kind of claim. Nonetheless, bioethics has this feature in common with science.

Syllogisms are ways of clearly laying out the structure of an argument, and like the scientific method, they are a way to clarify and put forward the considerations in favour of a claim.

Picking an Ethical Question or Claim

Selecting a hypothesis and null hypothesis in science is a critical first step, because the design of an experiment follows from the hypothesis that the experiment is about. Bioethics should be just the same: the ethical question selected, and what's required to provide an attempted solution to it, should drive the considerations that are mustered in support of it.

It's important to consider carefully whether the issue should be articulated as a question or a claim. It's usually important to think carefully about whether the issue is one of permissibility (i.e. should people be permitted to do this?) or morality (is this something that we

should view as moral and therefore required for moral acceptability?). For example, it might be that there are some moral objections to selecting the sex of one's children for reasons of family balancing, for example that it creates an unnecessary risk to the next child planned for a family. But it could also be that, while there is a moral objection, it is not sufficiently weighty to entail that public policy should be formulated that stops people from using reproductively technology in this way.

A risk for bioethics is that we select issues because they are of current media interest and when others are writing about them, neglecting issues that have an impact upon people's lives and matter. While it can be valuable to contribute to an ongoing debate about sentinel issues such as reproductive technologies or euthanasia, it is also worth thinking creatively about ethical questions that matter which have not been subjected to ethical analysis.

An example from my own work is the analysis I conducted of the castration of sex offenders in the Czech Republic (McMillan 2014). This was an issue that had not been discussed in the bioethics literature, yet was an important issue for the people involved and the European Union. I decided that this was an issue that should be analysed in more depth after reading reports by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) on castration being offered to convicted sex offenders in the Czech Republic (CPT 2009) and Germany (CPT 2012). The governments of the two countries responded, and attempted to rebut the finding that they offered degrading treatment.

When I read these reports, it was clear that neither the CPT nor the governments had fully grappled with the ethics of offering castration to sex offenders. Moreover, while there were some articles analysing the legal issues raised by castration, there were none that carefully worked through the ethical issues and reached a conclusion; so that was one of the reasons that I decided that it was a good issue to address.

While castration is not a public policy question that impacts upon a large number of people, it raises important issues about coercion. It also mattered because of the criticisms made about the Czech and German governments promoting unethical practices. Finally, it might result in therapy that could help prevent sexual offending not being offered to others outside the Czech Republic and Germany when there was no sound reason against it.

Constructing a Syllogism

Although I didn't create a syllogism when structuring that article, it is something that is worth doing when coming to grips with a complex argument. Creating a sequential representation of an argument is a way of checking that the considerations given in support of a claim do in fact build a case for that claim. We should try to make the strongest claims that our evidence implies, but it is also very important to check that inferential terms such as 'all', 'some', and 'every' are not over-stated, as an error there can provide an opportunity for a claim to be 'counter exampled'.

Think Creatively About All of the Issues That Might Be Relevant to That Question

Clarity about the ethical question, and how a case for it can be built, can then aid thinking creatively about issues that are relevant to that question which were not initially part of the argument. In my work on castration, I started to think about the link between changes in hormonal levels and the extent to which that influences behaviour. I was alerted to a dialogue at the beginning of *The Republic* in which two characters discuss the consequences of old age. One character remarks that it can bring a relief from the tyranny of many mad masters, meaning that we tend to be more impassioned when younger. I used that as a way of drawing an analogy between how castration might lead to behaviour change due to a drop is testosterone levels and how that occurs naturally in men as they age.

This is an example of what I call speculative reason, and in the next chapter I will describe a number of variants of this argumentative technique.

Think About Which Parts of the Argument Are Easy or Hard

Once there is clarity about how to build a case for a claim, it is often worth thinking about which parts of the argument are likely to be hard, and which can be shown more easily. The hard steps in an argument are potential weak points, and it makes sense strategically to be as thorough with these as you can.

In syllogism 3, premise (2) would require some careful support— and note also that it is primarily a factual premise. It would involve looking at the literature on children's decision- making and also relevant guidance about the legal standard for mature minor decision making: there might be some jurisdictions where there simply isn't a legal basis for this, in which case the argument would have to be refocused, perhaps upon what should be the case in that jurisdiction.

Questioning and Examining Factual Claims

Moral disagreements are not always over questions of value. In syllogism 3, most are likely to think that moral premises (1) and (3) are reasonable, and there shouldn't be too much disagreement over them. Premise (2) is a statement about the decision-making ability of children under the age of 12; that's a more factual premise that requires a discussion about what the evidence shows.

Clarifying the clinical facts, in the sense of what is known about a patient's condition, is an important first step in clinical ethics. Look- ing for points of disagreement about factual premises is a helpful strategy for scholarly bioethics too. Take for example the debate over the Ashley treatment. Ashley's parents wanted to be able to continue to care for her in their home. She had severe developmental delay and a range of disabilities that meant she would never develop cognitive abilities beyond those of an infant, but her body would continue to grow until she reached the size of an adult woman. Ashley was given

therapy that would stunt her growth so that she would remain at a size that her parents could manage in their home (Kerruish 2016). There are a number of ethical arguments for and against the treatment Ashley was given, but one crucial claim was that they would be unable to care for her at home if she continued to grow.

Is it true that Ashley's parents would not be able to care for her if she continued to grow? Note that the answer to this question is an empirical one, and if it is not true, then the case for this radical therapy is undermined. If it is true, then given that what quality of life Ashley seems to have consists in the physical contact and care she has from her parents, the case for this therapy is stronger.

A first response to this might be to point out that there are lifting aids that could be installed in the home, or that Ashley's parents should be offered support so that they could continue to care for her at home. These seem plausible, and it is not until what is in fact possible within the home is determined, and what the consequences of using lifting aids would mean for Ashley, that the plausibility of what her parents said becomes apparent. In a similar case in New Zealand, an interview with the parents of a child with serious developmental delay revealed that lifting aids would be unrealistic because of the number of times a day a child such as Ashley needs to be moved. For such severely disabled children, the physical contact of being lifted and moved by their parent seems to be what gives them pleasure in life, and aids would remove the physical contact that they need (Kerruish and McMillan 2015).

This example illustrates how important it is to identify the empirical premises in an ethical argument and consider them closely. It also suggests a strategy for those coming to bioethics with expertise in a health care profession, science, or some other discipline. In this case, knowing the realities of what is involved in caring for a severely disabled child implies a kind of expertise that can greatly enhance ethical debate. So, for those coming to bioethics with a background in a health profession or science, a useful strategy is to examine closely the empirical claims that are being made, to see whether they are realistic. This is a way that those who do not have much experience

in arguing about ethical concepts can make important contributions to bioethics.

There are instances of good bioethics where the argument focuses solely upon an empirical assumption that is highly relevant to an ethical argument. In England and Wales, the issue of whether artificial nutrition and hydration (ANH) should be withdrawn from a patient in a persistent vegetative state (PVS) is usually based upon whether it is in the best interests of that patient to continue being kept alive. Kitzinger and Kitzinger (2015) interviewed the family members of 51 patients who had been in PVS. They found that even when family members thought that it was not in the best interests of their loved one to be kept alive in that state, they did not agree that the withdrawal of ANH was justified as a way of letting them die. Kitzinger and Kitzinger correctly point out that this implies that those arguing about the ethics of withdrawing ANH should attend to the way in which people die after ANH has been withdrawn, as well as whether it is in their best interests to continue being kept alive. So, this is an example of good bioethics, because it is practically normative, but one where the argument is relatively simple and more effort has gone into conducting high-quality interviews that support a factual premise.

Minimize Your Theoretical Assumptions

In Chapter 3 I considered whether approaches to bioethics that are prefaced with a qualifier that the argument will be from a particular theoretical perspective are in effect instances of 'special pleading'. My suggestion was that it depends upon whether this is done in order to imply that this is the best approach to the issue or, as often seems to be the case with virtue theory, it is a way of bringing forth an aspect of an issue that might otherwise remain hidden. In either case, prefacing an argument with that kind of qualifier weakens an argument significantly. Consider the following syllogism:

Syllogism 4
1. Coercion in psychiatry usually violates the rights of patients.
2. A virtue theory interpretation of coercion would say that whether or not coercion is warranted depends upon the character of the psychiatrist.
3. Therefore, coercion in psychiatry does not violate the rights of patients when it is performed by a virtuous psychiatrist.

There are different accounts of what coercion is, and it might well be that a virtues-based account of it is an illuminating way of looking at coercion. However, note the way in which premise (2) has weakened the argument. For someone sympathetic to virtue theory, premise (2) might be quite plausible, and they will grant it. But someone who is not sympathetic to virtue theory can simply reject premise (2) without giving much thought to the issue and argument about it. Qualifying the moral argument as being from a specific theoretical perspective has significantly weakened the power of this argument.

As I showed in Chapter 3, Peter Singer's work on issues such as famine and animal rights is overdetermined by his theoretical commitments, and that detracts from the important points he makes. He weakened his argument by using unnecessarily strong theoretical assumptions: i.e. that our beneficence-based obligations to other persons apply equally to all persons irrespective of the relationship in which they stand to us.

In bioethics, at the same time as exercising epistemic humility, we should also be trying to convince as many people as we can that our analysis of an issue is correct. By developing positions to their maximum strength, and then testing them, we introduce rigour into bioethics, and our understanding of issues can deepen and progress.

In 'Active and Passive Euthanasia', James Rachels attempts to counterexample the claim that it always makes a moral difference to bring a death about via an action as opposed to via omission.

Smith stands to gain a large inheritance if anything should happen to his six-year-old cousin. One evening while the child is taking his bath, Smith sneaks into the bathroom and drowns the child, and then arranges things so

that it will look like an accident. In the second, Jones also stands to gain if anything should happen to his six-year-old cousin. Like Smith, Jones sneaks in planning to drown the child in his bath. However, just as he enters the bathroom Jones sees the child slip and hit his head, and fall face down in the water. Jones is delighted; he stands by, ready to push the child's head back under if it is necessary, but it is not necessary. While only a little thrashing about, the child drowns all by himself, 'accidentally', as Jones watches and does nothing.   (Rachels 1975: 79)

I will say more about the strengths and weaknesses of Rachels' argument, but for now we should note something about his strategy. In creating this pair of fictional cases, he has not only tried to make them as similar as he can so as to tease out the distinction he wishes to isolate; he has also made Smith and Jones equally wicked when viewed from the perspective of different normative moral theories.

The consequences, probability of death, and chances of the murder being detected are the same in both cases, so when viewed from a utilitarian perspective, there is no moral difference.

The duties that have been violated in both cases are slightly different, in that, in addition to acting on the intention to murder his cousin, Jones has also failed to save him. Nonetheless, there seems to be an equivalence of sorts in that both have intervened causally, one by acting and the other by watching and being prepare to act, with murderous intent. So, when viewed from a deontological perspective, they are equally wicked.

Both men have equally vicious characters: they are greedy, callous with respect to the life of an innocent, manipulative, and cunning. When viewed from a virtue theory perspective, they seem as bad as each other.

What this means is that Rachels' counterexample to what he describes as the acts and omissions doctrine cannot be objected to on the basis that it is merely a utilitarian, Kantian, or virtue theory argument. That's not to say that we should accept his counterexample, and there are a number of reasons why I think we should not. However, what Rachels has done very effectively is minimize the number of theoretical assumptions in his argument, and thereby maximize the potential for convincing others about his conclusion.

There are other well-known examples in bioethics where assumptions have been minimized so as to make a claim as strong as it can be. In the next chapter I will discuss influential examples from Judith Jarvis Thompson and Jonathon Glover that are designed to work without relying upon their theoretical commitments.

