

A Genealogical Critique of Beauchamp and Childress' Four Principles Approach to Medical Ethics

"...my main quarrel with Mr. Lewis is not for his attack on my profession, but for his attack on my species. I believe that, without any supernatural promptings, men can be extremely good or extremely bad. He must explain human evil by the Devil, and human virtue by God. For him, human freedom is a mere choice between alternatives presented to our souls by supernatural beings. For me it is something creative, in the sense that each generation makes newer and greater possibilities of good and evil."

J.B.S. Haldane, 'Auld Hornie, FRS'

This work is dedicated to:

Harriet Lloyd, whose faith in, honesty with, and love for its author inspired its (eventual) completion,

Kathleen Powell, without whose patience, support and encouragement it would not have been possible,

and to the memory of **Danny and Eva O'Brien**

With thanks to: Prof. Robin Attfield, Dr. Andrew Edgar, David Griffiths, Roger Powell, Helen Lewis, Harry Lesser, Daniel Ramirez, Rhian Rattray, Dr. Peter Sedgwick, Alison Venables and Michael Waltho

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Abstract

The purpose of this thesis is, through a critical account of the development of ethical thought in medicine from Ancient Greece to the early 21st Century, to demonstrate the value of Beauchamp and Childress' four principles of biomedical ethics both as an aid to moral decision-making in medical practice and as a contribution to philosophical moral theory. The first section, **Introduction and Method**, explores these aims in more detail and sets out some reasons for pursuing them in this particular way.

Part One examines the development of historical traditions of medical ethics from the ancient Near East through Greece and the medieval West to Europe and North America in the 19th Century. In doing so, it advances the argument that the Hippocratic and Professional traditions of ethics *do* reflect substantive ethical concerns in medicine, and that the responses they offered to these can be better understood with reference to the social and historical context in which they were produced.

Part Two considers the limitations of these traditions when faced with new moral concerns in medicine from the mid-20th Century onwards, and of the relationship between these concerns and the traditions themselves, before proceeding to examine how and why these concerns led to the growth of interdisciplinary efforts to tackle them. The section considers the contribution made by philosophy to these efforts, and concludes with a discussion of some criticisms of philosophical involvement in medical ethics from both within and outside the discipline. It is argued that these criticisms fail to properly understand the role philosophy played in late-20th Century medical ethics, and that the way in which philosophical approaches to these issues continued to grow and change throughout this time.

Part Three examines the development of Beauchamp and Childress' 'four principles' approach to medical ethics from the 1st to the 6th Editions of *Principles of Biomedical Ethics*, arguing that it has, thanks to changes in the authors' conception of philosophical moral theory, been able to productively incorporate the views of many of its critics over this time; that it is also able to incorporate features of different

ethical approaches such as virtue ethics, narrative ethics and ethics of care; and that, properly understood, it continues to provide a good framework both for moral reflection in medicine and the provision of concrete action-guides. The thesis concludes by considering this view of the four principles in the light of the earlier sections' approach, and attempting to demonstrate further demonstrate their value through two case-studies.

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Introduction and Method:

For as long as there has existed amongst humans a discipline (magical, religious, scientific or otherwise) concerned with the treatment of illness, injury and disease there appear to have existed a set of moral concerns related to it. Yet the relevance of these historical concerns to what we today understand as 'medical ethics' is a matter of dispute. As Beauchamp and Childress have argued, in the current (6th) edition of their *Principles of Biomedical Ethics*, '[medical] ethics [in Europe and North America] enjoyed a remarkable continuity from the time of Hippocrates until the middle of the 20th Century, when developments in the biological and health sciences created concerns about the adequacy of traditional moral guidelines'. For this reason, and as a result of what they contend are the failings of historical traditions of medical ethics (which they believe 'had neglected ethical problems of truthfulness, privacy, the distribution of health care resources, communal responsibility, the use of research subjects and the like') they elect to eschew historical investigation and instead employ an approach based on 'philosophical reflection on morality that is distanced from the history of professional medical ethics'¹.

