ETHICS BY THE PEOPLE

by

GEORGE KEVIN PAWLIUK

B.Sc., The University of Alberta, 1982

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER'S OF ARTS

in

THE FACULTY OF GRADUATE STUDIES

DEPARTMENT OF PHILOSOPHY

We accept this thesis as conforming
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA

April 1991

© George Kevin Pawliuk, 1991
In presenting this thesis in partial fulfilment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the head of my department or by his or her representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

Department of PHILOSOPHY

The University of British Columbia
Vancouver, Canada

Date April 26, 1990
ABSTRACT

The Problem I will be addressing is, quite simply, "What role, if any, can philosophers legitimately play in biomedical ethics?" When one considers the recent backlash against ethical theory; philosophers' own dissatisfaction with their relationship with biomedicine; and the depth and urgency of the pertinent moral issues, it is nearly impossible to be unmoved by the enormity of the challenge. But will philosophy meet the challenge? Many of those who are familiar with the current state of biomedical ethics are inclined to be doubtful.

The thesis I shall advance and defend is that this doubt is well-founded if we suppose that philosophers continue to apply their theoretical resources in biomedicine in the same manner as has usually been done. Unless philosophers dramatically change the nature of their approach in biomedical ethics, they will continue to face frustration and to be regarded as ineffectual. The role they must adopt requires them to work with many others (nurses, patients, doctors, lawyers, etc.) as equals, bringing their skills and talents to bear along with the skills and talents of non-philosophers. Without a strong inter-dependence between philosophers and non-philosophers, biomedical ethics will not prosper, nor evolve into the kind of tool that is direly needed in the health sciences.
In order to defend the thesis I am advancing, I will survey some of the literature that has dealt with the problems facing philosophers in the clinic in recent years. The case against biomedical ethics (and, in particular, normative ethical theory) will be explored to reveal the content of the criticisms and their force. Following some discussion of these criticisms, pursued in order to discover elements of a new approach to the role philosophers can legitimately play in biomedical ethics, I will attempt to build a constructive alternative from these positive fragments.

My conclusion, very generally, is that philosophers' skills and resources permit them to function best in close cooperation with others. I will rely on an account of a public forum (comprised of doctors, patients, theologians, nurses, etc.) to illustrate the kind of role philosophers could most effectively and legitimately pursue. Because of the nature of their activities, philosophers would, for example, often play an important role in isolating and defending significant value questions. A strong sense of inter-dependence would develop as physicians and the forum interacted. Physicians, who must be active in their roles as moral agents, would primarily be concerned with developing rules, guidelines, etc. for practical cases. Physicians would be assisted by a small group of non-physicians to ensure that important social goals are taken into account. The forum would act as an external critic of these rules, both prospectively and retroactively. The success of the forum would provide biomedical ethics
with important practical input that should be used for its growth and development.
# TABLE OF CONTENTS

**ABSTRACT** ........................................ ii
**INTRODUCTION** .................................. 1

**Chapter**

1. **MEDICINE AND MORALITY** ....................... 5
2. **TECHNOLOGY AND MORALITY** .................... 18
3. **MEDICINE AND ETHICS** .......................... 31
4. **BIG CHALLENGES AND BIG LIMITATIONS** ...... 42
5. **ANTI-THEORY** .................................... 59
6. **THE CONVALESCENCE OF CASUISTRY** .......... 70
7. **LIMITATIONS OF CASUISTRY** ................... 80
8. **PHILOSOPHERS AND BIOMEDICINE** ............. 89

**CONCLUSION** ..................................... 99
**BIBLIOGRAPHY** ................................... 101
INTRODUCTION

For the past few decades, moral philosophers have involved themselves more and more in the health sciences. Often, this involvement has not been very different from the usual activities pursued by philosophers in academic settings. Philosophers have mainly worked with theories that have primarily been developed in a highly abstract manner. Since these theories were seldom applied within a practical context, most of the criticisms raised against them have been of a logical or conceptual nature. Recently, however, moral philosophers have begun to encounter practical criticisms of their theories. It is not just abstract shortcomings that confront normative ethical theories, but also problems of application and relevance.

In the past, a few moral philosophers have developed certain approaches to moral reasoning that have had a very positive response from the health sciences. In particular, the applied ethics paradigm (chapters 3 and 4) developed by Beauchamp and Childress has been widely regarded as an acceptable method of moral reasoning for health care workers. Although in abstract discussions this method seems promising and is simple to learn, it is next to useless when one attempts to apply it in concrete cases.

Given the problems and failures of normative ethical
theory in the health sciences, philosophers and others have begun to reconsider the nature of the role philosophers ought to play in biomedicine. If normative ethical theories are really useless in resolving concrete difficulties, then, perhaps, such theories have no place in the health sciences (or anywhere).

Of course, alternate approaches to the applied ethics paradigm (and other uses of normative ethical theory) have emerged in recent years. Most noteworthy of these is casuistry. Even though there are certain promising facts about this method of moral reasoning, the mere fact that it is highly dependent on several elements of the applied ethics paradigm speaks strongly against it. In their attempt to avoid the approaches they criticize, the new casuists have, in fact, been unable to do without the very things they reject. This convergence on methods and resources employed by others suggests that this approach is not as unique as they claim.

Another development in moral philosophy is the anti-theory movement. This line of criticism holds, quite simply, that normative ethical theory has no role to play anywhere. For anti-theorists, such theories are not possible and will never satisfactorily do what those in the health sciences require of them. To date, however, the anti-theorists' have only made scattered attacks on normative ethical theory and it is probably too early to fully evaluate the success of their efforts. In addition, they have not yet provided those in biomedicine with a more successful alternative. To
merely destroy without replacing with useful tools seems senselessly radical and not particularly helpful for those working in the practical realm.

In opposition to those who would completely reject normative ethical theory as a useful tool in biomedicine, I argue, instead, that it has an important role to play. I claim that philosophers and their theories are a necessary part of the formation of policy and the resolution of difficult moral issues. However, due to the theoretical and practical limitations of biomedical ethics, philosophers must work cooperatively with the caring professions in order to be successful. Specifically, those in the caring professions (e.g. psychiatrists, social workers, chaplains, etc.) will ensure that the moral interpretations of perplexing cases aren't overly simplistic.

The public forum that I describe (chapter eight) will allow the talents and skills of philosophers and non-philosophers (nurses, doctors, lawyers, etc.) to be combined in an attempt to resolve practical moral problems. After some consideration of the notion of moral expertise and its relationship to moral philosophers, I conclude that it is only by working in close cooperation with others in the forum that philosophers will succeed in biomedical ethics.

I also argue that the extent to which philosophers are successful at resolving moral issues and forming policies will depend on whether there are rationally compelling moral theories and concepts. If there are, philosophers have a great deal
to offer. If there are no rationally compelling moral theories, philosophers may still contribute a great deal, for their ability to provide rationally compelling concepts will make the resolution of particular moral issues (e.g. abortion) a possibility. It is important to realize that if there are better theories and better concepts, then there is the likelihood of arriving at better answers to moral problems. The skills that philosophers work hard at acquiring make these better answers attainable. However, as one moves from the abstract to the concrete in biomedicine, more and more input from non-philosophers will be required.
CHAPTER 1

MEDICINE AND MORALITY

One thing seems clear about the very complex practice of medicine: it has been the source of several profound moral difficulties in recent decades. Why is it then that the claim that medicine is an inherently moral enterprise has not been simply rejected out of hand as being patent nonsense (Cassell 1973)? Apparently, this claim is not without its plausibility. An examination of the support for this claim (and others much like it) will be the task of this chapter. Of particular interest will be the notion that medicine, as an inherently moral endeavor, mainly involves doing what should be done.

Early Hippocratic Roots

The belief that medicine is fundamentally a moral, indeed sacred enterprise can be traced back to the fourth century B.C., when the Hippocratic Oath is believed to have been written (Zaner 1988, 206, 218). At this time it was believed that anything given to a patient produced a certain disposition of his soul. Since physicians knew this better than most people, they were no doubt aware of the potential for control they had over their patients. What stood in the way of their taking advantage of those in their care? The

... [Hippocratic] Oath sets out "the closest and most sacred relationship that can be imagined between
The practice of the art, therefore, seems to these physicians a most unique and demanding enterprise. While the virtues of justice and forbearance are inherent to every social relationship, that specific social relationship between physician and patient, and between physician and pupil, is sacred, such that the practitioner must be bound by moral covenant. Within these relationships, justice and forbearance are transformed into something more elevated and more demanding than is found in the common sorts of social relationships (Ibid. 211).

Because of its prominence in Hippocratic morality, it is necessary to consider in more depth the notion that everything given to the body produces a certain disposition of the soul. Around the time the Hippocratic Oath was written, bodily appetites were regarded as cravings for the presence or absence of various things. Regardless of whether unhealthy appetites are innate or acquired, they intensify until they bring about discomfort and sometimes misery. Pursuing an unhealthy lifestyle—in particular, eating an unhealthy diet—results eventually in illness and even death. It was the Hippocratic physician's primary duty to distinguish healthy desires from unhealthy and to prescribe a healthy regimen for his patients. Since these physicians believed that unhealthy desire is uncontrolled desire, they were very much concerned to alter the dispositions of the soul. In order to do so, they had to make important value judgments about what the patient should and shouldn't do. Thus, these physicians were essentially preoccupied with finding the right actions for a given patient. In other words, they desired both that their care for the patient and his corrected behaviour were a clear enact-
ment of what should be done (Ibid. 208).

The Long, Unbroken Tradition

Even though nearly 2400 years have passed since the Hippocratic Oath was written, it has continued to have a significant affect on the modern practice of medicine. This remains so despite the recent emphasis on the autonomy of patients and their rights. Edmund Pellegrino's position is, in many respects, a modern statement of many of the beliefs and values found in the ancient Hippocratic tradition. He claims that

clinical judgment on behalf of each specific patient... is infused with both scientific and value components, in its being uniquely governed by a fundamentally practical moral end--the right action for a specific patient (Zaner 1988, 155).

Specifically drawing attention to the notion of the right action for a given patient, Pellegrino argues that medicine is only justified when it is truly focused on the patient's needs (Pellegrino 1979, 171). In his view, a "value screen" is cast over the entire process leading to the right action for the patient, since what is medically indicated may not, in fact, be in accord with the patient's values (Ibid. 170). Someone's religious beliefs may exclude modern birth control methods as an option even though medical evidence has amply established their safety and effectiveness. Some people might regard this as an instance of moral relativism at the individual level: "Although birth control is right for you, it is out of the question for me." Be that as it may,
Pellegrino is on to something important, for he frequently draws attention to the need to unpack "the right action for this patient" in a way that stresses the patient's values.

H. Tristram Engelhardt Jr. has uncovered a deeply insightful way of looking at medicine as the enterprise that does what should be done. He believes that "medicine is the most revolutionary of human technologies. It does not sculpt statues or paint paintings: it restructures man and man's life" (Engelhardt 1973, 445). But medicine is not just a science or a technology, it is "the art of remaking man, not in the image of nature, but in his own image; medicine operates with an implicit idea of what man should be" (Ibid.). Of course, physicians must possess certain important values if they are to successfully remake humans in desirable ways. Medicine is, thus, essentially moral, because it operates with a dense nexus of values and expectations.

Alisdair MacIntyre's analysis of "social practices" also offers reasonable support for the claim that medicine is an inherently moral enterprise. Medicine is a social practice because it is a coherent and complex form of socially established cooperative activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence that are appropriate to, and partially definitive of that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended (Zaner 1988, 51).

As a social practice, medicine has both internal and external goods. External goods are only contingently
attached to the practice and do not define it (MacIntyre 1978, 28). Relevant external goods for medicine might be wealth, status, recognition, security, etc. Internal goods on the other hand are definitive of the practice, since they can be specified only in terms of the practice in question; and they may only be identified and recognized by those who have experienced the given practice (Zaner 1988, 51). Those who lack the experiences provided by the practice aren't able to judge the goods internal to it.

It is important to have a clear conception of an internal good. When a doctor accepts someone as a patient, he serves the patient's best interests and works, ideally, within a "covenantal resolve" to do the most good for the patient (Ibid.). For this specific reason medicine is an inherently moral enterprise. This therapeutic resolve is clearly an internal good of medicine as a social practice. The achievement of the internal goods of the practice benefits both practitioners and those who benefit from their activities (in this case, patients).

Zaner extends MacIntyre's analysis by claiming that medicine's internal goods are "expressed by its therapeutic theme and underlying moral resolve, and their situational specifications" (Ibid.). He argues that if these goods are attained, it is only during the attempt to meet the standards of excellence within the practice of medicine (e.g. observational acuity and diagnostic accuracy). The goods internal to medicine can only be achieved by those who participate in
the practice.

Zaner goes on to give an account of morality that "relates directly and deeply to the moral foundations of medicine and the experience of illness" (Ibid. 300). He bases his position on the writings of Herbert Spiegelberg and Albert Schweitzer, both of whom have much to say about the connection between human welfare and the obligations of morality.

Spiegelberg argues that the foundation for the moral life is not freedom, but the compromise, or imbalance, of an individual's opportunities as a result of the accident of birth (1974, 202). Because of the accident of birth, many people suffer undeserved disadvantages, while still others enjoy equally undeserved advantages. But justice requires, he claims, that we regard all persons as equals (1944, 113). Spiegelberg concludes that we must try to redress all undeserved inequalities of birth.

In opposition to certain widely held views of modern philosophy, Spiegelberg claims that

...the connection between desert and responsibility is not freedom or autonomy, at least not in the most basic sense. That connection is grounded in our essential human condition, and this is fundamentally shaped by the accident of birth—that is, by that over which we had no choice, our rudimentary and initial "lot," biological endowment, and social station in life (whether as privilege or handicap) (Zaner 1988, 300).

Since what we have and who we are constitutes an essential moral imbalance, whether positive or negative, and since this kind of inequality is wrong, something should be done about it.
Thus injustice is basic to the moral life, the "injustice inherent to our unchosen initial lots in life" (Ibid. 303). Because these initial lots are void of moral justification, they should be redressed, a view that suggests a universal equality of moral status. Zaner then draws important attention to the fact that not only are people subject to the injustices imposed on them by the accident of birth; they are also, unfortunately, subject to discrimination by others who have fared better in life's lottery (Ibid.). These two facts—inequality and discrimination—he claims are the foundation of the moral life.

In what way are Spiegelberg's conclusions related to the moral foundations of medicine and the experience of illness? Modern medicine can improve the quality of the lives of many of those who've been disadvantaged by the accident of birth. Modern research will soon make diabetes nothing more than a minor inconvenience. Medical technology offers the freedom of mobility for many disabled people. Certainly, improving the quality of these lives is an important form of redress. Although the injustice of human life is often a source of despair, we must do all we can to minimize the effects of misery and suffering. Since medicine's starting position is its therapeutic resolve, it is best situated to improve the lives of those in need.\(^1\) Clearly, if the right

\(^{1}\)One doesn't have to pursue this line of reasoning very far before it becomes obvious that no presently existing health care system would be acceptable from this perspective.
thing to do is to combat the injustices of existence, then medicine would appear to be a fundamentally moral endeavor. In the course of its daily business medicine corrects certain moral imbalances.

It is important to spell out in more detail the connection between desert and responsibility. To begin with, no one is responsible for his genetic make-up; where he was born; his family's economic status; etc. People aren't born into certain places and stations because they choose to be. In a similar manner, people aren't born into hardships because this is a fate they deserve. This is clearly the point of emphasizing the accident of birth. All people, however, are equal in their capacity to suffer and be miserable. Since all people are of equal moral status, each should receive whatever redress is justified to improve his initial lot. Thus, those who have been more fortunate have a responsibility to aid those who have fared badly in life's lottery. This is the case, because the advantages of the fortunate are as undeserved as the disadvantages of their fellow humans. To the extent that I heed my responsibilities and aid other less fortunate individuals, I behave morally. To the extent that physicians do the same, medicine is a moral endeavor.

