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Moral Enhancement: Do Means Matter Morally?

Reply to Elisabeth Shaw

Maartje Schermer and Farah Focquaert

By and large, we agree with the eloquent and sharp interpretation that Elisabeth Shaw offers of our paper. We believe many of her conclusions are very much in line with what we have tried to argue, and she provides some clarifications that we welcome. Nevertheless, there also appear to be some misunderstandings of our argument or points at which our argument has not been made sufficiently clear by us, and in the following, we will try to explain our position in response to Shaw's critique.

Shaw discusses three aspects of passive interventions that may make them more problematic than active interventions: the suddenness of the effects, whether it is possible to reject them, and whether the recipient rationally endorses the intervention and its effects.

Regarding the first point, Shaw rightly argues that direct interventions need not always be very sudden but can be gradual, too. We agree. Depending on the type of direct intervention (e.g. deep brain stimulation versus drugs), the likelihood of sudden changes can be higher or lower. Likewise, we agree with the claim that indirect interventions may also produce sudden changes in moral understanding or moral motivation, although we believe it is somewhat unlikely that this would happen without any previous involvement of the subject in some form of moral thinking.

It is important to note, though, that we do not *equate* direct interventions with passive ones and indirect interventions with active ones. We do NOT claim, as Shaw seems to have inferred from our paper, that all direct interventions can be distinguished from direct interventions by distinguishing between active and passive. We state that the distinction between active and passive is what really matters morally. *Only in so far* direct interventions are indeed passive, and indirect interventions are active, is the distinction between direct and indirect morally relevant. So, we'd rather not talk about direct and indirect anymore, but rather about passive and active. We do not claim those two distinctions neatly map onto one another. Our claim is not that direct interventions are all passive and therefore problematic, but that direct interventions are more likely to be passive and therefore more likely to be problematic.

The examples Shaw gives of indirect interventions that still bypass the recipients' ability for active mental involvement and moral reasoning, are very interesting. Subliminal messages and hypnosis, in our view, would not count as 'active' interventions. Although hypnosis may need some active mental involvement of the subject, this is likely to be minimal – the effects will mostly take place at some subconscious level and the subject will have little control over them. Hence, on the continuum we sketch between completely passive to completely active interventions, hypnosis would be more in the passive direction, and subliminal suggestion would be completely 'passive' (requiring no active, conscious involvement of the subject at all to take effect).

Another point that merits some further clarification, is about the way in which the opportunity to withdraw from a certain intervention relates to autonomy. Shaw argues that sometimes it may actually be conducive to a person's autonomy if he is unable to reject a change or withdraw from an intervention. Here it is useful to make a distinction between two conceptions of autonomy (also made by Feinberg, 1985). The first is autonomy understood as a right to self-determination, the right to make one's own choices in life, regardless of one's reasons, just because these choices are a person's own, and because of his sovereignty over his own life. This notion of autonomy supports the doctrine of informed consent and grounds the important right to refuse treatments and interventions. Another conception of autonomy is that of the ability to be self-directing and self-governing, to make choices based on one's own convictions, values and plans in life. Roughly, those two conceptions of autonomy could be equated to Berlin's notions of negative and positive liberty, respectively. Whereas Shaw is right that sometimes interventions against one's wishes (without consent) could be beneficial for one's autonomy in the second sense, they would still infringe upon one's right to make one's own self-regarding decisions (autonomy in the first sense). In case of Ulysses contracts as they are used in psychiatric care settings, this infringement is justified by the fact that the person themselves have consented to the intervention in a state of mental competence, whereas the intervention is performed at a moment when this competence is lost, due to mental illness (e.g. active psychosis).

We agree with Shaw's conclusions and the interpretation of our argument that it is important that recipients can rationally endorse the intervention (or more precisely: the changes it brings about) and that they have the ability to apply their own (moral) reasoning.

A final note, however: while changes in moral beliefs can (and should!) take place based on moral reasoning, this is more complex for morally relevant capacities like empathy, or self-control. One can choose to change these for rational moral reasons, but not necessarily by way of moral reasoning. Becoming more empathic or better able to resist aggressive impulses can be achieved by way of active practice and perhaps also by more passive interventions. If people autonomously choose and endorse such changes in themselves to be brought about by way of direct or passive interventions, this is morally acceptable, we have argued.

Comment on "Do Means Matter Morally?"

By Dr. Elizabeth Shaw

University of Aberdeen School of Law

In their thought-provoking and original article, "Moral Enhancement: Do Means Matter Morally?", Farah Focquaert and Maartje Schermer consider whether there is a morally significant distinction between "direct" and "indirect" methods of enhancing the capacities required for ethical behaviour. Direct brain interventions (e.g. psychosurgery, or psychopharmaceuticals) target brain structures/processes directly and thereby alter thought processes, whereas indirect interventions (e.g. moral education or cognitive behavioural therapy) target thought processes, thereby altering the underlying brain structure/function. Focquaert and Schermer argue that the indirect/direct distinction is important insofar as indirect interventions tend to be "active" and direct interventions tend to be "passive". If a moral enhancement is "active", then the recipient herself is involved in bringing about the enhancement through her own involvement and efforts, e.g. through engaging in moral deliberation or talking therapy. In contrast, a passive moral enhancement brings about its effects without requiring the recipient's psychological or behaviour involvement. This comment focuses on the section of Focquaert and Schermer's article that concerns trying to distinguish direct from indirect interventions on the basis that the former presents a greater risk to the recipient's autonomy.