Another way of thinking about the importance of minimizing assumptions is that it is the bioethics equivalent of parsimony in the philosophy of science. Einstein remarked:

the grand aim of all science [...] is to cover the greatest possible number of empirical facts by logical deductions from the smallest possible number of hypotheses or axioms.   (Nash 1963: 173)

A fundamental reason why bioethics should minimize its theoretical assumptions, and the use of normative moral theory, is for reasons of parsimony. Fewer assumptions usually implies greater normative power, in the sense that there are fewer opportunities for opponents to disagree with premises, arguments are more likely to track relevant considerations, and arguments are likely to be easier to grasp and therefore more likely to convince.

Freedom and Harm-Based Arguments

Before moving on to a discussion of speculative reason in bioethics, I will consider a specific argumentative form that has been very influential and is likely to be useful for those embarking upon a journey into bioethics for the first time.

Syllogism 5
1.   A wishes to ϙ (where ϙ is an action of a specific kind).
2.   B doesn't want anyone to be able to ϙ.
3.   A's ϙing will not harm B, nor any other person.
4.   Therefore A should be permitted to ϙ.

Many freedoms have been argued for this way. In *Children of Choice* (1996) John Robertson argues that because reproductive technologies often result in a person being brought into existence who would

otherwise not exist, so long as that person's life is worth living, it is unlikely they have been harmed by that reproductive technology. That fact means that it is difficult to see how reproductive technologies can harm people, so our presumption should be in favour of procreative liberty, even though some would like to restrict access to reproductive technologies.

In my article on the castration of sex offenders in the Czech Republic, my starting point was to see whether prisoners being offered this therapy would result in harm. The answer to that question seems to be no, although that is a contestable conclusion.

When growth attenuation therapy is offered to severely disabled children, a critical issue is whether or not they will be harmed or benefited by that therapy. If they will be harmed, that is a good reason for limiting parental autonomy in this case; but if not, it creates a presumption in favour of parental autonomy because parents are those who will take responsibility for what follows. I noted earlier that critical empirical analysis of whether or not it would be possible for Ashley's parents to care for her at home if her growth is not attenuated is a crucial consideration for that issue. If that kind of empirical investigation is then combined with an argument of this form, someone whose expertise is primarily in an empirical area can create powerful arguments that make a contribution to bioethics.

This form of argument is rarely adequate for addressing all of the relevant considerations in a complex issue. In the case of growth attenuation there are also ethical considerations around what such treatment would imply about disability, whether interventions that seem less medical should be given to people who cannot consent, and whether this is a medical solution to a social problem. Nonetheless, it is often useful when starting to consider a complex issue to begin the analysis by thinking through the relevant liberties and possible harms and then seeing what this initially suggests about an issue.

In the next chapter I will discuss argumentative strategies that fall under the general heading of 'speculative' moral reason.

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8

Speculative Argument and Bioethics

Broadly speaking, speculative arguments are those that pose a 'what if?' question in order to test a position, create an analogy, deepen moral understanding of a situation, illustrate a moral consideration, or simply think through what might happen. This class of argumentative techniques includes many of the most useful strategies for 'making a case' in bioethics, and they are strategies that bioethics shares with law, philosophy, and other disciplines that speculate about possibilities in order to develop an argument.

In this chapter I will distinguish and illustrate six distinct forms of speculative reason that are used in bioethics. These are: speculative practical reason, the counterexample, the argument by analogy, an attempt to deepen moral understanding, the intuition pump, and the heuristic device.

I mentioned in the last chapter that general claims need to framed carefully, because they are an invitation for those sceptical about a moral claim to construct a counterexample. Speculating about a future possible event, or imagining something that might happen which would be inconsistent with a general claim, is a common way in which speculative reason can be used to generate counterexamples. These can developed in the form of thought experiments, but they're also a feature of how we speculate when engaged in everyday practical reason.

Speculative Practical Reason

Suppose that a surgeon is considering treatment options for a 78-year-old woman who is under his care. She has a number of illnesses that are impacting upon her quality of life in a significant way, and it's likely that she will pass away within the next months. Her conditions include hypertension, chronic obstructive pulmonary disease (COPD), and tachycardia, and she was admitted to hospital after suffering an acute myocardial infarction (MI). Her COPD is assessed as being severe, and the surgeon is concerned about her ability to survive any invasive medical procedure, and whether it would be beneficial to her. Her family is very keen that everything should be done, and they insist that she should have a pacemaker inserted, as they have heard that this is often done after an MI. Ordinarily the surgeon would not insert a pacemaker into someone who is so unwell, but to think this through he imagines what's likely to happen in the future. One possibility is that her frail state is such that she does not survive what is a fairly routine medical intervention. Another is that there are complications for her, following the insertion of the pacemaker, that make her worse off than she would have been otherwise. A third possibility is that her tachycardia improves for the time she has left, and her family are content that all has been done.

Thinking through what might follow from a course of action is the paradigmatic form of speculative reason. All of us do this multiple times every day, and it is a core aspect of our practical reason. It's fundamental to our ethical reasoning too, and in the three areas of activity that constitute bioethics, thinking through what might follow from choices is intuitive and sensible. In the case above, whether or not the surgeon's choice turns out to be beneficial to the patient and consistent with her family's wishes depends upon how well he calculates what is likely to happen in the future.

A public policy body charged with deciding whether a new screening programme should go ahead will have to speculate, based upon the best available evidence, about whether the programme will produce

sufficient benefit to outweigh the harm that a screening programme inevitably causes (Raffle and Gray 2007). In the event that the programme does not produce more benefit than the harm it produces, it should be considered unethical.

Speculative reason plays a similar role in scholarly bioethics, and it takes a number of argumentative forms. While there are distinct ways in which speculative reason can contribute to a moral argument, perhaps the most common strategy in philosophy is the counterexample.

Speculative Reason: The Counterexample

James Rachels' Smith and Jones example is an imagined pair of cases that is intended to be a counterexample to the general claim that

killing someone is worse than letting someone die. But is it? Is killing, in itself, worse than letting die? To investigate this issue, two cases may be considered that are exactly alike except that one involves killing whereas the other involves letting someone die. Then, it can be asked whether this difference makes any difference to the moral assessments of the two cases.   (Rachels 1975: 78)

This is an attempted counterexample because we are supposed to agree that there is no moral difference between the wickedness of Smith and Jones. Because Jones did not do anything less wrong than Smith in merely let his cousin die, as opposed to Smith's killing, there is no difference between killing and letting die in this case.

For the sake of clarity I'll express this in the following syllogism.

Syllogism 1
1.   Active and passive euthanasia are morally different because the former involves killing, whereas the latter involves letting die.
2.   Smith and Jones is a case which involves killing and letting die.
3.   There is no moral difference between what Smith and Jones did.
4.   Therefore, it is not always the case that active euthanasia is worse than passive euthanasia.

When viewed in this way, it should be apparent that this is not an especially convincing counterexample. Rachels presumes that in order for there to be a moral difference between active and passive euthanasia, there must be a moral feature of killing that makes killing always worse than letting die. Recall that I explained in Chapter 7 that it is important to be wary of general statements about all cases, as they invite counterexamples. Even if we agree with premise (3) and concede that there is no moral difference between Smith and Jones, why is the conclusion of this argument a problem for those, like the American Medical Association (AMA), who believe that active euthanasia should not be permissible whereas passive euthanasia might? The AMA could simply bite the bullet and concede that in cases such as Smith and Jones, where two people are doing evil things, that need not imply that allowing to die be any less bad than killing. The AMA might also point out that, in general, active euthanasia is riskier than passive euthanasia, and even though there will be cases where active euthanasia is no worse than passive euthanasia, it is better overall to rule out all active euthanasia.

Another response—and this is one that seems to resonate with clinicians—is to point out that, while Smith and Jones are cases of killing and letting die, they are not instances of euthanasia. Even if it is true that the moral difference between active and passive euthanasia is due to the difference between killing and letting die, it doesn't follow that because Smith and Jones involves killing and letting die, these cases are therefore instances of euthanasia. Euthanasia is defined in various ways depending upon the use the concept is being put to, but the term literally means 'easy or good death', and that is obviously not what has happened to the unfortunate cousins of Smith and Jones.

While this is one of the best-known attempted counterexamples in bioethics, it is a surprisingly weak argument once you identify the assumptions that Rachels makes. The speculative reason involved in this counterexample is highly speculative, to the point that it ceases being an example of the relevant kind; but this need not be the case with speculative counterexamples.

Alan Williams was one of the architects of the Quality Adjusted Life Year (QALY), which is a tool designed by health economists for measuring improvements in quality of life that result from health care interventions. In a very influential early paper on the QALY, Williams defined a number of key concepts that follow from the QALY (Williams 1985). A beneficial health care activity is one that produces a positive number of QALYs; a cost-effective health care activity is one in which the cost per QALY is lower than alternative activities; and, more controversially, a high-priority health care activity is one where the cost per QALY is low and a low-priority activity is one where the cost per QALY is high. The last of these definitions is controversial because it means that when we view the health system, the only consideration we should take into account when prioritizing treatments is the cost per QALY. That implies that very expensive treatments are likely to be low-priority, even when they are the only therapy available to a person with the relevant condition.

John Harris identified a problem that results from viewing cost per QALY as the only consideration: this is referred to as the 'double jeopardy' objection, the core of which is a case that is a counterexample to this account of low priority health care activities. Suppose that two people, A and B, are competing for one scarce health care resource. Suppose that A will benefit more from the treatment than B, because B has been in a car accident and is paralysed. If health care should be allocated so as to maximize the QALYs produced, then it follows that A should be treated instead of B. Harris claims that this is double jeopardy: not only was B unfortunate to have been paralysed in a car accident, but her reduced ability to benefit counts against her and she is doubly penalized for her misfortune, and that is unfair. This is an interesting kind of counterexample in that it not only shows that a general claim is untrue but also demonstrates in what respect it is lacking, in this case fairness. It is hard to know whether Harris's objection led to the more cautious role that is given to QALYs—they continue to be an important tool for measuring cost-effectiveness but are generally viewed as one consideration among

many (McMillan et al. 2013)—but this thought experiment was one of the first critical objections to the QALY, and his point is sound.

Speculative Reason: The Argument by Analogy

Arguing by analogy, or on the basis of consistency, is essential in bioethics, where we are often faced with ethical issues for which the only way forward is by thinking about what we consider right in cases that are similar in some relevant respects. Arguments by analogy often take the form 'You think this about A, B is morally similar to A, so you should think the same thing about B.' Dispute about the conclusion often focuses upon whether or not B is 'morally similar' to A.

One area where this arises quite frequently is when thinking about how to calibrate how much harm or inconvenience is required to curtail another agent's liberty. Suppose that a government proposes to preventively detain particularly violent sociopaths, not on the basis of them having been found guilty of a crime, but because they present a danger to the public. This involves a very serious limitation on someone's liberty, so it raises the question of how serious and likely the harm has to be to justify overriding the liberty of a citizen. It is hard to answer that question without reasoning in a speculative fashion, and comparing this deprivation of liberty to other instances where liberty is, or is not, restricted on the basis of preventing harm.

There are some other instances where liberty is restricted and people are temporarily removed from society for the sake of the public's good.[1] One such example is infectious tuberculosis, where the risk to the public is such that, in many jurisdictions, infectious people can be quarantined and treated against their will. Once that comparator is found, relevant differences and commonalities can be explored. Both cases involve a significant deprivation of liberty and both involve harms: the risk of being infected with tuberculosis and the risk of being subjected to a violent assault are serious risks that we

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[1] See e.g. Gavaghan et al. (2014).

would rather prevent, if we can. However, while there are some analogous features, there are a few morally relevant differences which mean that quarantine for tuberculosis is not consistent with preventive detention. In the case of quarantine for tuberculosis, those detained will be treated for tuberculosis, which will benefit them, even if they do not think so. There is a definite period of time for which people will be quarantined: until their infection is under control. A major concern with preventive detention for sociopathy is that it is potentially indefinite: once someone has had their liberty restricted on the basis of their dangerousness, it is unclear how and when a judgement would be made that they were safe enough to have their freedom returned. Finally, the risk of others becoming infected with tuberculosis is likely to be readily quantified, whereas risk assessment, even in cases where someone has a track record of violent offending, is notoriously difficult.