For those who have fared well as a result of the accident of birth or who eventually enjoy happy circumstances in their lives despite early difficulties, a sense of gratitude or contentment may often be experienced. A sense of having enjoyed good fortune can sometimes be a humbling experience; but
it can also be a source of obligation. Albert Schweitzer stressed our need to pay back some of the good things we may enjoy, since these place on us a "special responsibility" for those worse off than we are (in Spiegelberg 1975, 228). Spiegelberg claims that Schweitzer was, in fact, mainly arguing that we should strive to deepen and cultivate our moral sense, a capacity that is mostly dormant but that is awakened in special cases (Ibid. 232).

What is the nature of these special cases? Schweitzer claims that anxiety and physical suffering bring people closer together, that there is a "fraternity of those marked by pain" (Ibid.). For those who pull through their difficulties, there is often a sense of obligation as a result of their good fortune. This is an awakening to the fact that others are in need of help, that one is surrounded by examples of the moral imbalances of life.

It is a fact that most physicians in North America have come from fairly affluent families; have enjoyed good educations, health, and recreation; and many will lead reasonably productive and rewarding lives. It is also a fact that society expends considerable resources to provide medical education. Physicians are no doubt among the most fortunate members of our society. Since most physicians have enjoyed considerable good fortune, it seems reasonable to assume that they have significant obligations to society, and, in particular, to those less fortunate than they are. It is, naturally, a happy outcome that those who bear the burden of
this obligation are also those who can do a great deal to
redress the injustices imposed by birth.

Since physicians spend most of their time around the
sick and dying, they ought to be acutely aware of the
fraternity of those battling disease and death. Spending
year after year watching people can, at least in some
cases, only make one grateful for whatever good health one
has left. This is, of course, another instance of an obliga-
tion imposed by one's relatively good fortune. Of course,
since the duty to help those in need is often stated as a
simple requirement of the profession, it may be possible for
some physicians to avoid feeling obligated as a result of
being fortunate. However, it is difficult to trade simple
concern for others for the sterile dictates of an abstract
duty. Concern for others naturally presupposes empathy and
sympathy. Exposure to the sick and dying can be the source
of a moral awakening, of a sense of the strength of the human
spirit and the power of hope. The sense of fraternity that
is present may, in some cases, be nothing more than a willing-
ness to assist the vulnerable so that one might expect similar
assistance when it becomes necessary. But in other cases it
may become something more profound.

Departures from the Hippocratic Tradition

It is time to consider where the discussion of this
chapter has brought us. We have examined a number of very
different arguments for the claim that medicine is an inher-
ently moral enterprise. Each of these views lends some support to this claim. Certainly, the fact that they each support Cassell's claim to a lesser or greater extent speaks in favour of its plausibility. It appears that the best support for the claim comes from Zaner's argument based on Spiegelberg's view (including my extension of it), since Zaner deepens the discussion significantly. It is important to realize, nevertheless, that if Spiegelberg's notion of "natural injustice" has the obligatory effects he claims, then medicine isn't unique in being obliged to overcome these injustices. In fact, all human activities ought to serve the end of redressing those disadvantaged by the accident of birth.

Despite the plausibility they offer Cassell's claim, some of the views examined in this chapter are clearly deficient. The Hippocratic understanding of medicine is becoming ever more remote from reality as medicine responds to the current emphasis on patients' autonomy and rights. The early Hippocratic tradition's preoccupation with diet and its avoidance of surgery and abortion (because of its derivation from the Pythagorean Cult) also fail to capture the plethora of health care options available to us and their accompanying problems (Zaner 1988, 207). Nonetheless, we owe our basic conception of medicine as the art of "doing what should be done" to the Hippocratic tradition.

MacIntyre's analysis fails to consider certain problems that may arise concerning "doing what should be done." For example, many physicians in the United States receive a brief
introduction to liposuction and then perform this technique without being adequately trained. In some cases, patients have died as a result. Why this tragedy? Certain external goods (money in particular) have caused these physicians to compromise the standards of excellence that are crucial to the moral practice of medicine. MacIntyre claims that the external goods are only contingently attached to the practice and don't define it. This seems mistaken. The liposuction case suggests that, at least in the American health care system, a lucrative technique and greed are having a substantial impact on the profession's standards of excellence, which are sometimes low indeed as well as being in conflict with an internal good (viz. the therapeutic resolve). If a patient comes to a physician for liposuction, she expects to have the procedure done properly or to be referred elsewhere. The ideal of therapeutic resolve becomes secondary, or worse, when a physician wants to try out a technique mainly because it is highly profitable. Thus, the internal goods of medicine are jeopardized when the question, "What should be done?", shifts from a primary focus on the patient's interests. To what extent the practice can retain the proper identity under these conflicts is worth pondering.

Even if we admit—as seems reasonable—that medicine is an inherently moral endeavor, it is necessary, of course, to admit that not every action performed by a doctor is moral. This was the Hippocratic belief. However, given the perplexing choices confronting today's patients and doctors, and the
tremendous variation of values present, it is difficult to be comfortable with such ancient conclusions. That doctors do what should be done is no longer a matter of great confidence in many cases. Why this is so is the subject of the next chapter.
CHAPTER 2
TECHNOLOGY AND MORALITY

In the Garden of Eden, we are told, Adam and Eve could live happily—provided they did not eat the fruit of the Tree of Knowledge. As long as they listened to God and avoided that tree, they could be confident they were doing the right thing. But, as we all know, the fruit was impossible to avoid. Their bites of the apple brought them into the throes of the knowledge of good and evil and ended their days in Paradise. The terror they felt upon their exile from Eden has worked its way into modern consciousness in numerous ways. The most eloquent expression of this horror can be found in the Brothers Karamazov, in the words of Ivan: "Without God, everything is permitted." Leaving most things up to God offered a comforting degree of certainty in the face of difficult choices.

Modern medicine, too, has found itself banished from Paradise. In the past, prior to the incredible successes of research and technology, there was often very little that could be done for the very ill and dying. Most people died because of problems with their health, a fact that was tragic perhaps, but expected and better accepted than it is today. What should be done for these people was all that could be done: very little or even nothing. With limited options, the trad-
itional principles and values of medicine seemed to be adequate to handle the choices available. However, after the technological revolution in medicine (i.e. after the apple was bitten), things became wonderfully and enormously different. New technology brought more options but it also escalated uncertainty. Although, on the surface, technology appeared to be the means to desired outcomes, it was often extremely difficult to decide which of the possible outcomes should be chosen. In fact, technology created choices that traditional values were not only inadequate to handle but also even seemed to give the wrong answers for (e.g. the Quinlan case and the early cases of organ retrieval). Because of these difficulties, it soon became apparent to those working in the health sciences that the traditional principles and values of medicine couldn't simply be extended to cover the new choices.

Dostoevsky's insight is especially pertinent to modern medicine: with options, everything is permitted, including the possibility that the wrong options shall be chosen. In this chapter, the roots of this uncertainty shall be considered in greater detail. Why is it that medicine, as an inherently moral enterprise, experiences such profound difficulties with knowing what should be done?

Moving Outside of Philosophy for a Clue

On 17 October 1990, Richard Taylor, who received his MSc. in 1952 from the University of Alberta, won the Nobel
Prize in Physics (Pilger 1990, 16). He received the award as a result of experimental work done between 1968 and 1973 at the Stanford Linear Accelerator Centre (SLAC), where he is a faculty member and former associate director of research. His work led to the first physical evidence for quarks, which was no small achievement, since quarks are now believed to be the most fundamental building blocks of matter (Ibid. 17). Oddly enough, although quarks comprise ninety-nine percent of all matter on earth, physical evidence for their existence had to wait until Taylor's work.

In order to obtain physical evidence for something as fundamental as quarks, Taylor had to work with extraordinarily complex and expensive technology (the accelerator cost 114 million dollars in the mid-1960s) (Ibid. 19). SLAC, near Stanford, is over three kilometers in length and is used to accelerate electrons until they obtain stunning amounts of energy (twenty billion volts). These high energy electrons are then used to penetrate the protons and neutrons at the atom's core.

What is the nature of Taylor's interaction with the technology he employs? He described his relationship with SLAC in an interesting way when he distinguished between the two kinds of particle physicists: theoreticians and experimentalists. Taylor, surprisingly enough, groups himself exclusively with the latter kind of physicist. In response to a question about whether prior to the physical evidence for quarks he had believed them to be only a mathematical
abstraction he replied: "Experimentalists don't have to decide--they just have to work." He then added: "We were out on a voyage.... The new accelerator gave us new room to look for things and we were doing just that" (Ibid. 17).

Is Taylor's casual, seemingly unreflective attitude toward technology simply the product of a brash form of Albertan modesty or is there something deeper and more ominous behind this posture? Is this posture confined to the modest men and women of SLAC or is it more widespread through modern, industrialized societies?

In a recent C.B.C. Radio interview [20 January 1991], the New York psychiatrist Robert Jay Lifton was asked to comment on the distorted reports about the technology being used in the Persian Gulf War.¹ The reports are distorted because the viewers aren't being shown who is being killed and wounded, only how. He explained that the most devastating effect of these reports is a form of dissociation between knowledge and feeling in the viewers, such that they know the technology is brutal but they do not fully appreciate its consequences. Indeed, for too many people watching the media coverage of the war, the suffering the technology produces has been forgotten, or at least temporarily repressed. This leads to what Lifton calls "psychic numbing," a state in which legitimate emotional responses to the horrors of war are denied.

¹This interview was also shown on C.B.C. Television on 23 January 1991. Lifton has long been a vocal opponent of nuclear weapons and has recently written a book titled Nazi Doctors.
Instead of considering who's on the receiving end of the cruise missiles and the B52s' payloads, the highly anxious T.V. viewers are being lulled into a trance by the stealth bomber and the patriot missile.

Because of their deep anxiety, the T.V. viewers are very receptive to the wishes of strong authority figures (e.g. George Bush and his generals). Highly anxious people permit themselves to be manipulated by those who promise to remove that which threatens them. However, when the public snaps out of its trance and realizes the high cost of having allowed itself to be manipulated, it will experience a deep sense of anger. The high costs, of course, are the environmental tragedies, the civilian casualties, the archeological destruction, the instability in the Gulf, etc.

The anger that will be experienced is necessary, since it allows one to escape from a state of psychic numbness. To assist us in our escape from our psychic numbness, Lifton encourages us to use our "moral imaginations." This involves imagining, say, a cruise missile heading towards an Iraqi nursery school. In order to avoid being pawns in our leaders' hands and to be capable of anger, we must develop our moral imaginations.

Of course, a number of objections can be raised against this view. It can be objected that we should also direct our moral imaginations towards the people of Kuwait, the Kurds, and all of the other victims of Saddam Hussein. If we do so, we will, no doubt, agree that the Gulf War had to be fought.
While me may concede that Saddam Hussein had to be defeated (i.e. we support the goal), we can be selective about which means of defeating him we will support. Though we may approve careful bombing of military targets, we can consistently refuse to endorse the use of chemical, biological, and nuclear weapons. In addition, carpet bombing of civilian targets (e.g. Hanoi) is difficult to approve of if one applies one's moral imagination to the Iraqi civilians.

Another objection is as follows. Imagine that in 1936 Daladier and Chamberlain decided to go to war with Hitler to prevent him from achieving his sordid goals. If the war had been fought at that time, 100,000 people would have been killed, a tiny number in comparison to the many millions who actually perished in World War Two. Imagine, however, that the journalists of the day began to send pictures and stories back to the pacifistic people on the home fronts. The effect of such reporting probably would have turned the public against the war, thereby permitting Hitler to commit countless atrocities. In this case, wouldn't the pacifistic moral imaginations undermine a cause that ought, instead, to be given full support?

While it is essential to defeat such evil regimes, there are a number of ways to do so, not all of which are morally acceptable. Certainly, as a result of the terrible bombings of Dresden, Hiroshims, Nagasaki, Hanoi, etc. many people refuse to support indiscriminate attacks on civilian targets. Instead, they expect their leaders to be moral
and humane in the pursuit of justified goals. In the Gulf War, we are told, the coalition forces went to great lengths to avoid civilian casualties. If this is true, then we have just goals pursued in a moral and humane fashion, a state of affairs that is very different from dropping napalm on Vietnamese civilians or fire-bombing peaceful Dresden. The public's refusal to support the wholesale slaughter of civilians is a natural consequence of the acquisition of a healthy moral imagination. Given the horrors of the twentieth century, it is no surprise, perhaps, that many people are selective about what causes they'll support. If we couple a healthy moral imagination with the courage to stand-up to despots, we produce a group of individuals who can be confident of their values and goals. Thus, Lifton is right to insist that people know and feel the horrors of war.

Naturally, a considerable amount of coordination would have to exist in a society that desired both to fight despots and to not become involved in morally unacceptable wars. The nation's foreign policy and arms regulations would have to be such that despots aren't allowed to flourish (e.g. Hussein as the leader of the fourth largest army in the world). The media would have to be controlled to allow the desired public opinion for the particular conflict. Whole-hearted support for just causes would be necessary, while widespread protest would be best in cases where involvement appears unwise. The military would have to be trained to value winning major wars at the least cost. Instead of trying to carpet bomb
every square metre of a country (e.g. Vietnam and Nazi Germany), they might pride themselves on how little "collateral damage" they inflict. While we must resoundingly defeat those who torture, rape, and use barbaric weapons, we must not employ the same means and share the same values to do so. To the extent that we compromise our moral standards, we also make a farce out of the notion of a "just war."

Applying These Clues to the Health Sciences

It is time to relate the insights derived from Taylor and Lifton to the practice of modern medicine. First we will consider the role of those who operate the "state of the art" technology that is becoming ever more routine in the health sciences. Understandably, those who are first introduced to the machines they will operate feel highly anxious. Their fears centre around their "greenness." They are concerned about breaking the machine; embarrassing themselves; obtaining inaccurate data; etc. Of course, before long the sense of being a greenhorn passes and the machine operators can calm down and enjoy their work. However, because of the large volume of patients handled in many hospitals and clinics, what may have once been enjoyable soon proves predictable and even unpleasant. After the installation of highly automated analytic machinery, the lab technicians who once had to examine every test tube that arrived in the lab experience a sense of liberation. But even this sense of liberation
is soon masked by a new routine. More efficient labs can accept more test tubes and so the use of the new equipment itself becomes drab.

The impersonality of the modern health care setting is found most everywhere, but nowhere more clearly than among those who handle large numbers of "cases." Cases don't become persons for these people, since all that matters is getting the data right for the given case. In much the same way that Taylor didn't have to worry about the bigger questions concerning quarks, machine operators in the health care setting simply concern themselves with accuracy and don't often think about the patient's history, needs, fears, etc. Like the pilots who are amputating legs and dropping napalm, the thing that matters most is that the machinery is operated competently, not the broader implications. We take the x-rays because the doctor ordered them and we drop the bombs because it's our duty.

Lifton's remarks can be related to the patient's experience of the astonishing technology present in even the most humble health care facility. Most patients know very little about medicine and next to nothing about its tools. At best, a patient will know that a CAT scan is only ordered if some trouble is suspected. Because of their lack of information about their conditions and their ignorance about medical technology, most patients are extremely passive. They put themselves completely in their physicians' hands and submit themselves to the battery of tests and procedures deemed
necessary. As patients venture deeper and deeper into the labyrinth of medical technology, their sense of powerlessness and vulnerability increases correspondingly. The learned helplessness that many experience as a patient is not unlike the trance experienced by the anxious T.V. viewers. This state of passivity and powerlessness is a significant blow to the autonomy of patients and acts to cut them off from themselves. The result is a form of dissociation because the patient knows he is being dehumanized, but he doesn't acknowledge his feelings (i.e. he fails to express them). Despite the deep anxiety and fear the patient feels, he goes along with everything, because he wants to be a good patient, and he hopes everything will turn out O.K.

Naturally, from the patient's perspective, knowing what should be done becomes nearly impossible if he hasn't got a clue what's going on. His experience of the technology and its operators is but an unintelligible smear without any comprehension of "what it's all about."

When Taylor was asked whether he thought building blocks even more fundamental than quarks will be discovered, he replied that a far more important question is: "Do you want to keep on looking?" He said that the obvious answer to this question is, "Yes" (Pilger 1990, 17). For physicians, the question of what should be done is often decided by our current attitude towards and expectations of technology. Our attitude, certainly within the health sciences, is very much like Taylor's. Even in cases where we don't feel completely confid-
ent about the morality of what we're doing, we continue to use technology to "help" patients. Why is this so? We keep people connected to machines because these are the only machines we have and because we are all confident that we'll have much better ones tomorrow. Like Taylor, health care workers answer the question, "Do you want to keep on looking?" affirmatively. Thus, the interesting question for most health care workers is not, "Are we abusing this technology?" but, rather, "How can we overcome the limitations of this machine?" Often, then, what should be done is answered in terms of the best use of the available machinery. The moral uncertainties can be and often are displaced by the relative confidence presented by the belief that everything possible is being done for the patient.