Insofar as such an approach follows from their conception of the 'failures' of historical traditions, however, it may be seen to prompt three further questions. To begin with, there is the matter of just what that tradition entails. Jonsen, in *The Birth of Bioethics*, has argued that it is composed of works covering three distinct areas. First of all were those that outlined the 'character or qualities of persons that might win them praise or blame', meditations on the character and virtues of 'the good physician' or 'bedside manners' such as those found in the Hippocratic Corpus. Secondly, and following these, came those comprising injunctions as to 'the duties and obligations that bind humans to perform, and to refrain from performing, certain actions' (matters of 'a more grave morality' governed by oaths or the 'stringent rules' laid down in church or state legislature) which he sees as epitomised by the Hippocratic *Oath*. Finally (and after a considerable period of time) emerged those that explored the social dimension of such characteristics and duties and '[inquired] how the existence of communities is related to the purposes of the individual'. Jonsen sees

these 'social ethics', which attempted to define the responsibilities of the physician to society, as exemplified by the professional ethics of the 19th Century².

We will further consider the validity and/or utility of such distinctions later in this section. For the time being, however, it is enough to note that they prompt our second initial question. It is clear from such an account that, whatever 'remarkable continuity' may have been present in medical ethics over the course of the two-and-a-half millennia since Hippocrates of Cos drew (or so it was once supposed) the line forever separating naturalistic medicine from superstition, historical traditions of medical ethics in Europe (and later, North America) *did* change and evolve over time. We are, then, compelled to ask why these traditions seem to have found themselves unable to cope with the pace of change brought about by medical advances in the 20th Century. This is a question for which Beauchamp and Childress, in their choice of method, appear to have an answer: what had been missing, or so they seem to suggest, was the 'philosophical reflection' they aim to provide.

Yet this answer itself prompts another question for, as long as there has existed medicine in a sense that we may recognise it (that is, since at some point around the time of Hippocrates), there has also existed some form of philosophical reflection. Despite their having shared a common time-frame, and despite an assumption amongst some writers that the two have always been linked, at least one historian has '[dismissed] as balderdash the notion that philosophical theories have [historically] influenced medical ethics'. This is a curious state of affairs, given that both disciplines have found themselves unable to resist the urge (or imperative) to explore (and, in some cases at least, claim the authority to pronounce upon) moral matters. Why then, we may ask, have philosophical ethics 'influenced medical ethics only during a few brief periods'? Why is it that, '[aside] from these periods... doctors dealing with medical ethics did not dialogue with philosophers or apply moral philosophy to moral issues in medicine'³? It is these questions that this work will investigate. In a critical account of the historical relationship between philosophy, ethics and medicine from Antiquity to the present day, it will consider both such dialogue as has existed and the periods of silence which appear to have punctuated it. Has medicine changed? Has philosophy? Have *both*?

A Genealogical Approach

Morrice has identified ‘an intellectual and historiographical problem’ which (he believes) lies at ‘the heart of any endeavour to write the history of medical ethics’. As he sees it, this problem tends to ensure such accounts are divided into three kinds of approaches, a possible reason for which lies in the differing academic backgrounds of those who attempt to write such histories (with social historians, who account for two of the approaches, on the one hand and those concerned with ‘the current discipline and philosophical basis of medical ethics’ on the other⁴). Authors in the latter tradition are seen to favour viewing medical ethics simply as a collection of ethical problems. Morrice contends that this produces (in the words of R. French) ‘a history of practice, not of [the] ethical [problems]’ themselves⁵. Authors in the former tradition instead aim to consider why certain problems are considered ethical at given times and why some are not. In doing so, Morrice contends, they adopt one of the two further approaches he describes: those that argue ‘that the content of medical ethics has simply changed as the social context and day to day work of doctors has changed’ and those that argue ‘that beneath this apparent shift lies a more profound continuity of social function’⁶.