With all arguments by analogy, a judgement has to be made about whether the two situations being compared are similar enough for a moral judgment in one to consistently be applied to the other.

Casuistry is a moral tradition that involves looking to past experience for similar situations and analysing a new situation in the light of past judgements (Jonsen and Toulmin 1988; Jonsen 2007; Arras 1990). There is more to this tradition than argument by analogy:—a casuist is likely to take advantage of a full array of moral concepts and argumentative strategies—but nonetheless a component of it is thinking back to judgements that were made in similar cases, and reasoning through whether they are analogous, in the fashion I have just followed with tuberculosis and preventative detention.

Some instances of speculative reason can involve more than one variant of speculative argument at the same time. Judith Jarvis Thomson's examples in 'A Defense of Abortion' are in part, arguments by analogy, but they also can be considered some other variants of speculative reason as well.

You wake up on the morning and find yourself back to back in bed with an unconscious violinist. A famous unconscious violinist. He has been found to

have a fatal kidney ailment, and the Society of Music Lovers has canvassed all the available medical records and found that you alone have the right blood type to help. They have therefore kidnapped you, and last night the violinist's circulatory system was plugged into yours, so that your kidneys can be used to extract poisons from his blood as well as your own. The director of the hospital now tells you, 'Look, we're sorry the Society of Music Lovers did this to you—we would never have permitted it if we had known. But still, they did it, and the violinist now is plugged into you. To unplug you would be to kill him. But never mind, it's only for nine months. By then he will have recovered from his ailment, and can safely be unplugged from you. Is it morally incumbent on you to accede to this situation? No doubt it would be very nice of you if you did, a great kindness. But do you have to accede to it?

(Jarvis Thomson 1971: 48–9)

The abortion debate tends to stall because of a stalemate over premise (2) in arguments similar to the following.

Syllogism 2
1. Termination of pregnancy necessarily involves the ending the life of a foetus.
2. The foetus has the moral status of a person.
3. We should not be permitted to act in ways that lead to the end of a person's life.
4. Therefore we should not be permitted to terminate pregnancies.

Up until Jarvis Thomson's article, debate tended to focus upon premise (2), and there is a large literature about moral status. Her strategy here is to 'assume the contested premise', which is often a very good way to progress a seemingly intractable disagreement. If you give in to your opponent, and grant for the sake of argument the premise that they think is the clincher, it might be that what they think follows from it, doesn't. In this case, the presumption had been that the foetus has a right to life, and that this would trump a woman's right to choose. Jarvis Thomson, via the violin player case, asks us to reconsider whether we would think that the right to choose really is trumped by a right to life.

This is an analogy because she has tried to create an example that has the relevant moral properties in common with a termination of

pregnancy, with the additional property that the violin player clearly is a person.

The Society of Music Lovers connected you to the violinist without your knowledge or consent. They have instrumentalized you, and used your body with no regard to your preferences or plans, and it is a violation of you as a person. So it seems reasonable to suppose that the analogy here is with a pregnancy that has resulted from rape. There's nothing unreasonable in Jarvis Thomson drawing the comparison in this way, as there are some jurisdictions that will not permit termination of pregnancy, even when it is the result of rape.

If we varied the details of her thought experiment so that, instead of being kidnapped by the Society of Music Lovers, you had been socializing with them one evening, we might have different intuitions. Suppose that you knew that they had a reputation for dodgy medical rescues of this kind and, despite this, had a few drinks with them, relaxed, and vaguely recall a discussion about how it would be wonderful if only someone could be found to help out this incredible violinist. In that variant, our intuitions might change a little. While you still did not knowingly enter this arrangement, you have some responsibility for it in that there were warning signs that were not heeded.

Note also that we might consider this example of speculative reasoning to be a counterexample. Jarvis Thomson thinks that although it would be morally praiseworthy to give up nine months of your life to save the violin player, you should not be required to do so, in this case. So, if those opposing abortion claim that it can never be permissible to end the life of another human being, this is—if we accept what Jarvis Thomson says about this case—a counterexample to that general claim.

Whether or not you think the famous violin player is a useful argument by analogy is likely to depend upon whether you think the obvious differences between this imaginary case and actual pregnancies are such that they are disanalogous. Here are some of the differences that you might think important:

- The gestational relationship between a pregnant woman and a foetus is different from this case in morally relevant ways.
- The violin player case is extremely odd; perhaps that is the reason why we would not expect anyone to continue with such an arrangement.
- The process of disconnecting the violin player is different from termination of pregnancy in morally relevant ways.
- The relationship with the violin player only lasts for nine months. Pregnancy is different not only because is there a gestational relationship, but because the woman will always be at least the gestational and genetic mother of that child.

There will be other reasons why some consider the violin player case to be disanalogous, and that is likely to be the principal way that those seeking to escape Jarvis Thomson's conclusion will attempt to do so.

However, those sympathetic to this example could point out that it is the nature of analogies that they never compare two things that are the same in all respects: if two things are not different in some respects, they are the same thing. Moreover, the violin player and a woman contemplating a termination of pregnancy are the same in the most important moral respects: should she be compelled to spend nine months of her life to enable someone else to have a life?

The law, especially the common law, often argues by analogy. Legal precedent involves looking to past judgements and the legal reasoning they used, so as to tease our how legal precedent applies to a new case. Tony Bland was crushed at Hillsborough Football stadium in 1989, and this left him in a Persistent Vegetative State (PVS). Airedale NHS Trust and Tony Bland's family applied to the court for permission to withdraw Artificial Nutrition and Hydration (ANH) from him so that he could die. It was an important case at the time as there was no legal precedent, and clinicians withdrawing ANH could be found guilty of an offence. The Law Lords ruling on this case had to grapple with challenging arguments and at a number of points argued by analogy. Lord Brown-Wilkinson explained via an analogy how a physician

who withdrew ANH from Tony Bland could be considered guilty of a serious offence.

> a person having charge of a baby who fails to feed it, so that it dies, will be guilty at least of manslaughter. The same is true of one having charge of an adult who is frail and cannot look after herself: Reg. v. Stone [1977] Q.B. 354. It was argued for the guardian ad litem, by analogy with that case, that here the doctors in charge of Anthony Bland had a continuing duty to feed him by means of the nasogastric tube.   (House of Lords 1993)

The analogy is that, on the face of it, withdrawing ANH from Tony Bland is analogous to other instances where people who fail to provide basic care and sustenance to those they have a duty of care toward are guilty of manslaughter. In order to evade the implications of that comparison, the judges found a legal reason why failing to provide basic care and sustenance is different in the case of physicians: that ANH should be considered medical treatment, and physicians have to be able to decide when that is clinically appropriate.

The surgeon who has to decide whether or not a pacemaker should be inserted into the 78-old-woman with severe COPD is likely to reason by comparing this situation to similar clinical situations he has managed. That too is a form of reasoning by analogy. Given that it is such a familiar way of thinking for all of us, it's an obvious place to start when making original arguments about bioethics. While arguments by analogy are one of the basic building blocks of argumentation in bioethics, speculative reason can also work via detailed descriptions that aid moral understanding.

Speculative Reason: Deepening Moral Understanding

Narrative ethics is a popular perspective within bioethics, and those who promote this approach tend to distinguish it from methods that are more philosophical, principle-based, or legal (Montello 2014). The argument in an example of narrative ethics is likely to be less overt than bioethics that is written in a more philosophical style.

Nonetheless, it should not be concluded from this that narrative ethics does not play a role in bringing moral reason to bear upon moral issues. The central aim when engaging with an issue in bioethics is to build a case for a position about it. A narrative approach to scholarly bioethics will often aim at deepening our understanding of a moral issue or situation. Even in cases when narrative bioethics seems to run counter to arguing about ethics, that itself can be read as a kind of objection.

Tolstoy's *The Death of Ivan Ilych* is included as a reading in many courses in bioethics. It is valuable because Tolstoy weaves together so many ethical themes that demonstrate the richness and complexity of many of our most important questions. It is partly about Ivan Illych's illness and fear of death, but also raises profound questions about what gives life meaning, and those things that can blind us to what really matters (Tolstoy 1886). Tolstoy wasn't 'doing bioethics' when he wrote this book; it is a work of literature. Nonetheless, when read within the context of the issues bioethics grapples with, and the need to work toward practical normativity, it illuminates a number of issues that are central to bioethics.

Understanding dying is important for debates about the value of palliative care and the implications that legalizing aid in dying might have for such care. The way in which important preferences and feelings can be transformed during intense human experience is a reminder of the epistemic humility that we should have toward our own apparently settled views, as well those of others. Literature can give us reason to reflect upon such issues; and while reflection isn't enough to constitute doing bioethics, the links that can readily be drawn to ethical issues explain why it fits with the concept of bioethics I have argued for.

The connection between the aims of bioethics and narrative can be seen in films such as *Gattaca*, which explores the lives of characters living in a future where we have much greater control over the genotypes of our children. One of the film's characters has been born with an optimal and selected genotype, yet he has failed to find meaning in life and is paralysed in an accident. The other main

character is born with a genotype that was not selected for and is disadvantageous, yet he thrives and excels, partly as a reaction to the obstacles placed in his way, because his genotype was not selected. Again, while this film is not a work in bioethics, the subject matter and the moral issues it brings to life are fundamental to debates in bioethics.

Julian Savulescu (2001b; 2001a) has argued that those of us who are creating procreative plans have a moral obligation to have the genotypically best children that we can. The arguments he uses are well constructed and appear quite compelling: if it is the case that some non-disease traits do correlate with living a longer, happier life, then what reason could we have for rejecting such a duty? The discomfort that some will feel when considering such a duty is brought to life in narratives such as *Gattaca*, which explores the ways in which selecting non-disease traits could influence important life events, and the overall shape of people's lives. So although some more argumentative work needs to be done in interpreting such narratives, and showing what they mean for debates in bioethics, they can play an important role in deepening our moral understanding.

The Death of Ivan Ilych, *Gattaca*, and books such as *The Handmaid's Tale* (Atwood 1998) are works of literature, and as such can be used to deepen our moral reason: they speculate about the nature of lived experience under a set of circumstances that tease out issues particularly relevant to bioethics.

Speculative Reason: Intuition Pumps

Imaginary cases are sometimes used in philosophy as what we might call 'intuition pumps'. Rather than developing an analogy, counter-exampling, or deepening our understanding, this is a form of speculative reason that works by developing intuitions about a specific case that can help shed light on a broader issue. Intuition pumps are less common in bioethics, as their value seems primarily as a way of shedding light upon a philosophical issue. Nonetheless, there are some famous intuition pumps that, although they are at the periphery

of bioethics as I have described it, are known and referred to in bioethics. They are sometimes used in moral philosophy to tease out intuitions about absolutist moral rules, and it might be that intuition pumps could be used more in bioethics for that purpose.

A party of potholers has imprudently allowed the fat man to lead them as they make their way out of the cave, and he gets stuck, trapping the others behind him. Obviously the right thing to do is to sit down and wait until the fat man grows thin; but philosophers have arranged that flood waters should be rising within the cave. Luckily (luckily?) the trapped party have with them a stick of dynamite with which they can blast the fat man out of the mouth of the cave. Either they use the dynamite or they drown. In one version the fat man, whose head is in the cave, will drown with them; in the other he will be rescued in due course. Problem: may they use the dynamite or not?

(Foot 1967: 2)

This thought experiment is an intuition pump because it aims at drawing out in a vivid way the conflicting moral intuitions we have about taking life to save life. On one hand, it seems intuitively correct that in such a case we should save as many as we can; but only being able to do this by attaching dynamite to another human being and exploding them, intuitively, is wrong.

The doctrine of double effect says, among other things, that we should never intend the death of an innocent human being, and it might be thought that his case illustrates that doctrine. However, double effect only applies in cases where we try to bring about a different, valuable end, and in which we do not use the death of an innocent as a means to that end, but foresee that an innocent might be killed (Uniacke 2007).