The "pie in the sky" expectations possessed by many people who become ill also create problems for determining what should be done. People want to keep out of the clutches of death indefinitely; we want to escape pain, to have "perfect" bodies, to shake off the blues, to stay young for-ever. Given expectations like these, the demands placed on the medical profession are daunting indeed. Of course, technology is often called upon to satisfy the wants of an outrageous public, so much so that, again, what should be done gets displaced by what can be done.

Regardless of what values someone might have, he or she is confronted with the fact that medical technology is applied in certain narrowly prescribed ways. Thus, an individual who
does not share the follies of the "denial society," or the enthusiasm of the philosophy of progress, may find his or her own values very much at odds with how things are routinely done in hospitals. Although many people view the present heterogeneity of values as somehow endemic to modern society (cf. MacIntyre's *After Virtue*), this fragmentation can also be viewed in an entirely positive light. If everyone shared the same values, attitudes, and expectations with respect to technology, then very little time would be spent worrying about what should be done. Instead, because some doctors and nurses are disturbed by their work, and because some patients don't like what modern medicine sometimes has to offer, an atmosphere of disagreement becomes inevitable. This disagreement is exactly what is required to make people ask important questions like, "How can we overcome the limitations of this machine in a way that is morally acceptable?"

In the end, we must, like Ivan Karamazov, accept the horror of freedom: even though we believe that some of the options available to us shouldn't be chosen, we are forced to accept that no matter how cautious we are we remain fallible. Fortunately, many of the unexpected problems caused by medical technology have served to snap significant numbers of people out of their trances, making them more critical of the role technology plays in the health sciences. While there sometimes is no agreement about what should be done, there is at least more reflection on the question. In the next chapter, we shall examine the role ethics is asked to play in the
determination of what should be done and the resources it has to offer.
CHAPTER 3

MEDICINE AND ETHICS

The ability to shoot down SCUD missiles is the result of a lengthy interaction between theory and practice (in a couple of senses of "practice"). It is easy to assess the success of such theoretical resources: they're adequate if they produce the desired result. In exactly the same manner, medical engineers who are attempting to design a better form of medical technology will have a direct, quantitative way to measure their progress. As we saw in the last chapter, these individuals aren't primarily concerned with questions like, "What is the potential for abuse of this technology?", or "How will this technology change the nature of human existence?" Questions like these, however, are inescapable, since technology has a strong tendency to lead us into problems of enormous magnitudes. When nations hostile to us and our values possess nuclear, biological, and chemical weapons, we may have occasion to regret the impact technology has had on our daily lives. When loved ones are impaled upon sterile and menacing life support systems, with no likely prospects of regaining a life of self-possession and dignity, we have to confront the dehumanization and chaos that await us when our luck runs out.

Are we doomed to an existence of slavery to technology or
can we shape the kind of people we will become and the role technology will play in our lives? Although the situation may seem much more threatening in the case of military technology, the problems posed for us by medical technology are also disturbing. Awareness of these problems isn't confined to those who have been ill and have had unpleasant experiences with the health care system. Even for many health care workers technology is no longer an unmixed blessing. As Zaner observes: "Beleaguered by the emergence of profound moral issues in the very midst of its own research and practice, medicine appealed to philosophy and others of the humanities for help" (1988, 20).

Strange Bedfellows

Why medicine turned to philosophy, essentially a theoretical field, is an interesting question. Perhaps some of the reasons are as Arthur Caplan sees them. Because of new technologies and procedures, the scientific community faced serious policy choices. "Some scientists were unwilling qua scientists to make decisions concerning the regulation and application of these new devices and techniques" (Caplan 1980, 24). Caplan claims that others within the medical and scientific communities were eager to involve philosophers and others in social policy debates in order to legitimate these policies "in the eyes of a skeptical and even hostile public" (Ibid.). He adds that doctors welcomed medical ethics in the late 1960s and early 1970s as a way of dealing with
public and governmental discontent with the way medicine was being practiced (Ibid.). Of course, some physicians were no doubt prepared to acknowledge that advances in medicine and biomedical technology raised new substantive issues of genuine philosophical and ethical importance. As the capacity of medicine to intervene at all points in the human lifespan has increased, issues concerning confidentiality, autonomy, rights, paternalism, the definition of disease, and the determination of life and death have come to the fore. It was only natural that some existing effort be made to extend traditional philosophical analysis of ethics to the world of medicine (Ibid. 24-25).

What, then, could philosophy offer medicine? For the moment, let us confine our attention to the resources philosophy has made available to deal with the moral issues emerging from the practice of medicine. Whether these resources have been what those in the medical profession have desired or expected will be briefly considered below and explored in greater depth in the next chapter.

Applied Ethics: A Resource-Based Industry

Many undergraduate biomedical ethics courses are now offered in colleges and universities throughout North America. These are usually taught by philosophers who have at least some background in ethics. The courses standardly discuss various types of ethical theory (e.g. deontological and teleological theories); define a number of terms (e.g. "paternalism", "autonomy", "informed consent", etc.); and involve exposure to an assortment of articles offering arguments for one side or the other in various moral issues related to medicine (e.g. abortion, euthanasia, and confidentiality). The courses are
taught very much from the vantage point of those involved in academic philosophy and are often a standard ethics course in a new package. Students leave the courses knowing a little more about philosophy, and, if all has gone well, with a desire to pursue the subject further. Whether they have been trained to make moral decisions in difficult cases is doubtful.

Although most nurses and doctors receive some training in matters of ethics and values, few of their courses are much like the standard biomedical ethics courses just considered. In a survey conducted by the Institute on Human Values in Medicine, in which 122 medical schools were asked whether they offer courses in ethics and values, it was learned that these schools had 1,064 faculty members teaching in the area of 'human values,' and that nearly half of these were physicians (Pellegrino 1981, 2). Only about ten percent of the total number of faculty were bona fide humanists (Ibid.).

Of these only one out of five actually devotes more than 25 per cent time to such teaching. Institutions which have hired philosophers as regular faculty have been commended for 'practicing what they preach' (Mahowald 1986, 144).

Although this survey suggests humanists have only had a minor impact on medical education in the past, they have, nevertheless, produced an impressive array of resources for biomedical ethics. Humanists were actively involved in the founding of both the Hastings and Kennedy Centres (both involve people of diverse backgrounds). A veritable flood of books have appeared on the market and there is no end in
sight. The last twenty years have seen the rise of a number of journals in the field and a variety of philosophical anthologies for biomedical ethics. While acknowledging these advances, one must be careful not to overestimate their influence. It would be very interesting to see the results of a survey conducted of health professionals that determined their level of awareness of these many resources. Unfortunately, it seems likely that most of them would make very little, if any, use of them.

Even while admitting that participation in biomedical ethics is rather skewed towards philosophy, it is nonetheless true that it functions best as a multi-disciplinary endeavor. As Mary Mahowald notes, it is not only the contributions made by medicine and philosophy that are valuable; so, too, are those from theology, law, and the social sciences (1986, 146). The external criticism medicine has undergone for many years has had a significant impact on the way it is currently practiced. Not surprisingly, the backlash against biomedical ethics' early role in the health sciences is also having an influence on how the field is evolving. At this point, perhaps, medicine is becoming more concerned with the moral justifiability of the results it produces and biomedical ethics is being forced to pay closer attention to the essentially practical side of the health sciences. This interplay between disciplines is healthy and certainly both medicine and philosophy are dynamic enough to withstand the threats of intellectual ruts and moral uncertainties.
Philosophy and What Should Be Done

It is time to consider the role philosophers were expected to play in dealing with questions about what should be done within the health sciences. Philosophers are often regarded as possessing some form of moral expertise.

Philosophy...retains the distinction of being the only discipline explicitly engaged in the study of ethical theory as one of its special subject matters. Unlike practitioners or theoreticians in other disciplines, who assume the truth of one ethical theory or another without critical investigation, philosophers traditionally attempt to justify the theories they propose (Fox 1986, 4).

What follows from this is perhaps not surprising:

...when one seeks answers, not only to what is right or wrong in particular cases, but also to questions of correct principles, it seems only natural to turn to philosophy for answers (Ibid.).

Thus, the claim that philosophers possess some expertise on practical problems is plausible. We will explore the extent of this expertise in a later section (chapter eight) and discover that there are some profound limitations associated with the kind of role philosophers ought to play in the health sciences.

For some philosophers, engagement in biomedical ethics has simply involved a slight adjustment in the way they pursue their daily activities.

Medical ethics is a special kind of ethics only insofar as it relates to a particular realm of facts and concerns and not because it embodies or appeals to some special moral principles or methodology.... It consists of the same moral principles and rules we would appeal to and argue for in ordinary circumstances. It is just that in medical ethics these familiar moral rules are being applied to situations peculiar to the medical world. We have only to scratch the
surface of medical ethics and we break through to the issues of "standard" ethics as we have always known them (Clouser 1978, 115).

In much the same manner as Clouser, Hare attempts to make medicine fit into the Procrustean bed of philosophy. Hare sees philosophy's primary task as being conceptual analysis and clarification, since philosophy involves

...training in the study of tricky words and their logical properties in order to establish canons of valid argument or reasoning, and so enable people who have mastered it to avoid errors in reasoning...and so answer their moral questions with their eyes open. ...once the issues are thoroughly clarified in this way, the problems will not seem so perplexing as they did at first and, the philosophical difficulties having been removed, we can get on with the practical difficulties (Hare 1977, 52).

An interesting question for Hare, of course, is whether one should group value conflicts among the philosophical difficulties or with the practical difficulties?

Not surprisingly, perhaps, Caplan finds assessments of applied ethics that resemble Hare's comical:

Oftentimes in the course of trying to explain to the uninitiated of health care what it is that philosophers do, those in philosophy and, in particular, applied ethics will mention such talents as being able to analyze the meanings of words, detect logical confusions and fallacies, and the ability to establish canons of sound and valid argumentation. Thus, one skill that someone expert in applied ethics can provide to those working in a medical setting is felt to be that of patrolling and policing logical malefactors (1983, 313).

Because of the remoteness from clinical reality of views like Hare's and Clouser's, they have begun to fall into ever more disfavour. After a couple of decades of trying to approach the problems of biomedicine in its standard way, moral philosophy has begun to lose steam. Some philosophers,
like Eric Cassell, see this floundering as a sign of complete failure (Zaner 1988, preface). Zaner's own criticisms, while not as harsh as Cassell's, are no less telling:

At first generally thought to be an exercise in philosophical analysis of concepts, rules, and applications, biomedical ethics has gradually, and only with much resistance, been forced to realize that this approach simply has not had much bite or relevance for the actual contexts of doctor's clinical practices and interventions in the lives of real patients struggling to restore or maintain themselves in the face of painful, highly emotional, and wholly individual decisions within their own respective moral and social frameworks (Ibid. xii).

We will return to the problem of the lack of "bite" and the irrelevance of the standard approach to biomedical ethics in the final chapter.

Ironically, in order for us to see why Zaner's criticisms are so forceful, it is necessary to consider briefly one of biomedical ethics' greatest successes, Tom Beauchamp's and James Childress' *Principles of Biomedical Ethics*, a work that first appeared in 1979. I will quickly outline this methodology in the remainder of this chapter and examine its deficiencies in the next.

**A Neat and Tidy Paradigm**

Prior to the appearance of Beauchamp's and Childress' work, the literature of biomedical ethics mainly consisted of essays and articles, some of which were gathered into anthologies that began by offering brief remarks about them. "These essays usually discussed the current perplexing cases and issues...but only rarely offered much in the way of methodology"
(Jonsen 1990, 32). For many philosophers, the most positive feature of *Principles of Biomedical Ethics* was the link it made between the currently interesting ethical questions of biomedicine and the currently accepted approaches of moral philosophy (*Ibid.*). In addition, the paradigm maintained a strong connection with the dominant traditions in moral philosophy and the important values of the day (anti-paternalism, individual rights, etc.), and did so in a way that seemed comprehensive and coherent. The result was a methodology that was both easily taught and learned, a virtue that no doubt guaranteed its popularity.

Beauchamp and Childress rely on an approach to deliberation and justification that has four levels: 1. particular judgments and actions; 2. rules; 3. principles; and 4. ethical theories (Beauchamp 1989, 6).

Judgments express a decision, verdict, or conclusion about a particular action.... Particular judgments are justified by moral rules, which in turn are justified by principles, which ultimately are defended by an ethical theory (*Ibid.* 7).

For example, a doctor might decide to tell his patient that she has a terminal illness because he subscribes to a rule dictating his telling the truth in all but very exceptional cases. This rule might then be justified by some higher level ethical principle, such as "respect for persons." This principle might then be defended by a utilitarian or deontological ethical theory.

Interestingly enough, although individual philosophers often act as if there is only one legitimate ethical theory,
a significant number of theories have emerged from a diversity of viewpoints. Be that as it may, none of these seems likely to emerge as the currently accepted theory and none is entirely free of problems. For their part, Beauchamp and Childress discuss what they consider to be the two major types of theory, one of which is teleological, the other deontological. As to which of the two they regard as most suitable for defending the principles of biomedical ethics, they reply:

...the distinction between consequentialist...and deontological theories, while important, can be and has been overestimated. There are major differences within each type of theory--regarding the grounds of the theory, the number of its principles, and whether the...theory's principles apply directly to acts or are mediated through rules. But there are also major similarities across certain rule-oriented theories. ...some...converge on the same principles and rules (Ibid. 62).

The four principles of biomedical ethics are autonomy, nonmaleficence, beneficence, and justice. The logical nature of these principles offers critical force, because they are intended to play a significant normative function (Arras 1986, 15). The normative function must be used thoughtfully, for the principles were intended to offer both moral criticism and evaluation of the practice of medicine and guidance for physicians at the bedside. As well will see in the next chapter, however, the principles are mainly ineffective in offering guidance. Thus, physicians were bombarded with criticism (e.g. for being paternalistic, deceptive, sexist, etc.), but were offered very little support at the same time. Normally, people who are criticized by others who appear to
have relatively little constructive to offer soon become resentful. This resentment, no doubt, has had a negative impact on medicine's attitude toward philosophy and sometimes has left medicine unwilling to pool resources. Let us now turn to some of the problems associated with the role and resources of ethics in the health sciences.
CHAPTER 4
BIG CHALLENGES AND BIG LIMITATIONS

As a result of its involvement in the health sciences, normative ethical theory has come under severe attack, both from inside philosophy and without. The intense criticism philosophy has undergone in this regard may prove beneficial in the long run, for the backlash has made more philosophers highly sensitive to defending the relevance and efficacy of their activities. However, like a radical masectomy that removes the good with the bad tissue, many of the recent criticisms have been indiscriminately hacking away at philosophy's role in the health sciences. If the knife is pressed too deeply, it may turn out that most philosophers will prefer not to involve themselves in biomedical ethics, perhaps as a result of a lack of confidence in themselves and their art. It is time to consider some general criticisms of philosophy's role in biomedicine (and the resources philosophy has to offer). Later in this chapter, problems with Beauchamp's and Childress' "applied ethics paradigm" will be discussed.

Practice and Theory

One of the most glaring disparities between medicine and philosophy is also most responsible for the lack of interdisciplinary cooperation between the two fields.

...the philosopher remains an interloper, a theorist
in the land of therapists.... The philosopher's stock-in-trade is principles, concepts, and theories--not therapy or guidance counselling. The philosopher is concerned with foundations, arguments, and logic, not with, as often seemed the real agenda for physicians, sensitizing health professionals to values, ethics, and morals (Zaner 1988, 5).

The source of many problems, of course, is a significant misunderstanding of the nature of moral philosophy on the part of some physicians. No doubt, they had hoped to be presented with a defensible set of values; to be trained to recognize the moral dimensions of a case; to see what should be done; and to want to do what should be done. The expectations of both philosophers and physicians as to how the former would operate in the health sciences could hardly have been more opposed. As we saw in the last chapter, many philosophers (e.g. Clouser) wanted to get on with their usual business despite the change of context. Physicians, who as a result of their training are results-oriented, wanted something very different. They expected clarity, precision, and confidence; instead, they received uncertainty, doubt, and confusion.