According to Focquaert and Schermer, the "gradual nature" of active, indirect interventions provides the recipient with more opportunities, as the intervention progresses, to reflect on it and potentially withdraw from it, whereas direct, passive interventions "cannot be deliberated on in the same gradual manner and cannot be similarly selectively endorsed or rejected".[1] They give the example of a person with impulse control and anger management problems receiving cognitive behaviour therapy (an indirect, active intervention). This person has many opportunities during the course of the therapy to reject the treatment if she decides that the therapy is undermining things she finds important – e.g. risk-taking and spontaneity. They argue that passive interventions pose a greater threat to autonomy than active ones, because "part of being an autonomous individual involves having the freedom and ability to withdraw from interventions or treatments that we no longer rationally endorse. This means that after giving one's informed consent, it remains possible to withdraw from the intervention or treatment at any given time."[2] Focquaert and Schermer conclude that although direct interventions carry a greater risk to autonomy than indirect interventions (e.g. moral dialogue), robust consent procedures can mitigate this risk.

I agree with Focquaert and Schermer that direct interventions are more ethically problematic than moral dialogue and that direct interventions can nevertheless be acceptable if the recipient gives free and informed consent. However, I suggest a clarification/modification to the way they argue for this

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[1] Focquaert and M Schermer, "Moral Enhancement: Do Means Matter Morally?" (2015) *Neuroethics*, p7.

[2] Ibid, p11.

conclusion. It is important to distinguish clearly between three different considerations that feature in their argument: whether the intervention takes effect suddenly, whether it is possible to reject the intervention whenever the recipient wishes to and whether the recipient rationally endorses the intervention. I will argue that the issue of suddenness and the possibility of rejecting the intervention at will are not always good ways of distinguishing between direct and indirect interventions because i) a direct, passive intervention might take effect gradually and provide opportunities to withdraw from the treatment, ii) an indirect, active intervention might take effect suddenly and may not be possible to reject whenever the recipient wants to reject it, iii) the fact that an intervention takes effect suddenly and cannot be rejected at will does not necessarily create any risk to autonomy and iv) a person's autonomy may be more at risk if the intervention takes effect gradually and provides them with opportunities to withdraw from it. However, I agree with Focquaert and Schermer that it is important whether the recipient rationally endorses the intervention. The way in which this rational endorsement comes about can help to distinguish direct interventions from certain indirect interventions, such as moral dialogue.

Firstly, direct interventions can be gradual. Imagine a drug that had to be injected once a week for several months and after each injection the recipient's capacity for empathy was slightly strengthened. This would be an example of a direct, passive intervention that nonetheless took effect gradually, leaving the recipient with many opportunities to reflect on the treatment and reject or endorse it.[3] Secondly, an indirect intervention might produce a sudden change in moral understanding/motivation. A single event can be enough to "teach someone a lesson" – e.g. a conversation with an inspiring moral educator, or perceiving the results of a reckless action, or being cautioned by the police. It may not be possible to reverse the effects of such interventions whenever the person wishes to. For instance, someone might believe prior to engaging in moral dialogue that a particular action is both in their self-interest and morally good. After engaging in moral dialogue (the indirect intervention) the person may have reached the inescapable conclusion that, although this action does promote their self-interest, it is morally bad. The person may really wish to reject this new moral insight (because it would be much easier for them if their self-interest and moral beliefs coincided) but might be unable to do so because the moral argument has instilled in them a strong moral conviction. In this example, the indirect intervention would have brought about a moral enhancement (a new moral insight) without it being possible for the recipient to reject the enhancement just because she wishes to. Thirdly, the fact that a change in someone's moral decision-making occurred suddenly (e.g. because the person has learned his lesson first time round) and cannot be rejected (because of the strength of his moral conviction) does not necessarily give rise to a worry about the person's autonomy. If a reckless driver were immediately convinced never to drive that way again after listening to a moving talk from a victim of a road traffic accident or after a single visit to a hospital ward where car crash victims were treated, we would not be concerned that the suddenness of the change in the driver's moral understanding and motivation put his autonomy at risk. Fourthly, being deprived of the opportunity to withdraw from a procedure can arguably sometimes promote autonomy more than a procedure that takes effect gradually, allowing the recipient opportunities to withdraw from it. Ulysses contracts involve binding oneself to act in a particular way in the future. The name comes from the story of Ulysses who wished to hear the Sirens' song, without the song luring him to his death. He ordered his sailors to stuff their ears with wax, bind him to the mast and ignore his pleas to be allowed to jump overboard. Being prevented from changing his mind gave Ulysses the freedom to hear the Siren's song and survive. Being allowed to change his mind part way through the process would have been lethal. Similarly, if an instant cure for addiction were discovered, this might better promote autonomy than a treatment for addiction that took effect gradually over a period of time, with more potential for the addict to quit the treatment.