So, while blowing up the overweight spelunker might appear at first to be an unintended effect of the others saving themselves from drowning, it does not meet the traditional conditions of the doctrine of double effect for two reasons. First, the death of the overweight spelunker is a means to the end of saving the other cavers, and that is ruled out. Secondly, in order for an effect to be foreseen and unintended, it cannot be merely unwanted. While the other cavers, presumably, do not want to kill him and if there was any other way of

saving themselves they would take it, when they attach dynamite to the body of the overweight spelunker they cannot say that they do not intend his death.

Foot uses this thought experiment knowing that it doesn't capture the doctrine of double effect, but to engage our intuitions about this issue. If we grant her the assumptions about what will happen if they do not explode the man, then it is a choice between killing him and letting themselves die. This brings to life our intuitions about what's involved in such choices—giving up one's life and lives of the other cavers in order to not kill one innocent. It is also a useful starting point for refining our intuitions about cases where the doctrine of double effect does apply. Many are likely to have different moral intuitions about a situation where a physician controls intolerable pain by using a pharmaceutical that is effective at controlling pain but does have a possible secondary effect of hastening death. So long as the physician intends only to control pain, and the hastened death is not intended, nor intended as a mean of controlling pain, then what the physician does seems much more straightforwardly permissible.

Derek Parfit's *Reasons and Persons* is clearly moral philosophy, yet an intuition pump from this book has influenced the way in which bioethics approaches the ethics of assisted reproduction.

The 14-Year-Old Girl

This girl chooses to have a child. Because she is so young, she gives her child a bad start in life. Though this will have bad effects throughout this child's life, his life will, predictably, be worth living. If this girl had waited for several years, she would have had a different child, to whom she would have given a better start in life.   (Parfit 1984: 358)

Intuition pumps are used throughout *Reasons and Persons*, and in this imaginary case Parfit encourages his reader to grasp an important point about the nature of personal identity, and the interests of future people. He asks his reader to consider whether the person born to the 14-year-girl could criticize his mother's decision to have him at this early age. Parfit's answer is that the child could not, because if she had postponed the birth of her first child until she was older, and able to

give her child a better start in life, then this child would not be the person who was, in fact, born to her at age 14.

Bioethics was quick to discover and tease out the implications of this intuition pump, and numerous publications followed applying it to reproductive technologies, and other ethical issues about our obligations to those not yet born (Buchanan et al. 2000; Scott 2007; Savulescu 2001b; 2001a; Hope and McMillan 2012).

It played a role in public policy debates too. The Brazier Report recommended that the British Parliament should not permit commercial surrogacy arrangements because they risked children being born into family arrangements where parenthood and responsibility for caring for the child could be complicated or confused (Brazier et al. 1998). John Harris objected to this recommendation on the basis that the only sense that could be made of the Human Fertilisation and Embryology (HFE) Act's requirement that the welfare of the child resulting from a reproductive technology should be paramount, is that it implied children should be born from surrogacy, as it would be that child's only chance of having a life at all (Harris 2000).

The way that Harris and some others have used Parfit's thought experiment should be a salutary lesson for bioethics. First, Harris misquotes this provision of the HFE Act in his article and in its title; the relevant section says account should be taken 'of the welfare of *any* child', which is a different meaning from that conveyed by the definite article (McMillan 2013). Moreover, and perhaps even more worrying, the Human Fertilisation and Embryology Authority (2018: SS8) misquoted its guiding legislation in the same way. Another problem is that Parfit's aim in *Reasons and Persons* is to undermine the importance that we attach to identity when thinking about people not yet born; he thinks that in the case of the 14-year-old girl, she should have postponed procreation, which is a point contrary to that which Harris and others infer.

There are instances in bioethics which might be called 'misguided intuition pumps'. These are thought experiments that generate intuitions that what is proposed must be wrong, but arguments are

provided that claim we should overcome these intuitions. A good example is John Harris's 'The Survival Lottery':

Y and Z [two patients who will die without donor organs] put forward the following scheme: they propose that everyone be given a sort of lottery number. Whenever doctors have two or more dying patients who could be saved by transplants, and no suitable organs have come to hand through 'natural' deaths, they can ask a central computer to supply a suitable donor. The computer will then pick the number of a suitable donor at random and he will be killed so that the lives of two or more others may be saved.

(Harris 1975: 83)

Most of will have a strong intuition that such a scheme would be appallingly wrong, and Harris spends the remainder of the article explaining away reasons that might be given against such a scheme. Leaving aside what we think about Harris' claim, his argumentative strategy is worth unpacking. A misguided intuition pump is used to generate an intuition that many would share, but which is contrary to the claim being made. Then he sets himself the task of dismantling the arguments that might be offered in support of that misguided intuition. If we accept that he has explained away the arguments for our intuitive response, then he can conclude that our intuition is incorrect. While we might not agree with assumptions that Harris makes, the ambition of this argumentative strategy should be admired.

Jonathon Glover also uses misguided intuition pumps. When arguing against the acts and omissions distinction (which now tends to be described as the acting and allowing distinction), he develops a thought experiment that is designed to meet head-on the strong counter-intuitions that follow from abandoning this distinction. He asks his reader to suppose that the Chancellor of the Exchequer (the British minister responsible for the budget) knows that unless he funds a subsidy for old age pensioners to pay their gas bill, 1,000 of them will die during the next winter (Glover 1977). Glover claims that if the Chancellor fails to fund the subsidy, he is just as morally culpable as if he had lined up 1,000 old age pensioners and machine-gunned them to death. That implication follows from Glover's abandonment of the acts/omissions distinction, and he has

constructed a thought experiment in which the intuition of many people is likely be contrary to what he is trying to show. If he can then explain away that intuition, and show why it is misguided, he has succeeded in subjecting his position to a serious test and has also answered what are likely to be strong objections to his claim.

I've made the point before that while epistemic humility is important in bioethics, we should also strive to create arguments that are as strong as they can be; this is a way in which our thinking about moral issues can progress. An interesting feature of the misguided intuition pump is that if successful, it can be part of a strong argument: subjecting a position to strong contrary intuitions and then showing why they are misguided is an ambitious and strong way to argue.

A final variant of speculative reasoning has a more subtle aim than producing intuitions that count as evidence in favour of or against something. Sometimes thought experiments can simply aim at provoking us to think more carefully about an issue.

Speculative Reason: The Heuristic Device

Sometimes in bioethics, it is important to pause and reflect upon where a proposed solution to an issue is heading, and the gravity of that course of action. Grant Gillett (1998) has described how when making actual life-and-death decisions, physicians should 'pause', so as to ensure that they have not lost sight of the gravity or reality of the decision they are making. Literature and medical anthropology can play a similar role for bioethics, and bring epistemic humility to the discussion of an issue.

Thought experiments that have this kind of heuristic role are a feature of moral philosophy too. While this thought experiment belongs to moral philosophy more than to bioethics, it is sometimes referred to in bioethics and worth knowing about for that reason, as well as because it is a different kind of speculative argument.

Jim finds himself in the central square of a small South American town. Tied up against the wall are a row of twenty Indians, most terrified, a few

defiant, in front of them several armed men in uniform. A heavy man in a sweat-stained khaki shirt turns out to be the captain in charge and, after a good deal of questioning of Jim which establishes that he got there by accident while on a botanical expedition, explains that the Indians are a random group of the inhabitants who, after recent acts of protest against the government, are just about to be killed to remind other possible protestors of the advantages of not protesting. However, since Jim is an honoured visitor from another land, the captain is happy to offer him a guest's privilege of killing one of the Indians himself. If Jim accepts, then as a special mark of the occasion, the other Indians will be let off. Of course if Jim refuses, then there is no special occasion, and Pedro here will do what he was about to do when Jim arrived, and kill them all.   (Williams 1973: 3)

Many will read this and think that the correct answer is for Jim to kill the Indian. Others will think that it is wrong for Jim to do so, because he will thereby intervene in the causal chain, and make certain what was only threatened. However, Williams is well aware that different answers will be given to the question of what should be done, and the correct answer to this moral problem is not the point of the thought experiment. Williams illustrates that on a utilitarian moral theory, the right thing to do is straightforward: killing one Indian will mean that nineteen fewer die, and that is obviously the right thing to do. However, what is missing from this picture is what it will mean for Jim to kill one of the Indians; his integrity, and what it will mean for him as an agent to find himself cast as a killer of innocents, barely enters the equation. So the purpose of this thought experiment is not a counterexample to utilitarianism; it doesn't show that a general claim the theory makes is false; rather the problem is how poorly it fits with human psychology and what we hold dear. Jim and the Indians is a heuristic, like Gillett's 'pause', that gives us reason to think again about what's important and perhaps missing from what we are being told to believe about a situation.

Conclusions

Speculative reason is fundamental to practical reason and all of us will pose some form of 'what if?' question to ourselves several times

a day. Using situations both real and imagined is likewise a funda-
mental part of ethical reasoning and a methodological foundation
for bioethics.

There probably will be kinds of speculative reason that I have not
discussed in this chapter; nonetheless these examples should be
sufficient to see how such reasoning can range from playing an
evidential role (when it takes the form of an intuition pumps) to
showing that a general claim or common distinction cannot be true
(as in the case of a counterexample); there are also broader uses that
aim to expand or deepen our moral thinking, as in the case of
heuristics and narratives. It is important to note that speculative reason
can function in bioethics independently of normative moral theory,
which is another reason why we should consider moral argument to be
basic in bioethics. In the next chapter I will describe a second class of
argumentative strategies that I call 'drawing distinctions'.

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9

Drawing Distinctions
Defining, Reclaiming, and Analysing Moral Concepts

While posing 'what if?' questions is fundamental to practical reason, 'drawing distinctions' is the second pillar upon which almost every ethical argument rests. Distinguishing one moral concept from another can determine the obligations that follow, and whether an action is right or wrong. Ambiguity in the concepts we use can lead to misunderstanding and be an obstacle to developing a shared moral understanding.

Just as speculative reason plays a role in the three kinds of activity that constitute bioethics, drawing distinctions is a starting point for biomedical issue consultation, bioethics and public policy, and scholarly bioethics.

James Rachels attempts to counterexample the distinction between active and passive euthanasia, and that attempt relies upon there always being a sharp moral difference between these concepts. One problem with Rachels' argument is that his examples are ones that involve causing death for malevolent reasons, and that seems at odds with what those who think we should permit assistance in dying for benevolent reasons. How distinctions are drawn, and the names that we give to them, clearly play an important role in how we view assistance at the end of life in public policy, scholarly bioethics, and case consultation.

There are a number of ways in which we make distinctions, and awareness of these differences is useful when critically engaging with

bioethics. The first point that should be made is that our choice of term for a concept is rarely neutral, and the normative baggage that a concept comes with can be used to promote the plausibility of a moral position. The debate around assistance toward the end of life includes a number of programmatic distinctions—ones where the terms used are intended to further a position.

Drawing Programmatic Distinctions

When Rachels wrote 'Active and Passive Euthanasia' (1975), these were the terms most frequently used to describe physician involvement in the process of dying. An obvious response to his article is to object that his cases are not instances of euthanasia. Tom Beauchamp and Arnold Davidson give what they claim are a set of necessary and sufficient conditions for euthanasia, which follow from and codify the etymology of the term. Included within these conditions are the requirement that the person euthanized be acutely suffering or comatose, and that the primary reason for ending their life is to bring their suffering to an end in the least painful way possible (Beauchamp and Davidson 1979). Their definition is plausible, and making this distinction implies that Rachels' counterexample fails because it is not an example of euthanasia.

One of Beauchamp and Davidson's aims was to define euthanasia in such a way that it could be used consistently in debate, and also in a way that didn't imply that it was good or bad. Programmatic definitions are those which give an account of a term that is intended to promote the view that it is good or bad. For example, the slogan 'Marriage is slavery' is not principally a definition of what marriage is; rather, the point is to draw out negative features that those who use this slogan believe marriage has.