The source of this uncertainty, doubt, and confusion was likely the fact that the central concerns of the philosophers had become so abstract and general--above all, so definitional or analytical--that they had, in effect, lost all touch with the concrete and practical issues that arise in actual practice, whether in medicine or elsewhere (Toulmin 1986, 278).

Like a person who has been too long in the darkness and then ventures out into brilliant sunshine, philosophers fumbled around awkwardly in the face of medicine's needs. But,
unlike the person who can't hide the fact she's sun-blinded, some philosophers have continued to pursue biomedical ethics as though nothing is amiss. This, in itself, implies any of a number of things. Some philosophers may regard physicians' dissatisfaction with normative ethical theory as being the result of a lack of philosophical aptitude among most physicians. Other philosophers may be relieved to have a job and understandably don't want to make waves. Still others may accept the criticisms, yet attribute them to philosophy's relative inexperience in the health sciences. Perhaps, with time, philosophical normative theories will evolve into effective tools that can be applied satisfactorily.

But can medicine wait for philosophy and for how long? It is apparent that medicine needs results soon, and expects them to be defensible. One approach open to medicine, of course, is that it develop its own resources for dealing with moral issues. In some cases, this is, in fact, what is occurring and for a number of good reasons.

1. As Mahowald explains, increasing numbers of physician-philosophers or nurse-philosophers are appearing in the ranks of the health care workers (1986, 144-145).

2. At present, the majority of people teaching courses in human values at medical schools aren't philosophers. In fact, many physicians are now offering some form of instruction in these matters.

3. Increasing numbers of books in biomedical ethics are being written for physicians and other health care professionals (e.g. Brody's Ethical Decisions in Medicine and Clinical Ethics by Jonsen, Siegler, and Winslade).

The advantage of being a physician-philosopher or a
nurse-philosopher is that you can shape philosophy's resources to meet your needs as a health care worker. This is clearly an attractive option, since the modification of philosophy is done from inside the health sciences and will mainly be driven by familiar, concrete concerns.

A major advantage of having experienced physicians give courses in human values is that the medical school retains control over what gets discussed and how it gets discussed. Thus, it is possible to rely on detailed cases to illustrate problems, an approach that permits a strong connection between the practical and ethical sides of medical education. Instead of focusing too much attention on Karen Ann Quinlan and renal dialysis, physician-educators could draw on more routine problems and also on particularly difficult cases that have just occurred. Of course, some control could also be exerted on the attitudes and feelings that are acquired by the students in response to the cases considered.

As Mahowald observes, books written by physician-philosophers for physicians are popular, because they are an "attractive alternative to the inconclusive speculations of 'pure' philosophers, and the isolated, detailed histories of 'unique' cases by practitioners" (Ibid.).

So, if this approach were followed (at philosophy's expense), we would have before us a case of medicine saving what it can use from philosophy, rather than medicine saving the life of philosophy. Despite the fact that this approach has much to recommend it, there are, however, a number of
serious problems associated with it.

First and foremost of the problems that will confront this approach is the fact that the physician-philosopher will feel more strongly drawn to the medical profession than to philosophy. The medical profession is a tightly-knit, high status body of individuals who share a common identity, certain important professional values, and a strong sense of fraternity. The starting point for most physician-philosophers would be a defense of the practice of medicine, because a considerable amount of self-respect and pride are associated with it. While the physician-philosopher might point out limitations and places needing improvement, he or she will likely feel some pressure to be selective about how criticisms are offered. In order to be welcome among one's peers, who are, in some sense, the elite of society, one's conduct must be acceptable.

William Ruddick is concerned that philosophers involved in the routine of clinical practice "will be absorbed into the medical center ethos and become collaborators in a flawed system" (Zaner 1988, 8). Physician-philosophers will not be collaborators: they will primarily be physicians working with the guidance provided by their medical training ("the medical center ethos"). They may think about a few things differently or treat people slightly differently, but, in the end, they are doctors working inside the system. As they are insiders, they are subject to all of the rules, laws, and expectations of the medical profession that any other bona fide doctor is
subject to. Thus, their feelings about and attitudes toward the health care system will be profoundly different than most, if not all philosophers. One can only collaborate with the enemy. It would be an odd doctor that regarded other doctors as his enemies.

Thus, relying on physician-philosophers, as opposed to ordinary philosophers, would deprive the medical profession of sometimes highly valuable external criticism. Even the best-intentioned self-enforcement can fail to notice every problem. Whether this external input would take place in the hospital corridor or at policy meetings would depend both on the medical profession's willingness to receive input and on the quality of the criticism. Clearly, if the input is delivered in a respectful, but persuasive manner, then it is reasonable to be receptive. But, as Caplan notes, "those doing applied ethics have been far more effective in influencing the formulation of health policy at the federal level than at the bedside" (1983, 314).

An obvious problem associated with medicine's reliance on physician-philosophers instead of fulltime philosophers is the fact that "it takes time, concentrated devotion, and hard intellectual labor to achieve either moral sensitivity to or expert knowledge of ethical phenomena" (Zaner 1988, 8). It also takes an enormous amount of mental, physical, and spiritual energy to be a good physician. As Mahowald correctly reminds us:

The first two years of medical school are often a
memory feat, the next two years an endurance contest. Moreover, medical students are at a point in their lives where they have zeroed in on a very specific goal, namely, to be a doctor. They are naturally drawn to subjects which will equip them to do that, and philosophy is not one of these (1986, 144).

Unfortunately, there are even drawbacks for a person who receives a Ph.D. in biomedical ethics and then goes on to complete a M.D. degree. This philosopher-physician obviously can't pursue a medical career fulltime if any more than a tiny fraction of his or her time is devoted towards ethics. If a physician takes the demands of the profession seriously, there is very little time left over after these demands (and family demands) have been met.

So far in this chapter we have considered one of medicine's responses to the problems associated with both the role and resources of biomedical ethics. It is time now to turn our attention to the problems relevant to Beauchamp's and Childress' approach so that we may examine the philosopher's response to the limitations of biomedical ethics. This discussion will carry over into the next chapter where the anti-theory movement in philosophy will be briefly explored.

The Paradigm Revisited

One of the standard criticisms of the paradigm theory of biomedical ethics is that it has very little of substance to offer in the face of the intense demands of routine medical practice. To see that there is some force to this criticism,
let us quickly consider a case in which a twenty-one year old woman visits her gynecologist and insists that he perform a tubal ligation for her (she is single). She has had three abortions already and greatly fears becoming pregnant again. She explains that she is certain she never wants to be a mother, because she knows she would be a disastrous parent. Her own family was highly dysfunctional. It's all she can do to take care of herself. The physician knows what she is saying is true, but he isn't sure that tying her tubes is the right thing to do. He tells her that he'll phone her with his decision later in the afternoon.

For the purposes of the discussion, let us momentarily ignore options like referring her to a psychiatrist or to another gynecologist. Let us assume that the physician wants to make a decision and wants to challenge it in order to be sure it is proper. He has, fortunately, read *Principles of Biomedical Ethics*, and has an adequate understanding of the approach it outlines.

He beings by trying to imagine what the relevant moral rule might be for this case. Unfortunately, since Beauchamp and Childress don't list the rules for him to consult, he realizes that he must think one up for himself. For the moment, he ignores the legal and professional rules and attempts to come up with what he takes to be a moral rule. He arrives at the following: "As a physician, you are under a prima facie obligation to perform the procedures that will benefit your patients." Since he deems the patient to be competent and
since the procedure is legal in this case, he decides that he ought to perform the tubal ligation.

Of course, the decision is justified by the moral rule he has thought up only if the moral rule is justified by one of the principles. He decides that the principle of beneficence justifies his moral rule, for he believes some good is done by preventing his patient from having further abortions and from raising a miserable child. Since he is a rule utilitarian, he defends his principles with that theory. After he finishes this process, he is left with a nagging doubt that it was too superficial, too remote, and far too mechanistic. He decides to try to reach the opposite decision as a test--just for his own peace of mind.

He tries to think of a moral rule that would justify his decision not to perform the procedure. He fixes upon: "As a human being who knows that life is difficult but also that help is available and adversity can lead to strength of character, maturity, and compassion, you are under a prima facie obligation not to aid others who resort to desperate measures to resolve their problems." He tries to think of conflicting obligations that would undermine the obligation stated by the rule, but he can't. Again, he relies on the principle of beneficence to justify the rule and on rule utilitarianism to defend the principle. To be careful, he considers in what ways he might behave beneficently towards his patient if he refuses her request.

To begin with, he comes across the notion that he might
promote her autonomy by denying her this procedure. If he recommends, instead, that she sees a psychiatrist to deal with her life's problems, she may later be glad that she was denied this option. It also occurs to him that by tying her tubes he would be "fixing" her reproductive system but not her emotional difficulties. The best outcome he could wish for her would be to have her consider herself as a person with feelings, fears, and needs, rather than simply as a physiological mechanism. Clearly, in at least one sense, he would be expressing respect for her as a person by trying to help her see "the big picture." Both of these considerations convince him that he does behave beneficently if he refuses her request.

Naturally, as a result of these deliberations, he is puzzled. Can this process offer him any confidence that he does what should be done? Or, as seems more likely, do his personal values shape the rules and guide him through the deductive process of justification? Perhaps in actual fact this method is superfluous to the process of moral reasoning or perhaps it is merely a comfortable means of feeling good about whatever one has decided.

Of course, one could proceed in many different ways until the desired justification has been found. The wording of the rules can be changed to reflect subtle nuances of one's values. The interpretations of the principles can be altered so that one seems to outweigh another. Since neither the rule deontologist nor the rule utilitarian can provide a universally accepted list of the moral rules (who could?), individuals
will subscribe to wildly variant codes of conduct. We can imagine that one physician would tie the tubes for the reasons we saw and another wouldn't for yet different reasons. Should the woman shop around until she gets what she wants? Those who value liberty and autonomy above all else will likely believe she should. But, for Beauchamp and Childress, autonomy is but one principle among four. They claim that how much weight it receives depends on the circumstances of the case. I claim that this approach is far too arbitrary.

**Further Problems with the Paradigm**

Jonsen and Toulmin raise other criticisms that are relevant to our assessment of the paradigm theory. In their discussion of the problems associated with principles and rules, they consider cases where no appeal can be made to any single simple rule, and observe that these are the source of genuine moral problems (Jonsen 1988, 7). They offer the following example:

If I go next door and borrow a silver soup tureen, it goes without saying that I am expected to return it...that is not an issue and gives rise to no problem.

If, however, it is a pistol that I borrow and if, while it is in my possession, the owner becomes violently enraged and threatens to kill...[someone]...as soon as he gets back the pistol, I shall find myself in a genuinely problematic situation. I cannot escape from it by lamely invoking the general maxim that borrowed property ought to be returned promptly (Ibid.).

As they observe, the pistol case involves a conflict between the obligation to return borrowed property and the obligation to prevent needless violence or homicide (Ibid.).
Jonsen and Toulmin also discuss the problems that arise when simple rules apply only marginally or ambiguously.\(^1\)

If I go to the pet store and bring home a tortoiseshell tomcat or a collie puppy, it is taken for granted that I will ensure that it is fed and cared for rather than abandoned to fend for itself. Once again, this is both legally and morally "beyond question."

But if a child goes out to the pond with a jam jar of water and comes back with frogs' eggs in the jam jar, it is not equally obvious that general maxims about the rights of innocent life and the need to avoid cruelty to animals have the same unambiguous force as before (Ibid. 7-8).

They claim that cases of this sort are as problematic as situations in which different rules clash. The important thing to realize, they insist, is that "no rule can be entirely self-interpreting" (Ibid.). Whether our gynecologist is the author of the moral rules in a given case, or whether he is applying someone else's rules,

\[\text{the considerations that weigh with us in resolving the ambiguities that arise in marginal cases, like those that weigh with us in balancing the claims of conflicting principles, are never written into the rules themselves (Ibid.).}\]

Although approaches to moral reasoning that resemble the paradigm are commonly applied in many fields, dissatisfaction with them is widespread throughout philosophy. Let us consider two kinds of criticisms to reveal the source of the dissatisfaction. Feminist philosophers criticize these theories for their failure to take into account the significant inter-

\(^1\) How Jonsen and Toulmin think these deficiencies can be dealt with will be considered in chapter six.
personal relationships that make up the social order. The bonds and associations among individuals should be the starting point for morality, they argue, not abstract principles that are blind to social realities. It isn't hard to see the relevance of such criticisms for biomedical ethics. The clinical encounter involves an enormously complicated nexus of roles and expectations. Our conduct is determined, to a considerable extent, by our socialization, training, psychological conditioning, and economic status, not by the amorphous dictates of a principle. For many individuals, ethical principles carry little or no force.

Barry Hoffmaster doubts that general principles such as the principle of normalization and the principle of the least restrictive alternative provide much help in resolving moral issues related to mentally handicapped individuals. The principle of normalization states that the retarded have the right to a range of goods and services that make their lives as normal as possible (Hoffmaster 1981, 319). The principle of the least restrictive alternative can be understood as requiring that the care, treatment, and habilitation provided to the mentally retarded, as well as the setting in which it is provided be the least restrictive of the person's personal liberty (Ibid.).

His criticisms of the principles are important:

...the principle of normalization seems to have acquired the status of dogma. The kinds of difficulties and questions just raised [how to interpret and apply the principle] are not being addressed because of the dogmatic status of the principle. More importantly, other value
questions are being obscured by a dogmatic allegiance to the principle (Ibid. 323).

The principles of biomedical ethics have, for many, also become dogma and often obscure important value questions. Since we are not told in very much detail how to assign weights to the principles, it is very difficult to answer questions like: "Why am I respecting her autonomy at the expense of my acting beneficently?" It is important to note that one's personal values will influence how much weight is attached to a given principle for a given case. If we dogmatically apply the principles, questions about the justification for the weights given to the principles will be overlooked.

Hoffmaster also argues that problems arise when attempts are made to apply the principle of normalization to concrete problems.

The difficulty is that the principle is too general or too vague to handle concrete problems, and in some cases it may come up with an intuitively correct answer (Ibid. 323).

He relates an incident involving a mentally handicapped individual to illustrate the difficulty.

A retarded person had found an apartment that over-looked a cemetery. But an objection, founded on the principle of normalization, was raised to allowing this person to live in the apartment. The argument was that it was not culturally normative to live in an apartment that over-looked a cemetery. Since most people do not live in places that over-look cemeteries, mentally retarded people should not be allowed to.... This example illustrates both problems with the principle. Does such a specific conclusion actually follow from the principle, and if it does, is it a conclusion that is acceptable (Ibid.)?
Departing from the Paradigm Or Abandoning It?

In the example of the gynecologist considered above, which of the conflicting decisions follows from the principle and how do we tell? Perhaps, it is, as was suggested, the decision that is most in accord with our values. This view, however, is clearly unacceptable. Can Beauchamp and Childress offer a more defensible account if they fail to:

1. Offer a "complete" list of rules;
2. Offer self-interpreting rules (and principles);
3. Offer complete directives about how to apply them;
4. Offer a satisfying account of what role values will play in their scheme of moral reasoning?

No doubt, they may continue to refine their theory in the years to come; nevertheless, it is difficult to believe they will succeed in overcoming its many limitations.

It may be objected that Beauchamp and Childress aren't major ethical theorists and so discrediting their work says very little about ethical theory. This is not the case, however, since no other ethical theorists have been able to attain the degree of success in biomedical ethics that these authors have. Admittedly, the kind of success Beauchamp and Childress have enjoyed is undeserved; but it is still true that no one else has advanced a more successful approach to date. As we shall see in the next chapter, some philosophers argue that it is because of problems inherent to normative ethical theory that success in applied fields has been so elusive.
One of the most significant problems confronting the applied ethics paradigm is raised by Jonsen; namely, "Is the relationship between ethical theory and moral distinctions as clear as Beauchamp and Childress seem to suggest?" (1990, 33). In the early part of their discussion, Beauchamp and Childress set out the tests for the adequacy of an ethical theory. These are, roughly, as follows.