Our own enquiry will consider, alongside evidence of ethics in the sense of ‘scholarly effort to articulate and analyze... rules, customs, and beliefs’⁷, a parallel history of moral thought revealed through the attitudes expressed in the actions of groups and individuals, and seek to explore the relationship of explicitly ethical works to the social and historical context in which they were produced. At its simplest, our approach will conflate Morrice’s description of the ‘content of medical ethics’ with scholarly traditions of ethics, and consider this against an ‘underlying continuity’ made up of the ongoing concerns which underpin these differing expressions of moral thought and practice. In doing so, it will enable us to enquire as to how and why certain forms of ethical thought with certain concerns arose at different times.

Through doing so, we will attempt to ensure these issues concerns are considered in the widest possible context and thus provide both a history of practice *and* of ethical problems. Beyond this, our account will also seek to demonstrate that the ‘underlying continuity’ of medical ethics is itself malleable, and that the concrete products of this continuity expressed under one particular set of historical circumstances themselves

effect how it goes on to be expressed in another. Furthermore, our account will seek not only to examine the history of one aspect of both ethics and morality, but to consider how this account may relate to the general nature of ethics and morality as a whole.

Our approach may be termed *genealogical* in that, like Foucault, it does not examine morality in terms of some abstract quality, but rather through examining how moral concepts have, historically, been ‘put to work’⁸. Moreover, it does not, as Foucault argued was the case with the thought of Paul Ree, ‘follow the English tendency in describing the history of morality [through] reducing its entire history and genesis to an exclusive [physical, metaphysical or linguistic] concern’⁹. Whilst we will argue that medical ethics *has* developed over time, it has done so for a variety of different reasons and in a variety of different ways. Our account is also genealogical in that, whilst seeking to uncover what lies behind the record of ethical thought preserved in laws, codes and systems, it will also consider how they may be related: in attending to ‘the details and accidents that accompany every beginning’¹⁰ it will consider how particular expressions of any ‘underlying continuity’ may, depending on how they have been understood, come to constitute the ‘details and accidents’ comprising the birth of each subsequent expression. Where Foucault’s conception of genealogy, however, primarily considers morality solely as the expression of non-moral elements, our own is concerned with the relationships between moral elements and non-moral elements, and moral elements and each other.

Clarification of Terms

Before proceeding with our enquiry, it is worth taking a moment to clarify some of the terms we will use in it. Many of these, both general (such as ‘morality’ and ‘ethics’) and specific (such as ‘moral dilemmas’, ‘ethical situations’ or even ‘medical ethics’ itself) are often contentious, perhaps unavoidably so, and require clarification. Some cases are less problematic than others: the word ‘doctor’ may carry with it certain connotations with regards to matters of social status (or as to why certain figures such as chiropractors may or may not use the title) which should not be ignored, but is worth keeping to avoid the necessity of unwieldy formulations such as ‘physician and/or surgeon’. Similarly, ‘ethics’ and ‘morality’ are notoriously difficult

to pin down to universally agreed meanings: some thinkers, such as Singer, elect to use the terms interchangeably¹¹ whilst others prefer to distinguish between the two. For the sake of clarity, it is adequate to say that, for the purposes of this work, 'morals' and 'morality' will generally be used in a wide sense to describe the whole sphere of situations and ideas commonly under discussion. 'Ethics' will be used more narrowly: firstly, to describe the articulation and systematic organisation of positions taken in such discussions (for example in codes of behaviour or philosophical ethical systems), and secondly in the discussion of the reasoning (and other) processes through which such positions are reached and/or defended (for example in philosophical or religious debate).

A related and yet more vexed question is that of what constitutes a 'moral' situation or dilemma in the first place. Beyond this, even on those occasions where agreement on this first question can be reached, there often remains debate on which aspects of such a situation can be considered morally relevant. An instructive example may be that of 'sexual morality'. To again take Singer as an example, he argues that 'sex raises no unique moral issues at all' as 'considerations of honesty, concern for others, prudence, and so on' are also raised (perhaps to a greater degree) by everyday activities (his chosen example being driving a car)¹². On the other hand, other thinkers have contended that particular sexual practices may in fact engender moral debate around similar issues to those involved in ethical discussions of 'family life, contraception and abortion'¹³. It should be noted that it is also perfectly possible to disagree with both points of view (either entirely or in part) and still concede that they might tell us something about our conception of morality in a wider sense (for example, one could point out in Singer's case that the very fact he feels compelled to explicitly distance himself from the discussion of matters of so-called 'sexual morality' demonstrates that they at least raise moral issues in the sense of discussions pertaining to *what* is to count as moral and *why*).