Since the publication of Beauchamp and Davidson's article, the term 'euthanasia' has become less neutral, and is used by those who argue against its legalization and usually avoided by those who argue for its legalization.

For John Keown, if legislation or policy amounts to euthanasia, even when it is called something else, it amounts to a form of murder and should not be permitted (Keown 2002).

The British Medical Association (BMA), following the *Bland* decision, produced guidance for British physicians on withholding and withdrawing treatment at the end of life (British Medical Association 2001). The BMA said that a medical team could, if it was judged by a body of responsible medical opinion that it was in the patient's best interests, withdraw or withhold medical treatment with the result that the patient died. Note that the BMA used the terms 'withholding' and 'withdrawing' treatment, which are neutral terms and not ones that have the same negative associations. They are concepts connected to medical treatment and the importance of physicians being able to exercise clinical judgement about when it should be offered, or discontinued.

Keown objects:

'Passive euthanasia' is not used here to mean the withholding or withdrawal of treatment which a doctor foresees will shorten the patient's life. A doctor whose intentional (aim) is to withhold or withdraw a life-preserving treatment because it is futile or too burdensome, merely foreseeing that the patient will therefore die sooner, is not committing passive euthanasia. Rather, passive euthanasia means the *intentional* hastening of the patient's death by withholding or withdrawing treatment: where causing death is the doctor's *aim*. Passive euthanasia is not stopping *treatments* that the doctor thinks are worthless, but about stopping *lives* the doctor thinks are useless. The Law Lords in Bland explicitly condoned the intentional termination of life of a patient which was judged by 'a reasonable body of medical opinion' no longer to be a benefit to the patient. The law therefore permits passive euthanasia, as least of patients in a PVS.   (Keown 2003: 462)

So Keown accepts that there are some instances where a physician chooses to withdraw or withhold treatment that are morally acceptable. Critical for determining these is that they are instances where treatment is futile, or too burdensome, and not because the physician intends that the patient should die. The Law Lords in *Bland* reasoned that continued treatment was not in Tony Bland's interests, and it was

therefore permissible for physicians to make a medical decision about further treatment not being warranted. Keown's complaint is that the BMA simply followed the Law Lords, and had empowered physicians to withhold or withdraw treatment when they think that the patient's life is no longer worth living, and that this amounts to intentionally killing a patient. For Keown, and most other natural law theorists, intentionally killing an innocent person is murder, and that can never be permitted.[1] On this view, euthanasia, because it aims at ending someone's life, even when this action is wanted and needed to control unbearable suffering, is murder.

When criticizing the Canadian Supreme Court of British Columbia's decision in *Carter* v *Canada*, Keown makes a similar point:

Its failure accurately to appreciate and affirm the fundamental legal principle of the inviolability of human life, a principle which has historically provided a bright line between, on the one hand, *intentionally* ending the lives of patients (euthanasia) and, on the other, treatment aimed at palliation, and the withdrawal of treatments because they are futile or excessively burdensome, where the shortening of life is foreseen.   (Keown 2014: 4)

Keown might object that by showing that *Canada*, the Law Lords, and the BMA have endorsed murder, he is not drawing a programmatic distinction, but merely demonstrating what these concepts mean. That seems reasonable enough insofar as his argument is from within a tradition that goes at least as far back as Thomas Aquinas. Nonetheless, 'murder' is one of the most morally prescriptive concepts there is, and the natural law account of murder includes within it withdrawing treatment for the morally praiseworthy reasons that Beauchamp and Davidson identify: to end suffering in the least painful way, when a person is comatose or acutely suffering. So to equate that kind of action with the malevolent, wholly immoral murders committed by Smith and Jones does seem programmatic (Rachels 1975).

While the term 'euthanasia' is still used in bioethics, those in favour of more control over the way in which we die are more likely to argue for 'aid in dying' (AID) or 'death with dignity'.

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[1] See also Finnis (1993); Keown (2002).

There is an important moral difference between AID and euthanasia in that the former involves a physician providing a patient with a medication that they could use to end their life. While euthanasia requires that an agent does something, or allows something to happen, with the intention of ending another agent's life, physicians who provide AID need not intend nor hope that the patient dies. In 1994, Oregon became the first US state to legalize and regulate AID; by 2014, 1,137 people had been prescribed life-ending medication and 752 people had died after ingesting that medication (Lee 2014: 95). So, any physician who provides a patient with the means by which they could end their life should do so in the knowledge that it is probable that this is how it will be used; but a patient might also find it supportive to know that they have the ability to take their own life safely in the event that suffering becomes unbearable. That the physician need not have the intention to end life opens up the possibility that AID might be defensible under the Doctrine of Double Effect (Gavaghan and King 2016).

While there is an important moral difference between euthanasia and AID, the terms have importantly different associations. To 'aid' someone in dying implies offering support to a person facing what is arguably the greatest challenge in life, which, while it might be a true description of purpose, is nonetheless a programmatic choice of terms.

The State of Vermont's legislation is called the Patient Control and Choice at the End of Life Act, which its defenders would no doubt say is an accurate reflection of its purpose (Buchbinder 2017). Even so, it is described in such a way that it is hard for detractors to object to it: autonomy and choice are moral trump cards for many.

'Death with dignity' is another programmatic slogan used by both sides of the euthanasia debate. It can be argued on Kantian grounds that dignity implies control over our body and our manner of passing, and this implication is in accordance with the wishes of an agent (Bell 2016). Yet there are also Christian accounts of dignity that consider the terminally person, their journey through dying, and the connection with God that this implies to be intrinsically valuable, and argue that assistance in dying compromises this form of dignity (Sulmasy 2017).

Drawing Distinctions That Mark Important Moral Differences

Keown thinks there is an important moral difference between withdrawing or withholding treatment when it is 'futile' or 'burdensome'. Both of these are concepts that have been theorized and can be distinguished in different ways, thereby having different moral implications.

One way to distinguish futility is by analysing treatment as a kind of action. Actions typically involve doing something in order to bring something else about. We tend to describe an action as futile when it cannot bring about what the action aims at. For example, if I am running for the bus stop, halt, and then say 'it was futile', I am admitting that my running was pointless as there was very little chance of my making it to the bus stop in time.

We can say the same of futile medical treatment: when it is very unlikely that medical treatment can achieve what it aims at, then it loses its point and it may as well cease. Viewing medical futility in this way makes sense of the prerogative that physicians are given to cease treatment that cannot achieve its aim, as occurred in the *Bland* decision.

Some have argued that the aim of medical treatment is to improve the well-being of the patient being treated, be that in terms of length of life, quality of life, or reduction in pain (Schneiderman et al. 1990). This is a plausible view in that ultimately, the point of health care is to improve our health, be that by the treatment or prevention of disease or by alleviating its symptoms. However, there is a problem: physicians are the experts on medical treatment, and when it should be discontinued or not offered, but is it obvious that they are the experts on what makes the lives of human beings go well? Insofar as the absence and treatment of disease and its symptoms are within the expertise of physicians, they probably are the experts, but how patients value various states of health and the process of recovering from treatment depends upon the preferences of patients. Moreover, in the situation where a person's health is very poor indeed, and there

is a question over whether their future existence will be of any benefit to them, as was the case with Tony Bland, what qualifies physicians as having expertise in that kind of matter? There is evidence which suggests that most patients will value their continued existence even in severely disabled states that most physicians would think not in their interests (Honeybul et al. 2015).

A number of attempts have been made to define medical futility, and the debate is ongoing about a concept that will in all likelihood continue to be contested (Misak et al. 2014). In saying that, a second, clearly distinct sense of medical futility is given by Keown (1997). He would agree that if we want to understand the meaning of medical futility we should analyse what it is that medical treatment aims at. He disagrees with the view that failing to benefit the patient is what renders treatment futile; instead, it is when medical treatment does not succeed as treatment that we should consider it futile.

Suppose that the inner tube from one of my car tyres has a puncture and I take it to be repaired. If, upon examining the tube, the person repairing it says, 'It's futile, it is ripped along the seam', she is not saying that attempting to repair the tube will fail to benefit me; her statement is more accurately interpreted as being about how a puncture repair will fail.

Keown is right that we should view physicians as experts about when a given treatment is likely to work; while they might have more insight into what a treatment is likely to mean for a person's quality of life, there is no reason to presume that they have a privileged perspective upon what makes a person's life go well.

It seems likely that clinicians use both senses of futility and perhaps some others too. Yet this one term, when distinguished into different senses, can mean different things that are important and have different moral implications. While someone needs to make a decision about when it is in the best interests of a patient in a PVS for treatment to be withdrawn, it is reasonable to hope that the clinicians making such judgements do so in a way that demonstrates they are cognisant of the fact that this is not simply a medical judgement.

Clarifying the Implications of a Concept

The sanctity of life doctrine can be defined as the idea that human life is a basic intrinsic good, even when it is not experienced as such by the person concerned. It is also a particularly important intrinsic good, so there is an absolute moral prohibition on the taking of innocent human life (Keown 1997). When understood in that way, the link between anti-euthanasia and anti-abortion arguments should be obvious: these are activities that end innocent human life and they therefore should not be permitted.

One way to engage with those who hold this view is to ask what it is about human life that's valuable. It's one thing to say it is a basic intrinsic good, but it is reasonable to ask someone promoting that view, given the significant implications that it has for public policy and for the lives of others, when and why human life has this value. In *Causing Death and Saving Lives*, Jonathan Glover sets himself the task of considering whether the sanctity of life doctrine could imply what it is taken to (Glover 1977). Glover argues by considering candidates for what might require us to sanctify human life, and shows either that all of them show that too many things should be valued in this way or that entities such as foetuses, those in a PVS, and those with severe disabilities might not be included within its scope.

He argues in the following fashion. Perhaps merely being alive is sufficient for grounding the sanctity of life. He quickly dismisses that explanation because it would rule far too much in: grass, flowers, and insects are alive, yet the sanctity of life doctrine does not extend to them. A more promising candidate is consciousness, but that too has the problem that it would grant this special status to far too many entities: chickens, fish, mammals, and a vast array of animals that are conscious.

Perhaps human life is sacred in virtue of its being human. It might be that this is, in fact, the actual reason for the sanctity of life doctrine, but it is not a reason that is convincing given what we now know about our genetic closeness to our primate cousins (Mikkelsen et al. 2005). Even if it were the case that the human genome differed by

more than 2 per cent from the chimpanzee genome, it's not clear why that alone could ground such an important distinction.

If an individual has the ability to live a life in accordance with a plan, to decide upon important projects, and to enjoy goods such as beauty and love, then that seems like the kind of account that could ground intrinsic value of the sort that the sanctity of life doctrine requires.

However, the problem with this explanation is that foetuses and those who are in a PVS do not live life in accordance with a plan, nor do they enjoy goods like love and beauty. Foetuses might have some primitive awareness in the later stages of their development, but they do not form life plans and experience goods of this kind.

Someone in a PVS could well have pursued life plans, and we might say that because they are continuous with the person who lived in that way, they should be accorded this status. However, that move seems question-begging in that it could be extended to that person's remains once they have died, as they too are continuous with the person who once had a life.

When Keown is examined closely, he falls back upon a claim that suggests it is in virtue of being 'human' that human life has the intrinsic value he thinks it does:

human beings possess dignity or worth because of that radical capacity, inherent in human nature, which normally results in the development of rational abilities such as understanding and choice. In some human beings, most obviously infants, these abilities have not yet developed. But a radical capacity should not be confused with an exercisable ability: for example, you have the *capacity* but may not have the *ability* to speak Swahili. In other words, you may not be able to speak it now, but you could do at some point in the future because you have the innate capacity, as a human being, to learn languages. All human beings, moreover, should be presumed to possess the radical capacities characteristic of their nature even though, because of infancy, disability or senility, they may not yet, or ever, or in longer be in possession of the abilities, which characteristically flow from these capacities. (Keown 2002: 40)

It is plausible to suppose that human lives have the value they do because of the way in which we create value via our commitments,

plans, and ability to see beauty, feel love, and so on. So in order to sidestep the problem of what this says about the lives of foetuses, infants, and those who have lost such abilities, Keown and others in the natural law tradition claim it is the 'radical capacity' to do these things, and its grounding in our 'innate capacity', that matters.