1. An ethical theory should be as clear as possible, as a whole and in its parts (Beauchamp 1989, 14).

2. An ethical theory should be internally consistent and coherent.

3. A theory should be as complete and comprehensive as possible in listing moral principles, rules, and their connections (Ibid. 15).

4. A theory should be simple to learn and apply.

5. A theory must be able to account for the whole range of moral experience, including the principles, rules, and judgments affirmed in common morality (Ibid.).

Quoting from all three editions of Principles of Biomedical Ethics, Jonsen traces the authors' deepening doubt about whether any ethical theory satisfies all of the above tests. By the third edition, they are reduced to the view that "[e]ven if no ethical theory satisfied all of these tests --and we think no currently available theory does--we can legitimately appeal to them..." (Beauchamp 1989, 14).

It is extremely unfortunate that Beauchamp and Childress never explain what they mean by saying that an ethical theory is "adequate." Perhaps by "adequate" they simply mean that the theory has passed all of their five tests.

Be that as it may, what are the implications of their
admission that no currently available ethical theory satisfies all of their tests? Beauchamp and Childress rely on either a utilitarian or deontological theory to defend their principles. As they argue, "[e]ach type of theory offers an important moral perspective from which we stand to learn, and there is no reason why only one type of theory must be selected as preeminent" (Beauchamp 1989, 47). But if neither of these kinds of ethical theory (nor any other) is adequate, then how well-defended are the principles of biomedical ethics? With poorly, or even undefended principles, one's moral rules lack justification. Failing to justify one's moral rules results in unjustified decisions. Perhaps, the solution to this problem will be found after normative ethical theories evolve to a more sophisticated level. While some philosophers favour this view (e.g. Rawls), increasing numbers are adopting an anti-theory stance. If no adequate ethical theory is ever possible, then approaches very different from the paradigm are required. In the next chapter, the anti-theory position will be briefly outlined in order to decide which, if any, resources philosophy can legitimately offer medicine to aid its determination of what should be done.
Modern moral philosophers have mainly focused on a single goal: to come up with a theory that offers universal principles that apply systematically to particular cases. This was, of course, the goal Beauchamp and Childress were striving for when they developed their paradigm. Increasing numbers of philosophers, however, have broken away from this venture and have begun to focus attention instead on "forms of moral conservatism that regard local moral practices as primary in moral reasoning" (Clarke 1989, 1). Rather than busying themselves with abstract principles which seem to have so little relevance to concrete problems, more and more philosophers are devoting their attention to the context in which moral problems arise.

Although there are several facets of the "anti-theory movement," each of which has its own unique approach and criticisms, there are a number of unifying features that give the movement its coherence. First and foremost of these is their divergence from the following understanding of morality.

[Some philosophers] seek to articulate normative theories that can guide our behavior by systematizing and extending our moral judgments. These judgments...can be thought of as consequences of applying abstract principles in an almost computational way, giving a procedure for deducing the morally correct answer in any given circumstances. The dominant conception of morality they represent requires it to identify universally binding principles which govern
all rational persons (Ibid. 2).

Adherents to the anti-theory movement reject rationalism of this sort, and, instead, claim that very different ways of moral reasoning are required. While they can acknowledge the underlying motive for seeking principles (to have good reasons for one's actions), they can also take issue with the identification of these reasons. In their rejection of abstract principles (which are, it is argued, inadequate in practical applications), anti-theorists aren't thereby committed to skepticism about the rationality of moral practice, because they insist that other conceptions of moral reasoning are available (Hampshire 1989, 140).

While considering the case presented by the anti-theorists, it is important to keep in mind that most philosophers who offer ethical theories wouldn't claim that their principles can be applied in an almost computational way. As Arras notes, the applied ethics paradigm (at least in its deductive-computational version) "represents nothing more than a straw man" (1986, 21). Arras claims that

\[\text{there may...be a few writers in this field who would be willing to stand under the shaky banner of deductivism, but the vast majority appear to employ a much more complicated and sophisticated method of applying principles to cases (Ibid.).}\]

Of particular interest to us in this chapter, are the alternate conceptions of morality that have emerged from the anti-theorist viewpoint. These alternatives often involve a negative characterization.

The expression "anti-theory" emphasizes opposition
to any assertion (whether in the form of a substantive moral principle or a meta-ethical theory about the nature of moral claims) that morality is rational only insofar as it can be formulated in, or grounded on, a system of universal principles. It also denies that the intellectual virtues of theorizing, such as universality, explicitness, consistency, and completeness, are essential to the moral life (Clarke 1989, 2-3).

As we shall see later in the chapter, broader options are available to rationalists who are willing to drop the consistency requirement.

The alternatives then offer positive accounts of morality in terms of custom and practice, and in a manner that is both normative and descriptive. Moral rationality is characterized in terms of critical reflection which receives no support from first principles of any kind (Williams 1989, 78). In opposition to the dominant rationalist paradigm, anti-theorists emphasize two features of morality:

1. A contextualism that favours specific rationales for particular cases and stresses the ways in which the practices of a community determine the meaning and appropriateness of deliberation and appraisal. No application of universally valid principles is required.

2. A pluralism that derives from the way in which practices determine conceptions of goods. Conceptions vary among communities and there are a plurality of practices within each community (each containing its own ends) (Clarke 1989, 3).

Anti-theorists also stress that there are several goods and that they aren't reducible to a single good (e.g. utility). In addition, such pluralism about goods permits the acceptance of principles that are neutral between competing conceptions of the good (Hampshire 1989, 154-157). Of most importance, however, is the anti-theorists' insistence that morality is
primarily concerned with the particular virtues of particular cultures—traits of behaviour whose sanction has nothing to do with universal principles (McDowell 1989, 93). An important question that ought to be dealt with by the anti-theorists is whether cultural values are immune to criticism? If they hold that they are immune, much of the initial plausibility of their view is soon diminished. Clearly, the values of some cultures will not remain intact after careful, rational criticism.

**What Do the Anti-Theorists Have Against Theory?**

It is time to examine in more detail the anti-theorists' rejection of normative theory. Any or all of three reasons are commonly offered for this rejection: normative theory is unnecessary, undesirable, or impossible. However, because the use of "normative theory" in the literature is not very precise, it is sometimes difficult to assess the success of certain criticisms. Two conceptions of normative theory have become widely accepted by moral philosophers: a rationalistic formulation (e.g. contractualist and utilitarian accounts) and, what may be better regarded as a methodology, the conception advanced by Rawls (viz. reflective equilibrium). On some occasions, anti-theorists are clearly attacking such positions; but on others they seem to be attempting to refute "any set of claims that could sensibly be said to constitute a 'theory'" (Clarke 1989, 4).

Be that as it may, let us examine some of the anti-
theorists' basic arguments against rationalist moral theory. Normative theory is intended to systematize the justification of moral actions and practices. That rationalist moral theory can't achieve this (because of its own theoretical requirements) is suggested by three main criticisms. In fact, some anti-theorists deny that the rationalists even succeed in producing a theory. But the three main criticisms are as follows:

1. The semantic features required of principles by rationalist theory are incompatible with those of norms as they function in moral practices (Ibid. 5). (This criticism is highly confused and obscure. Clarke and Simpson would have done better to have focused their attention on the problems of application of principles. Other philosophers draw attention to the fact that this criticism is not supported with very substantial argumentation.)

2. A rationalist theory requires an account of the virtues which is incompatible with the features they actually exhibit (Ibid. 6).

3. Moral practices exhibit irremovable conflicts and dilemmas that confound rationalist theories (Ibid. 8).

Let us briefly consider each of these in turn in order to obtain greater familiarity with the anti-theory movement.

The first criticism attempts to show that the vast semantic distance between principles and norms creates a serious problem for normative theory because the gap reveals that principles are useless in their purported justifying role (Baier 1989, 34). Unlike norms, which are interpreted by difficult-to-specify rules of background institutions and ways of life, principles must be definite in their meaning "in order for them to play their role in the deduction of
Norms, on the other hand, have to be vague in order to guide daily conduct. As Annette Baier argues, moral injunctions like "Don't steal" have to be enmeshed in a network of cultural assumptions if they are to actually prohibit anything. It is important to remember, however, that if norms are too vague, they will have little value as a means of guiding one's conduct. In addition, it seems reasonable to hold that principles are much more complex than they appear to be on the surface because they take account of these cultural assumptions. Finally, it is hard to see how reliance on norms would be helpful since the virtue of norms as opposed to principles is supposed to be the vagueness of norms, and it's difficult to see how vagueness can help. If one instead throws in cultural assumptions, then the principles become more complex, which is acceptable; however, that is not to replace principles with norms nor to supplement principles with norms. One should also not forget that the cultural assumptions are open to criticism, even though one may be inclined to place the onus on the critic.

The semantic distance between abstract principles and concrete ways of life also prevents the rationalists from using theory to generate correct answers independently of any reliance on norms. Unless one invokes the interpretive background of cultural institutions and moral practices, one's principles won't yield definite conclusions.

Some rationalist philosophers have acknowledged the semantic distance, but have claimed that normative principles
justifies the norms of moral practices, thus providing indirect justification for the moral judgments conforming to these norms. This approach is much like Rawl's wide reflective equilibrium methodology, one of the most popular versions of moral theory building today. This response won't work, however, since an appeal to principles won't justify the background institutions and cultural expectations that shape the norms. If one attempts to justify the background interpretations with explicit principles, one will still be faced with the problem of justifying the background interpretations for these principles and so on. In the end, since one can't close the gap between what can be justified by appeal to explicit principles and what is contributed to norms through interpretation, it follows that "a rationalist formulation of normative principles cannot function to fully justify the norms of moral practice" (Ibid. 6).

In some cases, the semantic difference between principles and norms is denied because it is claimed that the latter must also be precise (Ibid.). This final approach also fails since both norms and principles would be too abstract to be applied effectively. Without reference to the background institutions and ways of life which shape their meaning, norms and principles aren't able to serve in deductive justifications.

The features that rationalists require of principles make them unable to justify moral practices, and in this sense rationalist normative theory is not theoretically possible. Conventional practices arise from social history and agreement; no other sanction is needed... (Ibid.).
The second argument attempts to show that the rationalist account of moral language involves a limited and inaccurate account of moral practices. In their attempt to deal with the lack of connection between universal principles and many terms identifying virtues, rationalists claim these terms are culturally specific and morally irrelevant. But this strategy creates more problems than it solves, for statements of character assessment are vital in expressions of moral concern (Baier 1985, 214). Besides, because virtues impose significant obligations on us much like the "oughts" do, rationalists can't simply dismiss them if they pose difficulties (McDowell 1989, 101-104). It is important not to forget the significant normative character of much of our ordinary speech. To ignore or deny it is to pursue philosophy in a way that is oblivious to what is actually the case.

Baier claims that many virtues function independently of principles and are, in fact, "inhospitable to them" (1989, 7). She claims that when we aid someone in distress we are not guided by principles that we know in advance of the crisis. Instead, we enter the situation with good intentions and our response is shaped by the circumstances of the case (e.g. the victim's ingratitude, the onlooker's participation, etc.). Since circumstances and individuals vary enormously, it is not possible to apply abstract rules beforehand to determine how one should behave. It is important to note, however, that Baier fails to distinguish the problem of predicting how an individual will behave in such a case from the problem of
determining how an individual should behave. Of course, only the latter is relevant for our purposes. As for ingratitude, one can have principles dealing with that and also for the role of the onlookers. Naturally, there is a limit to just how many principles any typical person can learn and apply effectively. Perhaps, Baier would have made a better case if she had claimed that in many circumstances one doesn't have a lot of time to remember principles. Similarly, trying to decide which single principle—assuming one is burdened with many—is the one upon which one should act may not always be very simple if a number of them seem appropriate.

What follows from Baier's example is the view that there are virtuous practices which can't be stated in terms of principles (Ibid.). Since rationalists are unable to include actions justified only by the virtues expressed by their performance, they can't provide a complete theory of the virtues without arbitrarily excluding some as irrelevant to rational moral behaviour and reasoning (Ibid. 8).

The third argument is meant to show that the rationalist theories can't handle the conflicts and dilemmas that commonly arise from moral practices. Since practices involve norms that lead to mutually incompatible obligations (e.g. the King of Jordan's responsibilities to both the survival of his people and the Palestinian cause), conflict is an unavoidable consequence.

Once we begin to think of morality in terms of practices and virtues rather than calculation and deduction from
principles, there is no reason to expect reconcilability to be built into moral thought in advance (Clarke 1989, 8).

Support for this view is offered by Stuart Hampshire's claim that conflict can be related to the conventional status of much of morality (1989, 150). While for example the requirements of justice and benevolence can be partially grounded in universal features of human nature, he observes that certain norms derive from historically specific ways of understanding human needs and capacities (Ibid.). The upshot of this specificity is that the plurality of conventions in any society means the possibility of conflict that can't be resolved by rational principles. What follows from this line of argument is that rationalist normative theory makes demands of moralities that can't be met.

One response to this is to hold that moralities with conflicting principles should be modified to avoid the conflict. The anti-theorists seem to hold that such a response is automatically ruled out, but substantial arguments are needed to support this view. In addition, a sophisticated form of rule utilitarianism might hold that the most beneficial sort of morality would have fairly specific rules and that the price one must pay for that is the possibility of conflict between some of the rules. In that case, one would have a theory that didn't sacrifice an advantage that is claimed to be incompatible with theories.

If one accepts the conclusions of the three arguments just considered, it isn't necessary to become an advocate of
irrationalism. Clearly, if philosophers were to recommend irrationalism to physicians, the latter might just as well dismiss philosophy and go buy a pack of tarot cards. But if one denies the legitimacy of rationalist theories and principles, what sort of moral reasoning is possible? In the next chapter, we will examine casuistry, a method of ethics that recently has dealt successfully with certain substantive problems of biomedicine.
CHAPTER 6
THE CONVALESCENCE OF CASUISTRY

In light of the difficulties confronting ethical theory and other philosophical resources (the subject of the last two chapters), it is not surprising that some philosophers have urged a change of focus from abstract matters of theory to concrete issues of practice. As a result of their experiences with the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1975 to 1978), Albert Jonsen and Stephen Toulmin became convinced of the need to rehabilitate the practical resolution of particular moral perplexities, or "cases of conscience" (Jonsen 1988, 13). This approach is more commonly referred to as "casuistry." Despite the fact that Blaise Pascal thoroughly denigrated casuistry in the seventeenth century, more and more philosophers have come to see considerable merit in it. To see why this is so, we will briefly consider the activities and successes of the commission. Next, we will examine Jonsen's and Toulmin's account of casuistry so that we may assess its value for biomedicine (chapter seven).

The Commission: Success At Last

The commission was established in response to certain unsettling press reports about objectionable experiments on human
fetuses in Scandinavia and on rural black men in Tuskegee, Alabama (Ibid. 16). Because of the possibility of terrible abuses of experimental subjects, the commission was told to review federal regulations (in the U.S.) about research to ensure that the subjects' rights and welfare were protected. The commission also examined the ethical issues relevant to research involving prisoners, children, the mentally disabled, and human fetuses. Their goal was to produce general statements of ethical principle that would offer guidance in the future development of biomedical and behavioral research (Ibid. 17).

In response to these challenges, the commissioners came to realize that they had to begin within the context of the kinds of research and the details of the particular cases. It is important to point out, however, that the ethical principles the commission uses and supports are those of the paradigm theory. In fact, Beauchamp and Childress claim that the Commission Reports are a vindication of their work. As far as the new casuists are concerned,

...ethical principles turn out to be nothing more than summaries of meanings already embedded in our actual practices. Rather than serving as a justification for certain practices, principles within the new casuistry merely report in summary fashion what we have already decided (Arras 1986, 43).

Aristotle, Jonsen and Toulmin claim, is the key to understanding why the commissioners' approach evolved as it did.

Far from being based on general abstract principles that can at one and the same time be universal, invariable, and known with certainty..., ethics deals with a multitude of particular concrete situations,
which are themselves so variable that they resist all attempts to generalize about them in universal terms (Ibid. 19).