If it is difficult to decide what is meant by a 'moral' or 'ethical' debate in the wider sense, then deciding what is meant by a *medical* ethical situation may prove harder still. The above examples contain some areas of moral and ethical discussion which most people would agree to be the preserve of medical ethics (contraception and abortion, for example). But why is this? Should the term medical ethics cover only

those situations in which a medical practitioner faces what are felt to be ethical dilemmas in the course of their professional life? Could this be extended to cover the conduct of such individuals outside their profession or away from their patients, or to influence concerns which are not the direct preserve of medical science (for example, sexuality)? What of the responsibilities and conduct of those patients themselves, or of individuals whose behaviour or environment may adversely affect their health or that of others (for example, those who drive needlessly polluting vehicles)? With regards to these more difficult cases, even simple definitions have a habit of raising questions as to why some areas (often deeply contentious ones to others) have been excluded. It will better suit our purposes, then, to try to arrive at an understanding of what is meant by these terms by trying to understand what *kinds* of things have been understood by them in the past.

If this last point may be seen to further clarify just why we have chosen the method that we have, this can be further demonstrated by turning to an even more problematic definition: that of *philosophical* medical ethics. In part, our enquiry will consider this term in the narrower sense of that branch of ethics commonly referred to as ‘philosophy’ in academic circles. However, there are also wider issues to consider in terms of how philosophers (and moral philosophy) have engaged with ethical issues in regard to medical practice. To return to Foucault, we should not take it for granted that ‘words [have] kept their meaning, that desires still [point] in a single direction [or] that ideas [retain] their logic’¹⁴. We should not assume that ‘ethics’ and ‘morality’ consist only of what philosophers (and others) have chosen to *call* ethics and morality, either at the time or with the benefit of hindsight. Nor should we assume that ‘philosophy’ consists only of what philosophers have chosen to call ‘philosophy’. In order to determine what ethical philosophy *should* do we must also examine what it has been asked to do, what it has tried to do, and what it has done already. We must also examine *why*.

It will be necessary, then, to examine not only those topics on which moral and ethical philosophers have held forth but also (perhaps most importantly) those on which they have chosen to keep silent, and to investigate their reasons for doing so. In the first instance this will involve examining what role philosophers have felt themselves suited (or compelled) to play in such discourse and to consider their declared or

explicit intentions in producing works on the subject. This may not, however, be sufficient. To understand how philosophers have conceived of their role, it will also be necessary to examine how philosophers have linked their ideas to those of non-philosophers (be they doctors, theologians, sociologists or 'ordinary' individuals who found themselves bound to comment on 'medical' matters) and how these individuals have responded to philosophers' involvement. At this point in our enquiry, however, we have gone as far as we can without recourse to the detailed discussion of specific examples. For this reason we may turn now our attention away from matters of methodology and terminology, and towards the dawn of recorded history and the collection of cultures clustered around the shores of the eastern Mediterranean and the banks of the Tigris and Euphrates.

¹ Beauchamp, T. and Childress, J. *Principles of Biomedical Ethics (6th Edition)* (Oxford: Oxford University Press, 2009) p.1

² Jonsen, A.R. *The Birth of Bioethics* (Oxford: Oxford University Press, 1998) pp.6-7

³ Baker, R. and McCullough, J. 'Medical Ethics' Appropriation of Moral Philosophy: The Case of the Sympathetic and the Unsympathetic Physician' in *Kennedy Institute of Ethics Journal* 2007; 17 (1) 3-22 p.4

⁴ Morrice, A.A.G. 'Honour and Interests': Medical Ethics and the British Medical Association' in Maehle, A.-H. and Geyer-Kordesch, J. (eds.) *Historical and Philosophical Perspectives on Biomedical Ethics: From Paternalism to Autonomy* (Aldershot: Ashgate, 2002) p.13