The idea that the capacity of something can be a source of significant value is not absurd. In the 1920s, Alexander Fleming was clearing away used agar plates in his laboratory, and picked one up at random to illustrate an unrelated point to a colleague, when he noticed that the growth of bacteria on the plates was inhibited by some particles that had fallen onto the plate (Heatley 2012). Fleming thought that it was a noteworthy observation and that it might be of interest to the scientific community, so he published this finding (Fleming 1929). It wasn't until ten years later, once the Second World War had begun, that the radical potential inherent in Fleming's agar plate was recognized and penicillin was developed, with the effect that a vast number of people during the war and in subsequent years were cured of bacterial infections.

It is not unreasonable to extend that line of thought to the lives of human beings: but for the capacity we had as zygotes and foetuses, none of us would have the lives and value that we enjoy. However, there are two serious problems with Keown's 'radical capacity' view of value. The first is that in cases where we value something because of its capacity, that value is bestowed not because a zygote or an agar plate is intrinsically valuable, but because of the value of the human life or antibiotic that (we now know with the benefit of hindsight) will result. The second problem is that we know that anencephalic neonates will not develop full and rich human lives, yet Keown insists that disabled neonates have this capacity. Thus, what he actually means by a 'radical capacity' that it is rooted in our 'innate nature' is very unclear, and the only sensible way of interpreting this is by reducing it to 'human life'.

Thinking carefully and critically about distinctions upon which an ethical argument rests heavily, to see whether what follows from that distinction is what is needed for the argument, is one of the central

methods for arguing about ethics. Even with authors as clear and cogent as Keown, noting the work done in the argument by every qualifier such as 'natural', 'innate', or 'radical ability' can isolate major weaknesses.

As a method for bioethics, showing that a concept does not imply what someone thinks it does is one of the more sophisticated argumentative strategies. However, it is also one of the most satisfying, and potentially a fair and progressive way of arguing. A variant of this strategy has been used for the same concept by Ronald Dworkin.

Reclaiming Moral Concepts

Dworkin's strategy in *Life's Dominion* (1993) differs from Glover's in that, instead of trying to show that an important concept, the sanctity of life doctrine, could not do what its supporters think, he attempts to explain what's plausible about that moral concept and then show what does in fact follow from it. His strategy appears similar to Glover's in that he also poses the question of what really matters and tries to show how there is more to the sanctity of life than merely being alive, but he does this in a way which involves trying to reclaim 'the sacred':

Almost everyone recognizes, as I have suggested, that a normal, successful human life is the product of two morally significant modes of creative investment in that life, the natural and the human. But people disagree about the relative importance of these modes, not just when abortion is in question but on many other mortal occasions as well. If you believe that the natural investment in a human life is transcendently important, that the gift of life itself is infinitely more significant than anything the person whose life it is may do for himself, important though that might be, you will also believe that a deliberate, premature death is the greatest frustration of life possible, no matter how limited or cramped or unsuccessful the continued life would be. On the other hand, if you assign much greater relative importance to the human contribution to life's creative value, then you will consider the frustration of that contribution to be a more serious evil, and will accordingly see more point in deciding that life should end before further significant human investment is doomed to frustration.   (Dworkin 1993: 91)

The way this argument works is that Dworkin has given the traditional sanctity of life doctrine its fair due: he traces its origins in theological thought and concedes that most of us intuitively agree that there is something significant about human life—what he refers to in the above passage as the 'natural' investment in human life. In doing so, he cannot be accused of misunderstanding or not being fair to this tradition. At the same time, he develops the idea that the other component of what makes human lives sacred is the creative investment of humans in their own lives. We develop purposes in life, such as a career, family, marriage, and so on, that require continued commitment. Our human projects both create and reflect our values, and this is also a vital aspect of what makes human lives sacred.

In the above passage Dworkin says that one way of understanding the dispute between what he calls 'conservatives' and 'liberals' is as a disagreement over the relative importance of these two sources of intrinsic value. Conservatives, he says, are more likely to value the natural contribution, and will therefore think that abortion and euthanasia are wrong as they involve the intentional destruction of human life. Liberals will place more value upon the human contribution, meaning the plans, projects, and commitments that give our lives meaning. Foetuses do not have this latter kind of intrinsic value, as the plans, projects, and commitments that produce this value have not yet commenced. Someone who is in a PVS or demented is likely to have lost the ability to pursue plans, projects, and commitments and, if that is the case, then has a future in which there will be no future intrinsic value of that kind. So, when this is translated to the abortion and euthanasia context, a liberal should concede that there is something intrinsically valuable about human life, but that the woman's life project should trump that value in the case of abortion, and that prior wishes that are based upon a person's plans, projects, and commitments about not being kept alive should trump the natural value of human life.

Dworkin is the master rhetorician, and while in this passage he appears to be making just an explanatory move, he does more than simply show why conservatives and liberals tend to disagree about

abortion and euthanasia. His suggestion that almost everyone will agree that both sources of intrinsic value matter, and that the disagreement is over the relative amounts, implies that the conservatives are confused. By distinguishing these two sources of value and pointing out that we all should value them to some extent, he implies that conservatives, such as Finnis (1973), who accord the full rights of personhood to foetuses are missing something obvious that all reasonable people would see. Moreover, in cases where maternal and foetal interests conflict, conservatives who prioritize 'natural' intrinsic value will have a harder time of explaining why that matters as much as or more than the plans, projects, and commitments of a human life (Scott 2007).

Dworkin's argumentative strategy is to reclaim moral concepts such as 'the sacred' and 'sanctity' by broadening them to other important kinds of value that are in play in debates about abortion and euthanasia. What this does is deflate the sanctity of life doctrine's privileged role as a trump card for conservatives. Once these other sources of intrinsic value are part of the picture, the absolutism of conservatives such as Finnis and Keown is undermined. Clearly, Dworkin's strategy is ambitious, and perhaps one that would be challenging for someone new to bioethics. Fortunately, there are simpler ways of drawing distinctions that can progress argument in bioethics.

Clarifying Concepts

Futility is a morally important concept in bioethics which, as I showed earlier in this chapter, has very different implications depending upon its sense. Often the concepts that we use in arguments have not been carefully explored; when we think we are using it sensibly, we are in fact much less clear than we think about what we mean.

'Futility' could well have been a concept that was used, but not fully understood, prior to attempts to define what it is and implies. A number of other concepts that matter to bioethics were poorly understood.

Research ethics in many (but not all) countries usually discourages large payments to research participants. A concept that is used in many research guidelines is that payments should only be large enough to cover expenses, and should not be large enough to 'induce' a participant to take part in research. In order to evaluate that requirement, in terms both of what it means and of whether it is correct, it's essential to understand what it means to 'induce' someone to do something.

Wilkinson and Moore (1997) argue against limiting payments to research participants, and see that before developing a critical argument, it's essential to consider options for what that central concept means. One possibility is that an offer 'induces' when it provides research participants a reason to take part in research, when they otherwise might not. The problem with distinguishing the concept in that way is that it seems to rule out all payments for an irrelevant reason: being given money to cover transport costs is a reason to take part on research, but not one that is ethically problematic. Other options for explaining inducements include that:

- they are payments of a such a size that people will be tempted and consent compromised;
- they are payments of such a size that people will take on more risk than they otherwise would or should;
- they are payments of such a size that make altruistic participation impossible;
- they are payments of such a size that participants will be dishonest about pre-existing medical conditions, which places them and the results of the research at risk.

Wilkinson and Moore's conclusion is that none of the plausible ways in which we might understand 'inducement' implies what the concept is taken to be in the context of research ethics, and we should therefore not restrict payment to research participants. Once the concept of inducement is clarified in that way, we might consider whether payment for research participation is analogous to accepting payment for work (Stones and McMillan 2010).

As a method for bioethics, the important thing to note is that clarifying an undefined concept usually involves considering possible ways that the concept can be distinguished, and then checking to see whether that sense of the concept does the normative work that it needs to. Wilkinson and Moore reached the conclusion that none of the senses they could think of did the work that people supposed inducement would. There's an open question about whether they identify all of the possible senses of inducement, and it is still arguable whether the concept cannot do the work that is required of it. Nonetheless, the concept of inducement, and claims that follow from it, remain unclear and implausible in the absence of such a definition.

I've suggested that consistency arguments involve speculative reason. Consistency is another way in which we can help to think through the sense of an undefined concept.

The New Zealand Bill of Rights Act (1990, NZBORA) includes a right that implies all New Zealand citizens have the right to refuse medical treatment.

Right 11:   Anyone has the right to refuse to undergo any medical treatment.

This is an important right, and one that most of us would think is sensible and clear. However, the Act does not define what is meant by 'medical treatment', and up until 2013, there had been no cases that had tested the meaning of that concept. It might be thought that little would turn on how 'medical treatment' is distinguished, but in 2013 it became central to a New Zealand High Court judicial review of community water fluoridation (CWF).

In 2013, an organization called 'New Health New Zealand Inc' requested a judicial review from the High Court of South Taranaki District Council's decision to add fluoride to the drinking water within that region of New Zealand. New Health claimed that adjusting the level of fluoride in the water supply was unlawful for a number of reasons, including that it violated the right that citizens have under the NZBORA to refuse medical treatment. They claimed that fluoride

was in effect a medicine, administered with the aim of preventing dental caries, and that a Council that added medicine to its water supply was mass-medicating its population in a way that violated the right of citizens to refuse medical treatment. I was asked to act as an expert witness and to consider the ethics of CWF and whether it violated the rights of citizens.

A way to begin when defining a concept is to consider how that term and related terms function in everyday language and other contexts. I argued that in common language there is a distinction between something being 'a medicine' and something being 'medical treatment':

If it is true that fluoride is a 'medicine', then when I brush my children's teeth in the evening, I am applying a medicine to their teeth. I might even be described as 'medicating' my children. However, I consider that it is also clear that I am not providing 'medical treatment to my children.

(McMillan 2013: 3)

The status of fluoride as a 'medicine' under New Zealand's Medicines Act is not clear, but it seemed to me that even if it is 'a medicine' in the relevant sense, in common usage it doesn't follow from the fact that a medicine is provided that this is medical treatment. I elaborated upon that argument by explaining how if I gave some aspirin to a colleague because they had a headache, that did not necessarily mean I had provided 'medical treatment'—even though aspirin clearly is a medicine, and my colleague might say I had had treated their headache—because I am not qualified as a practitioner and therefore cannot provide 'medical treatment'.

At this point in the argument, it might be objected that I was merely splitting hairs, and that, while it might be logically possible to distinguish 'a medicine' from 'medical treatment', this did not amount to a significant distinction. It was therefore important to also show that something could be 'medical treatment' even when it does not involve the provision of 'a medicine'.

The Medicines Act states that 'bandages and other surgical dressings [. . .]' (The Medicines Act 1981, section 3(2)(b)) are not medicines. The General

Practitioner who binds my sprained ankle is providing medical treatment even though she does not dispense a medicine.   (McMillan 2013)

If you sprain your ankle and have it bound by a physician, this is clearly a case of 'medical treatment'. Rather than it simply being a question of these terms being logically distinct, a morally significant difference emerges from this example. If I, rather than a physician, bind your ankle, you will just have to take your chances and hope that I know what I am doing. I have had no training in how to bind sprained limbs, and while I can be expected to do my best, your ankle will not be strapped in the way that it would be if it had been strapped by a physician. 'Medical treatment' therefore implies that treatment has been provided in accordance with a standard that we would expect of those who have had training in medicine and who maintain their skills to the level required by that profession. Departures from that standard of care resulting in harm could be the basis of a complaint, and yet if I bind your ankle and the strapping comes off after a few minutes and you twist your ankle again, the worst I could be accused of is being poor at first aid.