It is difficult to see how Jonsen and Toulmin can reconcile the previous quote with the fact that they rely on the principles of biomedical ethics. Either the particular principle applies to all cases of a particular kind or it doesn't. A given principle won't apply to irrelevant cases, but it will apply to any and all cases that are appropriate. We will examine further difficulties with the casuists' methods in the next chapter. For the moment, let us explore their approach in more detail.

Most effective as a means of classifying the morally relevant similarities and differences between the various kinds of research was an approach that utilized moral taxonomies. Their reliance on moral taxonomies, Jonsen and Toulmin insist, was "one crucial factor in the commission's ability to agree on recommendations about specific types of cases" (Ibid. 44). New and problematic types of cases were subjected to analogical reasoning in an effort to fit them into a taxonomy. The commissioners appealed to understood and accepted paradigms in order to decide how to handle the unfamiliar and difficult. Thus, "they developed a 'casuistry' of biomedical and behavioral research using shared criteria by which to discriminate among research projects of morally distinct kinds" (Ibid. 265).

Even though each of the commissioners differed from every other in certain important respects (race, religion, gender, profession, etc.), the commission produced concrete results.
To do so, they had to come to agreement on how to resolve practical issues. This was a real possibility provided the commissioners remained at the level of taxonomy. What are the important features of casuistry that permit individuals from a divisive society to come to close agreement?

**Morality for the Practically-Inclined**

That casuistry has begun to interest more and more philosophers isn't surprising. Jonsen and Toulmin claim that when it is well-directed it "remains the single most powerful tool of practical analysis in ethics" (Ibid. 16). They define "casuistry" as being

\[\text{the analysis of moral issues, using procedures of reasoning based on paradigms and analogies, leading to the formulation of expert opinions about the existence and stringency of particular moral obligations, framed in terms of rules that are general but not universal or invariable, since they hold good with certainty only in the typical conditions of the agent and circumstances of action (Ibid. 257).}\]

Let us examine in more detail the various elements of the casuists' method so as to better appreciate the kind of moral reasoning Jonsen and Toulmin are advocating. Since the casuists wrote very little about their method, it is necessary to infer it from their practice (Ibid. 251).

The casuists relied on the Ten Commandments or the Seven Deadly Sins to distinguish one type of case from another. One can reasonably claim that these principles were for the ancient casuists what the principles of biomedical ethics have become for the new casuists. The former positioned their types of cases in orderly taxonomies, ones that reflected the connec-
tion between a specific kind of case and a given principle. For each of these kinds of cases, they constructed a paradigm case that was meant to be a clear indication of what was at issue (Ibid.). For each paradigm case, they constructed a series of cases such that each successive case in the series bore less similarity to the paradigm. This dissimilarity increased in direct proportion to the alteration of the circumstances and motives surrounding the case, with the result that the offense became less apparent as one moved away from the paradigm.

This gradual movement from clear and simple cases to the more complex and obscure ones was standard procedure for the casuist; indeed, it might be said to be the essence of the casuistic mode of thinking (Ibid. 252).

To decide, for example, if a woman's killing her abusive husband is morally offensive requires finding the relevant paradigm (killing in self-defense, perhaps) and deciding how different this particular case is from the paradigm. To make this judgment about the two cases, one factors in the relevant circumstances and motives, and then reasons by analogy.

The casuists used general moral principles to classify cases (e.g. the principles of biomedical ethics); however, they used moral maxims to bolster their arguments pertaining to specific cases. Numerous sources provided many maxims considered suitable for the diversity of cases encountered. Commonly, the Bible, theological writings, and the classics (Cicero, Virgil, etc.) were depended on to provide support for
the casuists' arguments (Ibid. 253).

Foremost among the elements of the casuists' approach to moral reasoning was the notion that circumstances create the case and nearly always modify moral judgment about it. If we vary a few circumstances in a case, we may no longer be confident that a given moral offense has occurred or we may decide that the offense is reduced for one reason or another (Ibid. 254). As Toulmin observes,

practical reasoning in ethics...is a matter of judgment, of weighing different considerations against one another, never a matter of formal theoretical deduction from strict or self-evident axioms. It is a task less for the clever arguer than for the anthropos megalopsychos, the "large-spirited human being" (Toulmin 1981, 37).

Making such judgments about the relevance and significance of circumstances requires considerable experience, and impressive powers of imagination. Also important are the sympathy and empathy one feels in one's dealings with others. In a crucial sense, then, to be a moral expert of casuistry requires far more than a grasp of abstract theories and principles. Of far more value are the insights and understanding one can bring to bear in case studies. Whether philosophers will be better at this than others is moot.

Another interesting feature of the casuists' method is their qualification of the probability of the conclusions offered for various cases. While the conclusions for the paradigm are certain, those for cases more remote from the paradigms became much less certain. The farther one moved away from the paradigm (a case for which there was wide-
spread agreement), the greater the divergence of views about the case (Jonsen 1988, 254). Plausible arguments for various opinions about the case often came from a number of casuists. These could only be assessed in terms of their intrinsic arguments and extrinsic authority. In other words, both how the opinion was argued for and who offered it were considered relevant to its probability. Jonsen and Toulmin claim that

the movement from paradigm through analogies, marked by slightly varying interpretations of accepted maxims, as applied to differing circumstances, gave the casuists a refined sensitivity to the manifold ways in which cases differed from one another (Ibid. 255).

Since the casuists weren't relying on a geometrically precise deductive system, the support for their opinions came as a result of the accumulation of reasons. Casuists would offer as many good reasons of diverse kinds as was deemed necessary to increase the probability of their conclusions. They didn't try to integrate the support for their views into coherent arguments; instead, they were content to merely sketch the shape of the relevant considerations (Ibid.). When someone wanted to know what to do, she assessed the quality of the intrinsic arguments in favour of various options, and took notice of who offered them, since both of these determined the probabilities of the opinions. Interestingly enough, the doctrine of prababilism permitted her to select a less probable opinion in favour of a more probable one. This was so because casuists acknowledged that all opinions are subject to change in the face of new circumstances. Since very few actions are intrinsically evil (e.g. basphemy),
an agent couldn't hope for more assurance than that offered by casuistry.

The Area of Concern of Traditional Casuistry

It is important to be clear about what matters casuistry was intended to deal with.

...casuistry had never been intended as a substitute for ethical theory.... It was not, in itself, a doctrine about what is the best life for man, what virtues characterize the good person, or what ideals humans should strive for. It did not even offer a general or fully elaborated doctrine about what sorts of acts are right, or about how principles and rules are to be justified. It was a simple practical exercise directed at attempting a satisfactory resolution of particular moral problems. In this respect, it resembles philosophy...less than it did present-day "counseling"... (Ibid. 242).

Certainly, because the casuists were primarily interested in dispensing advice from the confessional, it is not surprising that their concerns were very much the conflicts of ordinary people. This perhaps accounts for the casuists' minimal reliance on theoretical resources. Jonsen and Toulmin claim that no explicit methodology was ever developed by the casuists (Ibid. 250). Nor did they construct a formal theory of casuistry. At most, they relied on theology and jurisprudence to provide them with the doctrine of natural law (with its hierarchy of moral principles), and to offer a theoretical justification for their activities. In effect, casuistry was legitimized because it drew upon officially sanctioned institutions and their resources. To aid their activities, casuists developed a doctrine of "conscience" that distributed the moral principles taken from the natural law to individual
cases of moral choice (Ibid.). They also developed a doctrine of "circumstances" in order to clarify the relationship between exceptions and excuses and the weight of the obligations imposed by general principles (Ibid.). When one considers how important these two doctrines appear to be to the casuists' method, it is unfortunate, indeed, that Jonsen and Toulmin have so little to say about them.

Be that as it may, given the long history of casuistry and how very few of its practitioners were interested in theory, it is clear that casuists were more interested to hear what someone had to say about a case than why and how he arrived at his opinion. It was, in fact, the wide range of opinions available for many cases, plus the doctrine of probabilism (any opinion is fine provided it's probable), that led to the fall of casuistry (Ibid. 237).

Quo Vadis, Casuistry?

Despite what may be apparent deficiencies associated with casuistry, we are left with the success of the commission. It is hard to deny the value of practical results emerging from a field (viz. biomedical ethics) characterized by strife and disunity. Not surprisingly, given the success of the commission, Jonsen and Toulmin believe that casuistry has a great deal to offer biomedicine.

When properly conceived..., casuistry redresses the excessive emphasis placed on universal rules and invariant principles by moral philosophers.... Instead we shall take seriously certain features of moral discourse that recent moral philosophers have too little appreciated: the concrete circumstances
of actual cases, and the specific maxims that people invoke in facing actual moral dilemmas. If we start by considering similarities and differences between particular types of cases on a practical level, we open up an alternative approach to ethical theory that is wholly consistent with our moral practice (Ibid. 13).

The next chapter will deal in some depth with some of the problems associated with casuistry so that we may better assess the value of this approach in dealing with the problems of biomedicine.
CHAPTER 7
LIMITATIONS OF CASUISTRY

Among the strengths of casuistry is its inherent simplicity. Casuists were mainly concerned with offering their opinions about various cases, along with a rough idea of how these opinions were arrived at. Naturally, most casuists were interested in what other prominent casuists had to say about certain interesting cases. But, in the end, no one's opinions about non-paradigm cases were considered to be more than probable. It was, in part, the casuists' inability to judge with any precision the weight of the support in favour of most opinions that made the extrinsic authority matter so much. Thus, the simplicity of the casuists' method also did much to hasten its decline.

Perhaps how casuistry evolved prior to its decline was a natural consequence of the nature of its supporting institutions. The Catholic Church is notorious for its hierarchy of power and authority. For many centuries in catholicism, who has said something is often more significant than why it was said. Traditionally, appeals to authority (Aristotle, Augustine, and Aquinas) were used to render a position beyond criticism and doubt. For casuistry, excessive concern for who said what meant that extrinsic authority stifled intrinsic argumentation.

80
But there is nothing about casuistry that requires it to be only utilized by Catholics. Given the decline of the Church in recent centuries, it seems clear that casuistry must be adapted to meet the needs of a secular and pluralistic society. The commission's success suggests casuistry may be an effective form of moral reasoning for our times, since each of the commissioners came from very different backgrounds. Apparently, expert opinions are among the most important things casuistry has to offer. We turn now to an examination of the nature of these expert opinions.

Some Fundamental Doubts About the Commission

In their definition of "casuistry," Jonsen and Toulmin describe it as "the analysis of moral issues, using procedures of reasoning based on paradigms and analogies, leading to the formulation of expert opinions..." (Jonsen 1988, 257). It seems wise to consider what might be meant by "expert opinions," for this notion, in conjunction with some reflection on the nature of the commission, raises a number of troubling questions.

The most disturbing of these questions is suggested by the findings of social psychology, which offers an insightful explanation of the commission's convergence on certain opinions. The question is, quite simply, "Was this convergence the result of the methodology employed (viz. casuistry) or was it a product of group dynamics?" It is extremely likely that this convergence was the result of some or all of the commissioners' responses to solving group tasks. Social psycholog-
Ica studies suggest that how groups solve tasks depends mainly on the individual members' appearances, personalities and histories. Certain individuals are highly skilled at manipulating others to see things their way. Males tend to form alliances with females they are attracted to. Women often side with outgoing and confident men. Passive individuals prefer to let events develop in an undesired way rather than call undue attention to themselves. Does casuistry, as exemplified by the commission, exclude the possibility of such arbitrary and morally disturbing means of generating expert opinions? Of what value is consensus if these psychological factors are primarily its source?

Determining whether there is any force to these criticisms is possible in both principle and practice. If we were to simultaneously run twelve carefully segregated commissions, each of which had variations in the appearances, personalities, and histories of its members, we would be able to collect and compare the twelve sets of opinions. It seems likely that we would not receive twelve copies of one set of opinions. In all probability, we would have a number (twelve?) of distinct sets. If the convergence within any given commission is the result of the method and not group dynamics, why would we fail to produce twelve copies of the same set of opinions? It seems reasonable to conclude that group dynamics may have had a considerable impact on the commission's results. This raises an important question: Would any of the sets of opinions produced be more expert than the others?
In the previous chapter, we noted that the ethical principles that the commission uses and supports are those of the paradigm theory. If one accepts the criticisms of the paradigm theory, and supports the view that its results are too arbitrary and lacking in substantial justification, isn't one thereby committed to viewing the new casuists' reliance on some or all of the paradigm theory as being problematic? To the extent that the casuists rely on indefensible methods and resources, they weaken their own approach. Unlike Beauchamp and Childress, who regard the Commission Reports as a vindication of their work, we might prefer to regard the reliance on the paradigm theory as a sign of trouble or even failure.

**Problems with the Paradigm**

Let us assume for a moment that our commissioners are beginning to discuss their paradigm cases. If Paul Ramsey and Richard A. McCormick were ever on the same commission, it seems reasonable to not expect them to agree on the moral justifiability of nontherapeutic pediatric research (i.e. the child receives no benefit from participating). Clearly, these two individuals would not want to have identical moral taxonomies and would often have different opinions about certain cases. Contrast this situation with the Catholic casuists who widely accepted the Ten Commandments and the Seven Deadly Sins as models for their paradigms. Why did the Catholics accept these models? They are an inherent part of their faith.
In order to be Catholic, one has to take on many of its beliefs, values, rituals, etc. But would either McCormick or Ramsey have to give up many of his personal views in order to share the same moral taxonomies as the other commissioners? If someone objected to certain paradigms but was too passive to say so, the fact that he concurred in the selection of the moral taxonomies should be disturbing, not positive.

Of course, for the particular combination of commissioners who were, in fact, present, the paradigm cases may have been as acceptable as were the Ten Commandments to the Catholic casuists. However, had the commission dealt with far more divisive issues (e.g. abortion and euthanasia) and had it been highly polarized, it seems unlikely that the commissioners would have agree about a paradigm case for, say, a morally indefensible abortion. If commissioners can't agree on paradigm cases, divergence of opinions seems to be a likely result. In fact, it is hard to see how the commission could have remained intact if it was unable to produce at least one widely accepted moral taxonomy. Reflections of this kind raise a number of questions. Did the commission succeed because its moral taxonomies were pre-shaped for it by society's values, laws, etc.? Or did it succeed because the various commissioners didn't bring their own values, prejudices, fears, etc. into the process? To what extent did the group produce results at the expense of moral justification by failing to ask what are the reasons for accepting this moral taxonomy instead of that one?

Let us pursue the matter of justification a little fur-
ther. In the case of the Catholic tradition, God was the justification for everything that legitimized casuistry. But what legitimized the commissioners' paradigm cases and their moral taxonomies? Certainly not God. It may have been the United States Congress (at least as far as the commissioners were concerned). But we are interested in moral justification. Somewhere in the casuistical process it is reasonable to expect substantial moral justification to be provided. It would be unfortunate it, like the Catholic casuists, the commission devoted little or no attention to intrinsic argumentation because of the "legitimacy" conferred upon their findings by an external authority (viz. Congress).

At various stages of their activities, the commissioners should have been greatly concerned with providing moral justification. Did the commissioners review the moral justifications for the previous federal regulations? Did they agree with them or not? If these were lacking, did they attempt to supply them? It is one thing to observe that a given kind of research is prohibited by law. It is a very different task to enquire whether it should be and to ask for the moral justification of the prohibition. When the commissioners developed their own general statements of ethical principles (viz. the principles of the paradigm theory), did they accept someone else's defense of those principles, or did they defend them themselves? To defend them, did they rely on argument or intuition? Since only the former is potentially immune to group dynamics, we must hope that argu-
ments played an important part in the commissioners' activities. How did the commissioners assign weights to the cases that were being compared with the paradigms? Did they rely on a principled method or did they survey opinions until everyone came to some kind of agreement? Could they defend their finding case B similar to A if an independent group claimed that B was, in fact, more similar to C?

Jonsen and Toulmin have very little to say on this last point:

...anyone who has occasion to consider moral issues in actual detail knows that morally significant differences between cases can be as vital as their likeness. We need to respect not only the general principles that require us to treat similar cases alike but also those crucial distinctions that justify treating dissimilar cases differently (Ibid. 14).

How dissimilar must case B be from A before we are no longer justified in treating it like case A? Is there a defensible means of determining this or is it up to the opinions of the commission? In the event that A is similar to both B and C, how do we determine which of the two is most similar? If A doesn't really resemble B very closely, but we have nothing else to compare it with, are we justified in treating A like B? Who makes these choices? How are they made? Why these decisions instead of those?