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[3]If such a gradual course of treatment were possible, Focquaert and Schermer would consider this type of direct intervention preferable to a more abrupt direct intervention.

I have argued that the suddenness of the effects of the intervention is not always morally significant. I have also argued that being unable to resist the effects of an intervention whenever one wants to for *whatever* reason is not necessary for autonomy. However, if one interprets the ability to resist the effects of an intervention one no longer "rationally endorses" as the ability to resist its effects on the basis of one's own *moral* reasoning, then I think this is an important consideration. Indirect interventions that work by providing good reasons to change one's moral beliefs or attitudes do not undermine autonomy. It may not be possible to resist acquiring a new moral belief or attitude in this way, even though one might have non-moral (e.g. self-interested) reasons for wanting to reject the belief or attitude. Nevertheless, in this example, it would still be possible to resist acquiring the belief or attitude if on the basis of one's own *moral reasoning* one finds the grounds for accepting the belief or adopting the attitude unpersuasive. One's prudential reasons and moral reasons may conflict. An individual is not less autonomous just because she is unable to refrain from believing the conclusion of an argument she finds morally sound, but inconvenient from a prudential point of view.[4]

In contrast, direct interventions take effect without engaging the person's own reasoning processes. Therefore, in order for the person administering a direct intervention to show respect for the recipient's autonomy, it is necessary to seek the recipient's prior consent and subsequent endorsement. I deliberately use the phrase "to show respect" for the person's autonomy, rather than "to avoid undermining" the person's autonomy. This is because a change to one's brain functioning/structure that alters one's moral decision-making does not necessarily undermine autonomy even if it takes place without consent. For instance, it is likely that what one values is influenced to some extent by factors that influence the brain directly (e.g. hormone levels) rather than through being presented with reasons. A person (without any external intervention) might naturally undergo a reduction in the level of certain hormones and this change might have the effect of making risk-taking behaviour seem less attractive. Even if the person is unaware of the (natural) change in her hormone levels (and does not consent to this change) this does not necessarily undermine her autonomy. There is no reason to think that prior to the change, when the level of these hormones was somewhat higher and she was more predisposed to risk-taking behaviour, she was more autonomous. However, if *another person* were to deliberately alter this individual's hormone levels without her consent in order to manipulate her behaviour, this would fail to show respect for her as an autonomous agent.

To summarise, it is possible to distinguish between some indirect moral enhancements (e.g. moral dialogue) and direct moral enhancements in the following way. Moral dialogue respects the individual's autonomy because it changes the individual through giving her reasons to change and will only work if she is persuaded on the basis of her own moral reasoning. In contrast, direct moral enhancements bring about a change in the person's mental processes without giving the person reasons to change. In the case of direct interventions, in order to respect the recipient's autonomy it is necessary that she is able to rationally reflect on the intervention before and after it occurs and gives prior consent and subsequently endorses it.

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[4] I am assuming that causing someone to acquire a sound moral *belief* counts as a moral enhancement. Acquiring this belief probably increases the likelihood of acting in accordance with it. Autonomy may well require the ability to refrain from acting on the belief and arguably requires the ability to refrain from acting on it for non-moral reasons. What autonomy requires with regard to refraining from believing something is different from what autonomy requires with regard to refraining from action.

This distinction seems to roughly correspond to Focquaert and Schermer's active/passive distinction. However, it could not be used to distinguish *all indirect* interventions from *direct* interventions. Some interventions are indirect because they target thought-processes (and thereby affect underlying brain processes), but the recipient may not have adequate opportunity for rational deliberation and autonomous choice. For example, it might be possible to increase a person's level of self-control and reduce immoral, impulsive behaviour, by hypnotising or exposing someone to subliminal messages without the person's consent. This would change the person without giving them good reasons to change and could fail to respect their autonomy. Subliminal messages and hypnosis could count as moral enhancements on Focquaert and Schermer's definition. Their definition includes the case of reducing impulsivity in a person who possessed "(sufficient) understanding of what constitutes right and wrong, but at the same time may be unable to do good …actions due to impairments in impulsivity". Subliminal messages or hypnosis are not direct interventions, because they rely on the recipient being able to understand (albeit at an unconscious level) certain concepts that are being communicated, rather than working by, e.g, altering levels of neurotransmitters in the brain, which would change brain processes without requiring the recipient to grasp any concepts. Deception is another example of an indirect intervention that might bring about a moral enhancement in a weak-willed person, but does not show respect for the recipient's autonomy because it does not change the person by giving her good reasons to change. For instance, imagine deceiving the person into thinking that she had taken a pill that strengthened her self-control and this had a placebo effect of causing her to exert more self-control and behave in a morally better way.

In conclusion, one can distinguish between *some* indirect interventions (e.g. moral dialogue) and direct interventions by asking whether they change the person by giving the recipient good reasons to change. This is similar to Focquaert and Schermer's active/passive distinction. However, this approach will not distinguish *all* indirect interventions from direct interventions.