While my claim that there is a distinction between 'a medicine' and 'medical treatment' should be clearer at this point, why so much importance should be attached to it needs further argument. It was at this point where I used a consistency argument and showed how 'medical treatment' had been used to pick out an important moral difference in a different jurisdiction. I mentioned earlier in this chapter Keown's view that the Law Lords in *Bland* ended up permitting physicians to commit murder, and it was the Law Lords' discussion of medical treatment that I referred to when arguing what 'medical treatment' should mean in the NZBORA.

When considering the legality of withdrawing artificial nutrition and hydration (ANH) from Tony Bland, who was in a persistent vegetative state (PVS), Lord Keith in the House of Lords expressed the opinion that this constituted 'medical treatment' (House of Lords 1993). He considered it permissible for a physician to withdraw ANH if, in his or her opinion, ANH would produce no benefit to the patient, and that opinion is consistent with 'a large body of responsible and informed medical opinion'. On the other hand, if the same

action is performed by someone who is not a physician and not providing a regime of medical treatment to the patient, it might constitute manslaughter or murder. My interpretation of Lord Keith's judgment is that a central defining feature of medical treatment is that it is performed by physicians who are providing a regime of clinical care to a patient.   (McMillan 2013: 3)

While Keown thinks it is absurd to call ANH medical treatment when it is provided by a physician, but the necessities of life when provided by anyone else, the Law Lords argued in a way that is consistent with how we understand 'medical treatment'. Physicians are empowered to do things to other human beings that would constitute an assault if they were done for any other purpose. A surgeon is authorized to open the abdomen of another human being with a scalpel so as to remove a blocked appendix. If someone not medically qualified tried the same thing, that would be a serious assault, and criminal proceedings would be likely to follow. The same is true of ANH in that what is offered is part of a treatment regime that is organized and provided by people qualified to do so; their clinical judgement about when it is warranted, and when it should be withdrawn, should not be overridden without a particularly strong justification.

When viewed in this way, the full force of 'the right to refuse to undergo any medical treatment' becomes apparent. Given that physicians are permitted to do things to other human beings that would be serious crimes if performed by anyone else, it is vitally important that there is a clear right to refuse to 'undergo' medical treatment. This direct impingement upon the body is very different from a Council modifying the amount of fluoride in drinking water that is delivered via pipes, as citizens are free to turn off the local water supply and find a source of water in which the level of fluoride has not been adjusted.

The methodological point here is that it is usually not enough when distinguishing a concept to merely show that it is different from another. Showing how one concept is logically independent from another is an important first step. But, given that bioethics is about producing the best case for a moral position that we can, it is also important that the distinctions identified should encapsulate an important moral difference.

There are a number of other ways in which we can draw distinctions in bioethics, and all of them are potentially useful methodological techniques for someone embarking on bioethics. In the next chapter I will explain three more argumentative techniques.

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10

Drawing Distinctions
Novel, Sublime, and Slippery
Moral Concepts

While testing concepts for their implications and distinguishing those that seem undefined from others are useful methods, bioethics can also progress via the introduction of new concepts that are enable new or neglected issues to be identified.

Introducing Moral Concepts

Moral concepts enable us to perceive, understand, and communicate about moral issues. Without experience or engagement with the world, concepts are 'blind'; nonetheless, introducing a new moral concept is a way of enabling us to see and argue about an ethical issue that might not have been clearly visible before.

Building on and borrowing concepts developed in other disciplines is a positive way for bioethics to progress, and there are a number of examples of this. 'A nudge' or 'nudging' is that idea that behaviours that benefit health, minimize risk, or lead to some other good that is thought worthy of promotion can be brought about by structuring the social environment in such a way that people are incentivized, or find it easier to choose the preferred option (Blumenthal-Barby and Burroughs 2012). Examples can be simple things such as placing healthier fresh food in a more visible position than junk food. There is nothing new about attempting to influence people's behaviour in

this way, but by distinguishing 'the nudge' from other ways that behaviour might be modified, public health has introduced a new concept that has its own set of implications. It not only has enabled a specific kind of public health intervention to be identified, it has also opened up ethical debate about the pros and cons of nudges and when they are acceptable.

'Exploitation' is a concept that is important to political philosophy; and while there have been a number of attempts to distinguish it as a concept, Alan Wertheimer's is probably the most influential to date (Wertheimer 1996). Franklin Miller and Baruch Brody became concerned that the way in which we standardly think about the ethics of clinical research is confused, because it presumes researchers have a therapeutic obligation to research participants (Miller and Brody 2003). They were worried both because researching participants can give a false impression and because it is not justified, given the nature of the research process. They propose instead that 'non-exploitation' is a fundamental value for research ethics, so rather than focusing upon the benefits that participants receive, we should check to make sure they are not being exploited by researchers. They suggest that we should turn to Wertheimer's theoretical explication of exploitation so as to improve our thinking about the ethics of research. While there are reasons for caution about abandoning therapeutic obligation in the context of research (McMillan 2011), introducing the concept of exploitation to bioethics has enriched the quality of debate about a number of issues.

'Coercion' is a moral concept that has becoming increasingly important for understanding ethical issues in mental health. Mental health legislation can empower psychiatrists to compel or coerce patients into receiving treatment for a mental illness. There is a growing awareness of the impact of coercion and the importance of its being reduced or eliminated (Szmukler 2015), and there is a significant literature on the way in which patients experience community treatment orders as being coercive (Lawton-Smith et al. 2008).

Like 'exploitation', 'coercion' is a concept that matters for political philosophy and a significant amount of intellectual effort has been

exerted in distinguishing it from other concepts and exploring its ethical implications. While bioethics aims at bringing moral reason to bear upon ethical issues, in the course of exploring what a concept means for an ethical issue, that concept can be further refined. One of the ethical issues that arose in the work I did on the castration of sex offenders was whether being offered castration while they were imprisoned is coercive (McMillan 2014).

Coercion in the sense of a 'coercive threat' is quite well understood, and most are happy to agree with the definition generated by Robert Nozick.

For Nozick, P coerces Q when:

1. P aims to keep Q from choosing to perform action A;
2. P communicates a claim to Q;
3. P's claim indicates that if Q performs A, then P will bring about some consequence that would make Q's A-ing less desirable to Q than Q's not A-ing;
4. P's claim is credible to Q;
5. Q does not do A;
6.   Part of Q's reason for not doing A is to lessen the likelihood that P will bring about the consequence announced in (3).

(Nozick 1969)

It is worth noting that this distinction is like Beauchamp and Davidson's account of euthanasia, in that it includes a set of necessary and sufficient conditions that distinguish instances of coercion from other concepts. In other words, if any one of these conditions is not met then it fails to be an instance of coercion; if all of them are met then it has to be coercion. Condition (5) implies that it's only coercion if it succeeds in changing someone's behaviour. So in the event that someone resists someone else's attempts to coerce them, on Nozick's account this fails to be coercion.

Condition (3) means that coercion always involves a threat to bring about something bad unless the person being coerced does something that the coercer wants. Coercive threats are relevant to practices such as community treatment orders, where the threat of

compelled treatment in a hospital setting can, but probably shouldn't, be used to coerce a patient into accepting treatment in their home. It is important for thinking through whether imprisoned sex offenders are coerced into accepting castration, when it is connected with the possibility of their being released from prison.

Suppose that the warden of a prison tells a sex offender that unless he agrees to be castrated, the warden will make sure that the prisoner is not released for another twenty years. If the sex offender agrees to castration, then they are likely to be released within six months. This would be a clear-cut example of coercion, because the warden intends the threat of twenty years in prison to force the prisoner to be castrated. Given the nature of this intervention, there should be serious ethical reservations about any person, even a convicted sex offender, being threatened into having it. Such a threat limits the choices that the sex offender makes, and would invalidate any consent that the prisoner gave because such consent would longer be voluntary.

However, suppose that instead of threatening the sex offender, the prison warden tells him about the possibility of castration, and how it's likely to lead to his being released earlier than he otherwise would, but that the warden has no control over the offender's release date if he doesn't accept this offer. This is a more likely thing to have happened in Czech and German prisons where castration has been offered: the sensitive nature of this offer, and the scrutiny that any such arrangements are subjected to, would make any threat imprudent.

Nonetheless, there still seems to be something coercive about prisoners who are facing a long sentence being offered castration, when it's likely to mean an early release. It still seems coercive, even though castration increases their range of choices, and for that reason it is important to consider whether this might be we can call a 'coercive offer'. The possibility that it might be possible to enlarge a person's range of opportunities while also coercing them into one of them seems, at one level, counterintuitive, and has been discussed by a number of political philosophers (Feinberg 1986; Lyons 1975; Zimmerman 1983). I argued that if we are to make sense of such offer,

it cannot be understood as a problem with voluntariness or consent: given that a sex offender has a choice at their disposal that they otherwise would not, if it is a genuine offer, and if they are not thereby made worse off, it seems that they could freely choose whether or not to accept it. Nonetheless, it seems morally problematic because the background conditions against which the prisoner is choosing are so limited, and there is a risk of their being manipulated into castration. That seems like a lesser wrong than someone being threatened into doing something, but still something that should concern us morally. Applying the distinctions between coercive offers and threats made in political philosophy to a problem in bioethics not only brought to light an important issue but also contributed to our understanding of what is wrong about coercive offers.

While a number of new concepts have been introduced to bioethics, there are theorized accounts of moral concepts developed in other areas that have yet to be applied to problems in bioethics. The value of choice is often important to bioethics, and there are sophisticated accounts of this in philosophical works such as Thomas Scanlon's *What We Owe to Each Other* (1998) that could be applied so as to enrich the discussion of autonomy, consent, and decisions. For example, Scanlon explains how we can have 'instrumental', 'representative', and 'symbolic' reasons for valuing choice. The first reason is that which we most commonly emphasize in bioethics whereby choice has instrumental value insofar as it leads to what is best for us. Representative value derives from the fact that a choice results from the deliberation of a specific person, while symbolic value originates from the symbolic significance of that choice. Given the centrality of autonomy and consent to bioethics, drawing upon insightful conceptual distinctions such as these can enable us to understand and argue better about moral issues.

Truth-telling and confidentiality are central issues for clinical ethics, and we can enrich our understanding and analysis of such issues by drawing upon philosophical and sociological literature that explores the contours of such concepts more fully. Lying and secrets have been given careful and sophisticated treatment by Sissela Bok,

and her delineation of these concepts could be explored more fully in bioethics (Bok 1982; 1999). The German social theorist Niklas Luhmann has explored the nature of trust and how it functions within institutions (Luhmann 1979). His rich discussion and insights into this concept can be used to deepen our understanding and analysis of issues surrounding truth-telling and confidentiality.

Transcendental Distinctions

A subtle and interesting way of refining concepts is by using a strategy of Kant's from *The Critique of Pure Reason* (Kant 1998a) and *The Groundwork to the A Priori Metaphysics of Morals (*Kant 1998b*)*. I've mentioned the role that concepts have in making sense of the world: seeing a situation as one in which a person's autonomy is not respected implies that we have an understanding of the concept 'autonomy' and can make sense of what we have seen in those terms. The fact that we are capable of recognizing and understanding autonomy implies something about the nature of the concepts that we have, and that is the essence of what is meant by 'transcendental'.

While a 'transcendental distinction' sounds like something ephemeral—or, as I've suggested in the title of this chapter, 'sublime'—in fact it is a fairly intuitive idea. The fact that we can see moral issues in a situation implies that we have relevant moral concepts which are implicit within that experience. The ways we experience moral issues imply things about the nature of our moral concepts. For example, if I hear about how workers in a local sweat-shop are being paid half of the minimum hourly wage, not being given meal breaks, and only accept these conditions because of the fear of deportation, then I am likely to form the belief that this is wrong, and wrong because it is exploitation.