Casuistry and Biomedicine

It is time to briefly consider whether casuistry has, in fact, a great deal to offer biomedicine. As we have seen, casuistry offers results and it appears to summon consensus
within a divisive society. It deals with practical matters by offering concrete ways of handling difficult problems. At first sight, it seems hard to fault people for finding casuistry to be an attractive alternative to the applied ethics paradigm. But, given the casuists' reliance on certain elements of the paradigm theory (in particular, the principles), how very different is casuistry from the principle-driven approach it attempts to refute?

If physicians wish to be confident that their ethical resources are reliable, they must ensure that the results produced are morally justified. If physicians were to press the casuists to justify the various elements of their method, I suspect that they (and others) might be a little less confident about the defensibility of the casuists' results. Simply arriving at "solutions" to perplexing problems shouldn't be viewed as a measure of success (or of moral justification). If one chose, say, to decide moral issues by surveying citizens about their views, one would, no doubt, come up with results of some kind. Deciding the capital punishment issue based on the data gathered by telephone or mail might be acceptable to some; but there will always be a few who will challenge the morality of such expedient means. Society is, indeed, pressured to take a stand on many difficult issues. The stand taken, however, is of considerable importance and great care must be taken to ensure that our policies and values are rational and morally acceptable.

In the next chapter, I will offer my suggestions toward
the resolution of the problem of the fit between theory and practice in biomedical ethics. Considerable progress can be achieved if one relies on rule utilitarianism, with suitable emphasis placed on the concrete circumstances of practical cases.
CHAPTER 8

PHILOSOPHERS AND BIOMEDICINE

In this chapter I will outline the sort of role philosophers should play in biomedical ethics. In order to do so, however, I will also need to outline the roles of many other health care workers, lawyers, etc. so that what I have in mind will be clear. I will rely on a worst case scenario (viz. an AIDS epidemic equal in magnitude to the plague) to dramatize the need for physicians to not default on making decisions about moral issues. I am going to accept the criticism raised against the paradigm theory and casuistry in the previous chapters, and take it as a given that these resources suffer profound limitations. Despite these problems, I hope to show that moral philosophy still has something valuable to contribute. To this end, I will briefly discuss how rule utilitarianism could succeed in the method I am proposing.

Biomedicine and Public Policy

AIDS is terrifying because it is a merciless killer and because it is incurable thus far. Of course, if we could be confident that a cure will emerge in five years or less, we might feel that the problem will eventually go away and that AIDS will come to be seen as not much worse than the pre-penicillin deaths. Biomedical research and technology just might
see us through the perils of this syndrome. But let us imagine that no cure emerges for fifteen or even twenty-five years. If the virus spreads at its present rate (which is alarming indeed), we might find ourselves having to deal with some kind of worst case scenario as suggested by epidemiology.

Science, statistics, and a little imagination paint an alarming picture of what an AIDS epidemic would be like. I intend to focus on how a worst case scenario would affect health care workers and the technologies they operate so that I can briefly explore certain key moral issues and how they should be resolved.

To begin with, let us assume that about a third of the nation's population have contracted the HIV virus and that all of these will eventually die prior to the discovery of a cure. At this time, the death rate from AIDS is already very high and is climbing rapidly. The vast majority of those infected with the virus are younger than fifty years of age. This is a major problem since the nation's population has grown increasingly older. An older population places heavy demands on the health care resources of the country. It is apparent to all that these resources won't manage both the geriatric boom and an AIDS epidemic. Further demographic considerations reveal that the infected third of the population can't reproduce anymore without passing on the virus, so there will be a substantial decline in the numbers of young people who will be available to fund health care and to support the elderly. Everyone agrees that a crisis threatens to
engulf them, but not everyone agrees about what should be done. Not entirely satisfied with philosophy's past efforts, and unconvinced of the moral justifiability of casuistry's results, physicians decide to assume a stronger role in the moral debate, taking constructive input whenever possible.

To begin with, physicians decide they can no longer afford to default in making difficult decisions. Given the depth of the coming crisis (which they can only estimate), they are aware that they must make the most of their time and resources. Since the crisis is already partly upon them, they recognize that now, more than ever, decisiveness will be a medical virtue. Physicians must make choices and live with the consequences. In the past, their decisions have been shaped by codes of ethics, laws, rules, regulations. Now, however, few of these guidelines seem adequate to meet the demands of the crisis. In response to these inadequacies, physicians decide to initiate a public forum to assist them in confronting moral issues. The forum, it is decided, will be comprised of nurses, patients, philosophers, lawyers, public interest groups, theologians, etc. How will the forum operate? It will challenge the rules, regulations, and decisions made in response to the crisis by physicians and a small group of individuals (lawyers, philosophers, etc.) who will advise them. Before considering this forum in more detail, let us consider how physicians would deal with moral issues.

Given their limited time and resources and the intense
future demands expected to be placed on them, physicians would, in association with their advisory group, collectively decide how those resources would be allocated. The reasons favouring various alternatives would be considered, but, in the end, the options most likely to maximize utility would be chosen. In the case of an AIDS epidemic, allowing people to die in their homes might be selected. For the elderly, not initiating certain treatments might appear wise. These alternatives would then be used to formulate rules, regulations, etc. that would be applied uniformly throughout the national health care system. For some cases, if a doctor objects to the rules, he or she will be free to select another option. However, other cases will be such that one will have no choice but to comply. For example, if all of the available resources have gone to keeping HIV negative infants alive, then a physician will have to accept that an AIDS patient may have to be dealt with in accordance with the established guidelines. In another case, if available resources are being used to keep a donor's organs alive, then, again, not enough may be left for AIDS cases.

The rules, guidelines, etc. ("the rules") will be designed to shape the choices physicians will make in both routine and perplexing cases. The rules will be an effective means to guide and standardize conduct (especially among new and less-skilled physicians). Of course, no matter how thorough and carefully thought-out the rules might be, they could never cover every contingency. In the event that the
rules don't apply clearly (or not at all), the Canadian Medical Association could have a consultation service staffed by "experts" to offer suggestions. Since these would only be offered as suggestions, the doctor could take or leave the advice. If there is no time to seek advice, the doctor should act as she sees fit. The case would then be studied afterwards to permit the structuring of desirable rules.

The advantages of having physicians help shape the rules that will guide their conduct are numerous. In choosing to be a physician, individuals will be expected to conduct themselves in accordance with the standards of the profession. If these standards are backed by good reasons, an individual will hopefully feel a strong sense of obligation toward them. Rules of conduct that are clearly going to maximize utility offer greater motivation than the amorphous dictates of theory. Thus, a utilitarian justification of the rules will permit physicians to see "the point" of having the rules, unlike vague directives like, "Always do your duty" or "Always respect persons."

An obvious advantage of having physicians involve themselves more in guiding their own conduct is the fact that they, more than anyone else, know medicine. Physicians could work with others toward clarifying social goals with respect to the practice and outcomes of medicine. Medical and economic considerations, as well as ethical and social factors, need to be carefully weighed when one is formulating social policy. Doctors should have some say in the definition of their role.
Another advantage of having some control over their own conduct is no doubt controversial but important for physicians to consider. Physicians must ask themselves questions like, "What will it be like to practice medicine under conditions of intense crisis?" and "What can society reasonably expect of me?" While acknowledging that physicians have special skills and training, and that good fortune obligates (chapter one), how heavy can the demands we place on physicians be before they become crippling? Physicians need to take care of their patients, it is true, but they must also take care of themselves and the health care system. Indeed, it is a vicious circle, for if the health care system collapses physicians will be unable to take very good care of anyone. Moreover, if physicians aren't satisfied in their work, they will be less motivated to show concern for others.

**The Public Forum**

It is time to consider the activities and goals of the public forum. Of considerable importance is the forum's function as an external critic of the rules, policies, etc. adopted by the medical profession. Even if it were the case that physicians acted with the best intentions, from a deep sense of altruism, and after considerable deliberation, they would still be fallible. Certain rules might be challenged by the forum because they do not appear to be the ones that will, in fact, maximize utility. The onus would fall on the forum to provide a rule that would maximize utility and if
it could do so, then the C.M.A. ought to acknowledge the superiority of the new rule and, more importantly, adopt it.

Of course, not every criticism raised by the forum would lead to the adoption of a new rule. In order for a criticism to merit serious attention, some kind of consensus must emerge from the forum in support of the complaint. If, for example, some philosophers protest that denying hospital resources to dying AIDS patients doesn't respect them as persons, but others insist that this policy maximizes efficiency, the challenge posed to the rule may not be very focused or resolute. Physicians could, perhaps, counter the challenge by saying, "If you want more resources available for AIDS patients, you'll have to come up with more money." This sort of response takes the problem from the bedside and brings it up to the macro level where it belongs. Because physicians' rules have, in part, been shaped by macro decisions made by taxpayers, voters, and government, it seems appropriate for these people to reconsider their values if they're unhappy with the health care system.

As we have already seen, the forum would be comprised of nurses, philosophers, lawyers, theologians, patients, etc. While not all of these are considered to possess moral expertise (as Singer defines it), there is considerable advantage to involving diverse kinds of people in the forum. Nurses, probably even more so than patients and doctors, know the limitations and failings of the health care system. Their criticisms and advice deserve detailed and lengthy consider-
ation. Lawyers could offer a legal interpretation of the problems. Philosophers could try to suggest the moral dimensions of what is being described. Since patients have a significant stake in how the health care system evolves, their experiences, problems, etc. would also serve as data for the forum. In the end, however, everyone would be interdependent, since effective criticism and constructive alternatives could only emerge if the input and skills of all of the relevant parties are employed. In the forum, there would be no place for antagonism and competition; instead, its members would have to work cooperatively, sometimes with a sense of urgency, to resolve practical difficulties.

In the case of examining existing policies, etc., the forum would function as an external critic. A number of other roles suggest themselves as well. In the event that physicians were unclear about proposed rules for new problems (or anticipated ones), they could submit them to the forum for analysis. However, unless the forum could come up with better rules (i.e. ones more likely to maximize utility), those being proposed would be instituted to permit everyone to study the consequences they produce.

As we saw above, sometimes physicians must make decisions in the midst of crisis. The C.M.A. might agree with the choices made by a particular doctor, but want an external view of the case. Asking the relevant nurses, patients, families, etc. to offer their view of things is an important means of not overlooking anything.
The forum could also function to discuss the important value questions emerging as the consequences of the rules become apparent. Physicians might not isolate the issues very successfully if they are primarily concerned with pushing the health care system to deliver to the limit. The value questions must not be obscured by economic shortages or bureaucratic indifference. As the value questions become clearer, the criticism offered by the forum will likely become more substantial.

Philosophers and Moral Expertise

In chapter three, the question of whether moral philosophers can legitimately be regarded as moral experts was briefly explored. It is time to settle this question, for a definite answer to it will help define the nature of the role philosophers ought to play in the public forum. If it turns out that only philosophers possess moral expertise, and that only their skills and talents are relevant and effective in solving moral problems, then, perhaps, there is no need to involve nurses, patients, etc. in the process already outlined in this chapter. If on the other hand, philosophers have nothing of value to offer this process, then there may be no sense in involving them.

Among philosophers at least there is a fair amount of agreement that there are some advantages to studying moral philosophy. Although there may be a few philosophers who believe they are much better at solving moral problems than
ordinary people, there are probably none who maintain that only philosophers can find solutions for moral problems. Peter Singer is, for example, quick to deny "that only philosophers are capable of settling moral problems" (1982, 10). Since Singer has a number of plausible things to say about moral expertise, it would be wise to examine his position.

Singer thoughtfully emphasizes the fact that this alleged expertise does not consist in the possession of special moral wisdom, or privileged insights into moral truth, but in understanding the nature of moral theories and the possible methods of moral argument (1982, 9).

Of course, this sort of claim will not take us very far, since even Beauchamp and Childress can be regarded as having an understanding of the nature of moral theories and the possible methods of moral argument that is superior to the majority of nurses, doctors, patients, etc. Despite this advantage, however, neither Beauchamp nor Childress has proven the value of this alleged expertise. Can we reasonably claim that a philosopher who relies on their methodology and gets nowhere and a doctor who relies on her conscience and gets nowhere differ as to their relative levels of expertise? Obviously the quantity and quality of expertise must be assessed in terms of how successful it is in meeting certain goals. If the alleged expertise confers no practical advantage on its bearer, then the use of "expertise" to refer to whatever skills, etc. have been isolated for comparison is odd.
Let us explore how a philosopher might differ from an ordinary person who happens to face a moral problem. Singer claims that moral philosophers have four distinct advantages over others when it comes to dealing with difficult moral issues.

1. Philosophers are trained to understand logical arguments and to detect fallacies.

2. Undergraduate courses in meta-ethics (i.e. the study of what it is to make a moral judgment) provide specific understanding of moral concepts. Being clear about what trying to resolve difficult moral issues involves helps us to avoid confusion.

3. Undergraduate philosophy courses introduce students to moral theories. Knowledge of these theories, and of their implications and limitations, is useful in discussing practical ethical problems.

4. Moral philosophers can think full time about ethics, unlike other people who are too busy with their own careers (Ibid.).

Singer's discussion of these four advantages is particularly useful because it serves to highlight some of the limitations of moral philosophy. Before addressing these limitations, let us consider certain aspects of Singer's view which render it very plausible. Earl Winkler discusses the plausibility of Singer's view as follows:

...suppose...there are often better and worse answers to important moral problems, even if there are seldom uniquely correct answers. This difference among answers to moral questions must be a function of differences in adequacy and sensitivity in factual understanding, together with differences in quality and depth of reasoning and justification. Suppose further that training in philosophy does advance powers of analysis and clarification, and that it increases skill in moral reasoning and argument. This is the main burden of Singer's claims for the prolonged study of moral philosophy. If we now add Singer's final point, that the philosopher has the time to study and ponder practical
issues in depth, drawing on the researches and considered positions of others, why should we not conclude that there is, in general, an increased likelihood of "better answers" to moral issues when philosophy is consulted? (1991, 6-7).

As Winkler points out, if we deny that consulting philosophy makes better answers for moral issues more likely, then we have to hold that "conceptual clarity, power in reasoning and familiarity with our moral traditions are of no particular value in moral affairs" (Ibid. 7). Winkler argues we shouldn't deny this; instead, we should emphasize that it is the skills in question that matter and they can be acquired even by non-philosophers (Ibid.). More importantly, Winkler draws attention to the possibility that philosophy has "radically misconceived the real nature of moral reasoning and justification, with consequent distortions of its own powers (Ibid.).

Let us turn to a discussion of an actual case in order to illustrate some of the practical and theoretical limitations of biomedical ethics. This discussion will show that the standard approach of biomedical ethics often yields unacceptable answers, because it operates with a limited interpretation of cases.

A thirty year old male was enjoying a satisfying and rewarding life. He had an excellent education, was involved in a successful business, and was planning to marry and raise a family. He was extremely active in sports, particularly football and basketball, and had enjoyed exceptional health for most of his life. His latest interest was flying: he
had received his pilot's licence about a year ago. It was, unfortunately, flying that led to his terrible predicament, for he was involved in a fiery crash that left him both badly burned and paralyzed from the waist down.

His doctor and nurses informed him as carefully as possible about his condition, and about the treatments and therapies necessary for his survival and partial recovery. They didn't hide the fact that his life would never be quite the same again. It was this inescapable fact that prompted him to ask what would happen if he wasn't treated. He was quickly told that infection would strike throughout the burned tissues, leaving him with at most two weeks of life. Needless to say, the doctor and nurses were dismayed when he told them not to treat him.

Because his doctor doubted his competence, a psychiatrist was brought into the case. After a fairly lengthy consultation, the psychiatrist was satisfied that the young man knew what he was doing, so the doctor was told to respect the patient's wishes. Predictably, the doctor didn't want to, so he took his side of the case to court. Of course, as a result of the case going to court, the psychiatrist gained a little time. He managed to convince the patient to accept a few burn treatments--just to have something to do while the court heard the case. The court, not surprisingly, eventually sided with the patient, but while it deliberated he received a number of treatments. The end result was the doctor had to respect the patient's wishes and the patient began to accept more and more
treatments.