⁵ French, R. 'The Medical Ethics of Gabriele de Zerbi' in Wear, A., Geyer-Kordesch, J., and Frech, R. (eds.) *Doctors and Ethics: the Earlier Historical Setting of Professional Ethics* (Amsterdam: Rodolpi, 1993) p.72 in *ibid.* p.14

⁶ *Ibid.* p.14

⁷ Grodin, M.A. 'Introduction: The Historical and Philosophical Roots of Bioethics' in Grodin, M.A. (ed.) *Medical Meta-Ethics* (Dordrecht: Kluwer, 1995) p.6

⁸ Rabinow, P. 'Introduction' in Foucault, M. tr. and ed. Rabinow, P. *The Foucault Reader* p.6

⁹ Foucault, M. 'Nietzsche, Genealogy and History' in Foucault, M. tr. and ed. Rabinow, P. *The Foucault Reader* (Harmondsworth: Penguin, 1991) p.76

¹⁰ *Ibid.* p.80

¹¹ Singer, P. *Practical Ethics* (Cambridge: Cambridge University Press, 1993) p.1

¹² *Ibid.* p.2

¹³ Arras, J. 'Getting Down to Cases: The Revival of Casuistry in Bioethics' in *Journal of Medicine and Philosophy* 1991;16 (1) 29-51 p.34

¹⁴ Foucault, M. 'Nietzsche, Genealogy and History' p.76

Part One:
Historical Traditions of Medical Ethics

Chapter 1: Moral Concerns in Medicine in the Ancient Near East

There is a Greek legend which tells that Cadmus, founder of the city of Thebes, created the ancestors of the city's noble families by sowing dragon's teeth into the ground, from each of which a warrior sprang, fully-grown from the earth. One would be forgiven for thinking, following an account such as Grodin's, that medicine and medical ethics had a similar genesis, and that the doctor and the Hippocratic *Oath* which (so it would seem) informed his conduct had no antecedent prior to the ancient Greeks. Intuition alone would argue that this is not the case; the Greeks were surrounded by cultures of comparable sophistication and in some cases greater antiquity to whom the healing arts were not unknown in some fashion. Indeed few, if any, scholars would now accept this 'by their own bootstraps' view of Hellenic culture. As Carrick notes in *Medical Ethics in Antiquity*, there is now little room for 'serious doubt' as to the influence extended (in both directions) between the city-states and colonies of the Greeks and their neighbours south across the Mediterranean in Egypt and to the east in Mesopotamia.

Carrick is surely justified in contending that, in the context of a Near East which boasted civilisations of the stature of Egypt, Assyria, Babylonia and Persia, to 'overlook that the Greeks may have acquired useful ideas from their widespread commercial encounters... is to indulge an unaffordable provincialism'¹. This is not to say that the medicine and ethics of the Greeks do not represent a distinct or original strain of thought and/or practice, but if this *should* prove to be the case they may be described as original in contradistinction to what had gone before and to what was going on elsewhere. This notwithstanding, an enquiry into medicine and medical ethics (in such forms as we may find) elsewhere in antiquity may also throw new light on our understanding of the Greeks. We may yet decide that medicine and medical ethics *in such form as we can usefully relate to them* began with the Greeks, but to assert this as a matter of course would, in such circumstances, be premature.

Any such enquiry into ancient thought presents two challenges. The first of these is lack of evidence; this is, of course, the case for any historian considering the period in question, but it is an especially acute problem for the philosopher or historian of ideas,

who as a matter of necessity must rely primarily on written sources. Clearly there is a great deal of educated guesswork involved in reconstructing the image of a palace from its foundations, or a face from a skull, yet written sources (aside from being for the most part more fragile and perishable than masonry or bone) are particularly prone to distortion when viewed in an incomplete state. In the case of Egypt and the Near East (and, to a lesser extent, that of Greece as well) there is much that needs to be inferred and much that is simply not known. To take Carrick's example, that we have no written record of whether the Babylonians or Assyrians conceived of an 'ideal physician' after the manner of the Persians or Greeks constitutes no argument one way or the other as to whether such a conception actually existed².