Having that specific judgement implies conditions about when it is appropriate to apply and make sense of that situation as exploitation. The likelihood that these workers have agreed to lower wages, and poorer working conditions, because of their vulnerable position are key to my reaching this understanding of the situation, although they

are only some of the conditions that are involved in my seeing that situation as exploitative. The transcendental question is: what has to be the case about my concept of exploitation to make my ability to see, know, and communicate about exploitative situations possible?

Suzanne Uniacke is a moral philosopher who has used transcendental distinctions to make novel arguments about important ethical and legal concepts. Those who believe in the sanctity-of-life doctrine also believe in the impermissibility of intentionally killing an innocent human being. The inclusion of 'innocent' is important, because it enables those who think there is an absolute prohibition on murder to avoid being committed to pacifism—the view that wars are always wrong. It is also important so as to avoid the implication that we are absolutely prohibited from defending ourselves if we are subject to a serious threat.

As well as being an important aspect of the natural law tradition, this is also an important legal principle in most jurisdictions. If the only way of nullifying a mortal threat to us is by reacting in a way that leads to the death of someone who was the cause of that threat, then that is a defence to the charge of murder. It might be that we would be found guilty of a lesser crime, but the moral and legal nature of what we had done would be different. When discussing the conceptual preconditions of the right to defence Uniacke offers the following argument.

the positive right of self-defence is grounded in what is morally distinctive about justified self-defence: force used in self defence against an unjust immediate threat resists, repels, or wards off the infliction of unjust harm. This grounds a unitary right of self-defence against culpable and non-culpable, active and passive unjust immediate threats. It grounds a right to defend others. A unitary right of defence is not merely possible: it is implied by what is morally distinctive about the use of force in self-defence against an unjust threat.   (Uniacke 1991: 192)

While 'self-defence' is a concept that plays a well-established role in the law surrounding homicide, and has been viewed as important to the natural law tradition for at least as far back as Thomas Aquinas (1225–174), there are a number of accounts of when and why that

defence can be applied (Aquinas 2006). There is no doubt that there is a right of self-defence, but there is a dispute about the nature of that right and what grounds it, so Uniacke turns to what has to be the case about the concept for it to do the work it does.

She observes that it is justifiably used in situations where an agent resists, repels, or wards off the infliction of an unjust harm. One of the contested claims about 'self-defence' is that it applies in cases where the threat is caused by someone culpable, for example someone who has premeditated a violent assault and then carried it out. Uniacke argues that in order for 'self-defence' to do the work of applying in cases where there is unjust harm, it must apply in cases where there is a non-culpable as well as a culpable unjust threat.

We might consider transcendental distinctions to be a variant of showing that a concept does not imply what someone presumes it does. But what's distinctive about a transcendental distinction is that the concept is already used and matters, and rather than just looking for unwanted implications, it involves speculation about what must be true of that concept in order for it to be used in the way it is. This is a more complex way of drawing a distinction than others I have discussed, but it is a strategy that could be useful in bioethics, especially if we are considering important and commonly used concepts such as 'autonomy' or 'paternalism'.

Slippery-Slope Arguments

Someone who is only moderately familiar with bioethics is most likely to know the kind of argument represented by 'the slippery slope'. The kinds, strengths, and limitations of slippery-slope arguments have been discussed well and competently elsewhere in the bioethics literature (Spielthenner 2010; Douglas 2010; Helgesson et al. 2017). Nonetheless, the slippery slope is an important form of argument to grasp, partly because they are prevalent in bioethics, but also because some of them are plausible, and those that are not can be identified and criticized. They're also relevant to this chapter because one form of them relies upon a prediction about us struggling to draw

distinctions. Broadly speaking, there are two main kinds of slippery-slope argument, the 'empirical' and the 'conceptual'.

The following syllogism is an example of an empirical slippery-slope argument.

Syllogism 1
1. It is possible to create, via pre-implantation genetic diagnosis (PGD), a sibling who is a tissue match for a child with a condition such as beta thalassemia (Sheldon and Wilkinson 2004).
2. All being well, the cord blood from a saviour sibling should be all that is required to treat the 'saved' sibling.
3. Inevitably there will be cases where cord blood is insufficient for the treatment, and there will be a demand for other kinds of tissue, such as bone marrow.
4. In cases where there is a demand for other tissue such as bone marrow, the tissue-matched savour sibling will already exist, and we will end up harvesting bone marrow from them.
5. Creating a child to be a tissue match for an ill sibling and then harvesting bone marrow from that child is wrong, and we will inevitably end up doing this if we create saviour siblings.

In this syllogism, premise (2) is the course of action under consideration. While (2) on its own might not appear morally problematic, it is the slide from (2) to (5) that makes this a slippery-slope argument. Premise (4) is a prediction about what we will in fact end up doing at some point in the future if we permit (2). So the cogency of this argument rests upon the accuracy of this prediction, and we can therefore describe it is an 'empirical' slippery slope.

One of the attractions of the slippery-slope argument is that it is a way that we can object to something, by pointing to something that clearly would be wrong and in effect saying, 'That's what you're really going to permit.' The problem is that once we see 'building a case' as being important for arguing well about ethics, providing good evidence for why this prediction about what we'll do is correct can be hard, and there are often ways to prevent the prediction coming to pass. In syllogism 1 it's hard to know whether or not the prediction

in (4) is true: while the importance of saving a sick sibling might tempt us to do more to the saviour sibling that we planned or promised, it might be that not harvesting bone marrow is a firm commitment and we don't do it. One response to this slippery-slope argument is to make sure that, in the event that cord blood does not work, we will not subject the saviour sibling to bone marrow harvesting.

So, when evaluating and building a slippery-slope argument it is important to be mindful that while such an argument can be attractive in a rhetorical sense, as they seem to imply that someone is proposing something worse than they are, the evidence for that prediction is critical for the cogency of the argument.

Empirical slippery-slope arguments tend to have the following kind of prediction:

If we permit A (which seems morally permissible or benign) *we will as a matter of fact* end up permitting B (which is morally deplorable).

Conceptual slippery slope arguments differ in the following way:

If we permit A (which seems morally permissible or benign) *we will be unable to distinguish* A from B (and B is morally deplorable).

For example, see the following conceptual slippery slope argument.

Syllogism 2
1. Permitting voluntary, active euthanasia (VAE) is risky because the irreversibility of death means a poor judgement about what someone wants will have disastrous consequences.
2. In cases of unbearable suffering, a person might be better off dead.
3. So, VAE should only be permissible in cases of unbearable suffering.
4. Patients who are unable to express their wishes can experience unbearable suffering.
5. So (2) and (4) imply that we should permit non-voluntary active euthanasia (NVAE) (Keown 2002: 76–80)

Keown thinks that VAE is impermissible because he thinks it violates the sanctity-of-life doctrine. However, the point of this argument is that often those who argue in favour of more control over the way in which our lives end (such as Dworkin) will emphasize the importance of autonomy, and its being the reason we need control over the way in which we die. Those who think autonomy is a very important argument should be concerned about NVAE, because this is a way of ending life that does not result from the autonomous wish of a patient: we know this because if it was the result of such a wish, it would be VAE.

However, the problem with relying upon the autonomy argument is that the consequences of getting that decision wrong are dire, especially in cases where someone is not suffering and it appears they have a future ahead of them in which there is value. So, a way to guard against that outcome is to permit euthanasia only in cases where suffering is so bad that the person is better off dead. As Keown points out, the problem with doing that is that this looks like a sufficient reason, and it means we will no longer be able to make a moral distinction between VAE and NVAE.

If we grant the claim about unbearable suffering really being the judgement that in fact does all the work, then Keown's point seems fair: unbearable suffering can certainly be a reason for NVAE. But premise (3) can be resisted: there is no reason why someone could not bite the bullet and simply reject (3). Alternately, (3) could be modified so that it says, 'VAE should only be permissible when there is unbearable suffering and it is the autonomous wish of that patient.' When modified in that way, then we avoid the slide to (5), because we can distinguish VAE from NVAE.

This form of slippery-slope argument can be viewed as similar to some of the ways that we draw distinctions. When they work, they work because they show that a moral concept does more than what a person might realize. Just as viewing mere consciousness as the property that grounds the intrinsic value of human life implies too much, as it implies that any entity that has consciousness must have this intrinsic value too, relying upon 'unbearable suffering' in the euthanasia debate implies more than might be first thought.

Conclusions

While slippery-slope arguments are common in bioethics, in general they are not especially strong arguments because they either rely upon a prediction about future behaviour or require that we should not have thought through fully what follows from using a particular moral concept. Introducing moral concepts that have been theorized in other disciplines is often a productive and interesting way to shed light on important moral issues. The deep understanding that we can gain of a moral issue by thinking through what must be the case for this concept to do the work it does is a subtle and difficult method of argument, but one that could be used more often in bioethics.

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11

What It Is to Reason about Ethics

> [...] an examination, at once expository and critical, of the different methods of obtaining reasoned convictions as to what ought to be done which are to be found—either explicit or implicit—in the moral consciousness of mankind generally [...]
>
> (Sidgwick 1907)

I've followed Sidgwick's suggestion that studying the methods of obtaining reasoned convictions in ethics involves examining ethics in a way that is sensitive to how we reach reasoned convictions about issues but also views these techniques through a critical lens. Earlier approaches to the methods of bioethics have tended to look to normative moral theories, theology, or some other theoretical perspective, so as to generate a method.

When the methods of bioethics are viewed in Sidgwick's manner, its methods are, in fact, techniques for reasoning about evidence, moral concepts, and how they combine to build a case for a position. This conception of moral reason is Socratic, in the broad sense that it involves intellectual rigour and an openness to possibilities and different ways of understanding relevant concepts. But it must also be practically normative. and that means it either involves a method of engaging directly with those involved in issues or discusses concepts and arguments that are practically normative via a more indirect route.

A key skill in bioethics is being able to isolate the argument for a position. Once that skill is mastered, it is possible for newcomers to

bioethics to draw upon their expertise. Physicians, nurses, lawyers, biomedical scientists all have expertise that is specific to their discipline. Given the complexity of most issues in bioethics, the chances are that there is at least one important premise in an argument for which the expertise of each of these subject specialists can be used. This was the founding vision of bioethics, and focusing upon moral reason and argument is a way of unifying and taking advantage of the wisdom that can come from a range of perspectives.

It is important that the founding vision of bioethics as an interdisciplinary area of inquiry is built upon, and this means that the current interest in empirical ethics should continue. But, it should not be at the expense of working toward practically normative bioethics and approaches that are more toward the philosophical end of the methodological spectrum. There are problems when philosophical approaches become too removed from practical ethical issues, but there is also a risk in the other direction: too much empiricism can distract us from the Socratic element of bioethics. The days when the philosophical exchanges with medical sociology were limited to accusations they had violated the maxim 'No ought from is', and claiming social science should be viewed as a source of facts about public opinion, are over. But there is also a risk that exploring and describing moral phenomena without teasing out the normative significance is thought of as ethics.

The solution to this is to emphasize a conception of moral reason that is accessible and applicable, irrespective of disciplinary background. Many of the techniques described in Part III of this book are simple, and can be used by anyone engaged in bioethics. There will be other useful techniques that not have been explored in this book, but my aim was not to produce the final word on how one should argue about ethics. Part of the intellectual satisfaction than can come from ethics is the creative moment when a new way of making a point or expressing a concern is discovered. So, my hope is that others will see the creative aspect of moral reason, and build from and improve upon my suggestions about how we can argue.

The overarching aim of this book has been to steer bioethics toward that which is in common between different disciplinary approaches, and to introduce those new to bioethics to techniques that enable them to see what bioethics is and how to go about doing it. If it does something to foster interdisciplinarity and give newcomers to bioethics a smoother introduction to this area, I will consider it to have succeeded.

Reference

Sidgwick, H. 1907. *The Methods of Ethics*. London: Macmillan.

Index