If we had approached this case from the standard vantage point of biomedical ethics, we would have agreed with the court that the doctor should not act paternalistically in this case and the young man's autonomous wishes should be respected. In short, he should be allowed to refuse treatment and to die. In order to be clear about the practical and theoretical limitations of biomedical ethics in cases like these, let us focus on the role of the psychiatrist, who represents one of the "caring professions."

The psychiatrist's role is important, for it emphasizes the vital significance of carefully interpreting the underlying moral dimensions of even the apparently most clear-cut cases. Because of his special training and experience, the psychiatrist was very good at interpreting what was really motivating the patient. According to the psychiatrist, the young man suffered from a terrible sense of powerlessness and of not being in control of his own life (see chapter two). By refusing treatment and by allowing the dispute to go to court, the patient felt more in control of himself. He was able to agree to some treatments only after he began to regain some positive feelings about his role in the tragedy.

As a result of his accepting the treatments and later taking part in physiotherapy, the patient's condition improved considerably. After about a year, his burns were fully treated and he was able to get around on his own in a wheelchair. It is important in this case not to deny the extent to which
the psychiatrist's helpful input improved the outcome of this case. It seems reasonable to claim that his involvement helped ensure a moral outcome to the tragedy.

Can one retain full confidence in cases like these if only the standard approach of biomedical ethics is relied upon? Probably not, since this approach often leads to an under-interpreted view of the case. In order to ensure an outcome that is in accordance with the patient's best interests and true desires, it is necessary to adopt an approach that involves a sophisticated form of interpretation. Is there any reason to believe that moral philosophers (even those firmly in possession of Singer's four advantages) will be better at this than psychiatrists, social workers, chaplains, etc.? Of course not. In order to get the best interpretation of many cases it will be necessary to combine diverse forms of talent with the philosopher's skills. Individuals from backgrounds as varied as psychology and literature have a great deal to offer towards improving the interpretations of cases. If these other individuals work with philosophers, then many of the practical and theoretical limitations of biomedical ethics will eventually be overcome. Philosophers, of course, have a great deal to contribute in cases like these, since, for example, an analysis of "best interests" and "true desires" is necessary. Considerable clarification of these notions is required, plus some suggestions about what should count as being in the patient's best interests and which desires ought to be acknowledged and respected.
Philosophers and Policy

The case discussed in the previous section underscores the importance of drawing a clear distinction between policy questions and clinical questions. What are clinical questions? In the burn victim case, they center around what treatments and therapies will bring the patient from poor to improved health. In short, clinical questions probe the options available to an individual based on his physiology, metabolism, age, weight, etc. Questions about which antibiotic to use or how to heal burned tissues are best handled by physicians. Questions about whether a patient should be treated or not do involve an important clinical component, but also have a significant ethical dimension. For the most part, philosophers are extremely useful for dealing with the ethical questions arising from medical practice. In particular, philosophers are very effective in dealing with policy questions.

What are policy questions? Quite simply, policy questions arise when hospitals try to institute rules for dealing with the diversity of cases that confront doctors, nurses, etc. In the burn victim case, a policy is needed to help health care workers deal with patients who refuse treatment. The policy chosen, of course, would be very general, because it would cover many different kinds of treatment refusal. Philosophers could play an important role in helping health care workers understand the various policies and applying general policies to particular cases. More importantly, philosophers could help form policies and recommend standards to justify
the policies chosen.

How much philosophers have to contribute to the policy process depends on whether there are rationally compelling moral theories and concepts. If, for example, philosophers can provide a rationally compelling concept for personhood, one supported by strong rational arguments, then particular issues of biomedicine (e.g. abortion and euthanasia) can be settled. If philosophers can provide rationally compelling arguments for, say, rule utilitarianism (effectively showing it is a true moral theory), then they have a great deal to contribute to policy formation. This is clearly so, for if there are better theories and better concepts, then there is the possibility of arriving at better answers to moral problems. As the quality of the arguments in favour of certain theories and concepts increases, the likelihood that one has found the right answer also increases. A rationally compelling approach to ethics affords one a great deal of confidence in the policies that are chosen.

It seems obvious that some ethical theories are better than others. As a result of careful philosophical argument, we might reasonably prefer one over another. Clearly, any theory that involves false principles or is defended by weak arguments should be abandoned, for to rely on it in policy formation could be disastrous. To determine how effective a given theory is for policy formation, one could simply consider the consequences of the policies. If the policies improve the quality of life for patients, reduce suffering, and
minimize dehumanization, then one would reasonably be inclined to favour the theory defending the policies. Of course, philosophers could help determine what counts as good outcomes of the policies.

The discussion in the previous paragraph raises an important question, one that was briefly dealt with in chapter three. The question, quite simply, is "Why has biomedicine focused so much on what individual philosophers have to offer?" This is an odd thing to focus upon, since there are so many different kinds of philosophers, with so many different points-of-view, that is shouldn't be surprising that some answers to this question have left health care workers dissatisfied. A more interesting question, of course, is, "What does normative ethical theory have to offer?"

It is possible to provide an answer to this question. As we have seen, if there were rationally compelling ethical theories, philosophers would have a great deal to contribute to policy formation. But, surprisingly, even if this is not possible, philosophers still have a great deal to offer biomedicine.

As we have already seen, philosophers could offer rationally compelling analyses of many important concepts in biomedicine. This, in itself, is a major achievement and would make possible the resolution of many difficult moral issues. Another important role philosophers could play would be to organize and structure the ethical views of health care workers. For example, a utilitarian could organize and
structure the ethical views of two doctors presented in a debate, so that these views would be coherent. The utilitarian could highlight what their choices mean at the abstract level of principle and reveal what their fundamental oppositions are. Thus, the philosopher could use ethical principles to clearly explain the responses and views of ordinary people. Such clarification permits non-philosophers to see what ethical views they're committed to and to confront the implications of their choices.

It is important to realize, however, that even if there are rationally compelling arguments for, say, rule utilitarianism, philosophers would still depend on others for input for policy formation. Philosophers would provide the approach needed to get the answers for policy questions, but, as one moved further from the abstract to the concrete, more and more input from non-philosophers would be required. The input needed would depend on the cases being considered and would, no doubt, come from many different kinds of occupations. In many cases, the interpretive skills of non-philosophers would be valuable in choosing policies that are morally acceptable.

**Cases in Which A Philosopher Will Be of Particular Value**

While the interpretive skills of non-philosophers are invaluable, there are many cases in biomedicine that demand more than a non-philosopher can offer. For many cases in the health sciences, a philosopher's involvement will often
ensure a moral outcome. We will now consider a number of very different cases so that the kind of advantages a philosopher has to offer will be clear.

Let us imagine that a hospital administrator is searching for ways to save money. She is well aware that much of the hospital budget is being spent on keeping people alive in the intensive care units. Many of these people are resuscitated two or three times, only to return to a miserable few more days or weeks. Other patients don't ever regain consciousness; nevertheless, they are left attached to machines for months and even years. She calls in a moral philosopher to get some assistance with these problems.

The philosopher points out that it is senseless to resuscitate people just to maximize the quantity of life they will have. Instead, the hospital should primarily focus on providing a sufficiently high quality of life for its patients. If health care workers must jeopardize a patient's quality of life in order to raise the quantity, medical treatment appears unwise.

Regarding the patients who will never regain consciousness, the philosopher has a couple of things to say. He observes that a stream of consciousness is what makes life worth living. Since these individuals will almost certainly never regain a stream of consciousness, their lives aren't worth living. Thus, it makes no sense to keep them alive. He argues that the money being spent on those who will benefit
from medical treatment is often justifiably spent. However, the money being spent on those who will never regain a stream of consciousness can't be justified.

The administrator decides to present a number of other cases to the philosopher so that he can make some recommendations. She asks for his view on the question of whether it is morally acceptable to kill some fetuses but not others. He explains that since the fetus is not a person it is morally acceptable to kill it. Of course, killing it must be in accord with the woman's wishes and be done as humanely as possible. Since only very early fetuses don't feel pain, killing them is never a problem and can be done with the usual abortion techniques. However, since mid to late fetuses have the capacity to feel pain, killing them must be done much more humanely. Because well over fifty-five million abortions are performed in the world per year, killing mid to late fetuses in the usual manner causes a terrible amount of pain and suffering. The philosopher suggests that the pain and suffering of such fetuses are significant and must be weighed alongside the woman's mental and physical suffering. If the fetus could be killed humanely, considerations such as these would be unnecessary.

Given the dramatic increase in the geriatric population, and the increase in the number of senile patients, the administrator asks him what they should do about the extreme expense of caring for senile patients. He asks her whether the senile have lives of quality and pleasure. She informs him
that many of them lead miserable lives. He points out that this is, again, a case of maximizing quantity at the expense of quality. He argues that it would be morally acceptable for people to commit suicide before they deteriorate so far. Certainly, it would be an option that deserves serious consideration.

The administrator explains that there are many patients in the hospital in the final stages of AIDS. She asks whether it would be ethical to allow them to commit suicide. The philosopher asks what it is like to be dying from AIDS and is told it is terrible. He reminds her of the views he presented earlier: a good short life is better than a miserable long life. Since an AIDS patient's quality of life is decidedly negative towards the end, it makes no sense whatsoever to strive for quantity.

As a result of changing social conditions, the hospital has substantial numbers of infants whose mothers abuse alcohol or crack. Because of an early exposure to these substances while still in the uterus, these infants will likely have few or no prospects for a happy life, and because they will eventually cause major problems for society, the philosopher argues that at the very least it makes no sense to implement extraordinary lifesaving measures on their behalf.

The administrator asks for his views on some of the exotic transplant surgeries being performed. She tells him that the operations are expensive, the patients' quality of life isn't always very good, and even the quantity is some-
times only increased by a year or slightly longer. She explains that most of the operations are being done with the hopes that the procedures will be more successful in the future.

The philosopher asks the obvious question, "Could the money be better spent elsewhere?" He notes that such operations could still be improved if much fewer of them are performed. Perhaps, the number of doctors doing such procedures should be limited. In this way, a few doctors gain expertise in these techniques, studies can be done, and much less money will be spent, with the result that advances can still be made without raising the public's expectations unjustifiably.

The administrator asks whether philosophers have much to say about the distinction between passive and active euthanasia. He tells her that a great deal has been written on the distinction between killing and letting die. He explains that this work is highly relevant to many areas of biomedicine. Being clear on this distinction is necessary to avoid many errors and to make rational decisions.

Because of the long waiting lists and the shortages of personnel and resources, the administrator asks whether he can recommend a defensible allocation scheme for exotic medical lifesaving therapies. He suggests that she reads Nicholas Rescher's work on that subject to get an idea of the elements of such a scheme. He informs her that many other philosophers have also had a great deal to say on these matters.

The administrator explains that the hospital conducts
a large amount of research involving ordinary people. Recently, however, there has been some concern that mainly poor people are taking part in the studies. She says that while the risks are mostly slight, there are some studies that involve pain and discomfort for the subjects.

He asks what the inducements are for the studies and is told they are mainly money. She tells him that the amounts vary, but are appealing, especially to a poor person. He suggests that the amounts ought to be rather small, to ensure that the participants are there for reasons other than the money. Again, some philosophers have written on the ethics of inducing people to take part in such studies, and he suggests she read up on the topic.

The administrator asks whether there would be any advantages to having philosophers work inside the hospital. The philosopher notes that people accustomed to the hospital routine or worried about losing their jobs aren't likely to ask the kinds of questions a philosopher would. A philosopher enjoys the advantage of being an outsider, an external critic of what has become too familiar to health care workers.

After even a brief discussion of these many different cases, it should be apparent that philosophers have a significant role to play in biomedicine. Undoubtedly, the nature of that role will change dramatically over the coming years in response to the challenges posed by the health sciences. Philosophers will become increasingly effective in their role in direct proportion to the degree of clarity they attain.
about the practical and theoretical limitations of their field. Considerable progress can be made toward such clarification, a view supported by the rapid evolution of biomedical ethics in recent years.
CONCLUSION

Medicine is an inherently moral enterprise because it seeks to do what should be done for a patient. Physicians have an obligation to provide therapeutic benefits for their patients, but they are also obligated to serve humanity for other important reasons. Chief among these are the fact that good fortune obligates and the experience of suffering should awaken one's moral sense.

Knowing what should be done has become increasingly difficult. The impact of technology on the lives of patients and their families has resulted in a feeling of helplessness and a loss of dignity. Health care workers appear to be absorbed by the mechanisms they operate, with the result that they no longer see the persons in the cases they process. Some of the approaches to biomedical ethics have also failed to acknowledge the persons involved because of problems of under-interpretation of cases. Non-philosophers have found many of the issues arising out of the cases they confront on a daily basis to be perplexing. This is partly because they lack philosophical skills and partly because they have not always been very successful at isolating the important value questions the issues create.

Philosophers seemed to be natural candidates for dealing with such difficult value questions. Philosophers had a
number of skills and resources that they attempted to apply in the context of biomedicine. These resources have not always been received with much interest or enthusiasm by health care workers. (Two notable exceptions are the applied ethics paradigm and casuistry.) Even though the moral expertise philosophers have made available has been called into question by both philosophers and others, some philosophers don't seem to have a clear sense of their limitations. One example of a limitation is that philosophers might not work with sufficiently sophisticated analyses of cases if the cases haven't interpreted very carefully. Those in the caring professions can help augment the interpretations of both routine and bizarre cases.

Many of philosophy's problems are a result of the dramatic difference between biomedicine and philosophy. The former is primarily a practical endeavor, while the latter has long been a theoretical field. The medical community's response, in part, has been to develop its own moral resources, ones that are believed to be tailor-made for its needs. This response isn't without its own difficulties, however. In particular, medicine should not abandon having an external evaluation of its goals and purposes. In addition, most of the approaches medicine has considered are dependent upon people who have had some philosophical training.

While many philosophers acknowledge the limitations of their resources, not all agree about the implications. Some philosophers, like Rawls, think philosophical theory is
presently too primitive to deal effectively with practical problems. Many philosophers, however, have become part of an anti-theory movement that regards any efforts in the area of theorizing as being wasted. It is apparent that the anti-theorists will have a great deal to say about other conceptions of moral reasoning, ones that are very different from rationalist moral theories. Whether these alternatives will be more effective in a biomedical context is moot. It is probably too early to pass judgment on their efforts, but it is apparent that considerable work needs to be done by the anti-theorists.

Casuistry is an example of a method of moral reasoning that proceeds with no explicit emphasis on normative ethical theories. This is, in short, an example of a contextualist method that depends on new ways of understanding moral justification. Casuistry produces results, but probably only under strictly controlled circumstances. The casuists of today, just like those of Pascal's day, need to defend their method against charges of arbitrariness and inadequate argumentation. Their results don't appear to be supported by any substantial rational arguments. Instead, similarity, dissimilarity, and consensus seem to be the important elements of the casuists' method. Studies of the commission (and ventures like it) would no doubt undermine considerable confidence in the rationality and defensibility of the whole approach.

Despite the shortcomings of philosophy and its resources, it should not withdraw from biomedical ethics. Rather, phil-
osophers must be content to (for the present at least) be adherents of a soft science and they must be willing to soft-pedal their claims to moral expertise. Those who are adept at providing sophisticated moral interpretations for routine and perplexing cases (viz. psychiatrists, social workers, nurses, etc.) can help deepen the analyses of biomedical ethicists.

Despite these limitations, philosophers have a great deal to contribute to biomedicine, mainly because of their efforts to come up with rationally compelling moral theories and concepts. If philosophers can provide strong rational arguments in favour of a moral theory, then it is reasonable for one to adopt it. Reliance on a well-defended moral theory will make better answers possible in biomedical ethics. If philosophers can provide rationally compelling moral concepts, then considerable progress can be made towards resolving particular moral issues (e.g. euthanasia and infanticide). A strong interplay between philosophers and non-philosophers (who will supply necessary empirical input) will permit the rapid growth and development of biomedical ethics.
SOURCES CONSULTED

Arras, John D. "Methodology in Bioethics: Applied Ethics versus the New Casuistry." (Presented at the Institute for the Medical Humanities of the University of Texas, Galveston, forum on "Bioethics as an Intellectual Field," 1986).


Canadian Broadcasting Corporation Television Interview, 23 January 1991. R.J. Lifton was interviewed from their New York studio.