A second challenge relates to the absence amongst the cultures under discussion of modern distinctions between these disciplines and other areas of thought and practice. Of course, such distinctions can be fluid in our own time as well. The modern discipline of Bioethics is itself founded on elements of (and the interaction between) several different fields (notably philosophy, law, medicine and theology), not to mention several disparate elements within those fields and some which bridge them (philosophy of law, for example)³. The case of antiquity differs from this, however, in presenting us not with a number of recognised and differing areas of expertise in dialogue with each other but rather a set of emergent specialisations still enmeshed with one another to an extent that can render such distinctions confusing. In the case of ethics, questions of morality are bound up almost entirely with matters of law. In the case of medicine, rational and/or empirical methods are bound up with the magical and the supernatural. Furthermore, both law and magic are themselves hardly to be distinguished from religion.

Possible Moral Concerns regarding Magical and Religious Elements of Medicine in the Ancient Near East

Such fragmentary evidence as survives concerning ancient Near Eastern medicine (and such moral thought as seems to have been associated with it) generally reveals it to be primarily magical and/or religious. As Sigerist has it, in the case of Babylonian and Egyptian documents, although we may be 'impressed by the accuracy of some of the observations they relate, or the amount of accumulated empirical knowledge they

reflect' we may equally be struck 'by the grandeur of some of their incantations'⁴. In both cultures, disease was primarily conceived as 'caused by evil spirits or the anger of the gods'⁵. The Babylonian doctor employed treatments involving 'ritual... sacrifice and incantation'⁶ and whilst Egyptian records document pharmacological prescriptions, these are 'interspersed with magical spells... believed to impart efficacy'. Indeed, Longrigg has gone so far as to suggest that some of the more noxious ingredients of these prescriptions were included, not for any pharmacological effect, but specifically to be offensive to the demon or spirit causing the illness, as seems clearly to be the case from the incantation in the *Hearst Papyrus* intended to accompany therapeutic coprophagy⁷.

Jonsen advances, in *The Birth of Bioethics*, what may be thought of as an anthropological argument for the development of moral thought in such forms of medicine. This argument is based on two premises. Firstly, that the healer typically occupies a distinct cultural role: '[in] all cultures, individuals apply remedies and bring solace to their sick relatives' and '[in] many [of these cultures] special practices of healing are reserved for certain individuals who have learned particular skills and rituals'⁸. Secondly, that since magical and/or religious conceptions of disease view it 'as a consequence of a knowing or an unknowing transgression of the order and law of nature and society' (that is, view the natural and moral order as more or less the same thing, or as aspects of the same thing), they demand the application of 'remedies that restore order and reintegrate the sick person into conformity with [it]'⁹.

The result, Jonsen contends, is a widespread belief that 'the work of the healer must not only be correct [but also] right and good'¹⁰. Such a view is certainly plausible. It can be seen to have echoes throughout history, not only in the Babylonian patient 'required to atone for their sins' as a part of their treatment¹¹, but in the works of healing attributed to individuals (such as prophets and saints) held up as the ideal of a particular religious morality and even in the selfless, upstanding physicians who are the heroes and heart-throbs of countless afternoon television soap-operas and Mills and Boon romances. But we may pause to ask whether such beliefs really describe the kind of moral behaviour under discussion when we speak of medical ethics. On first reflection it would appear that, in one sense at least, they do not. Though demonstrating how moral concerns can be connected with the practice of healing,

they do not concern moral questions raised by the practice of medicine *per se*; rather, illness and injury are subsumed into wider moral practice as one of the many possible consequences of transgression against a natural order itself imbued with moral force.

Of course, such thinking is not the preserve of antiquity. In recent times, one can point to the common if not widespread belief that the HIV virus is divine retribution for the sins of homosexuality and/or promiscuity. The line can sometimes be a fine one. If one views the maintenance of health as a moral duty (whether to oneself or to the wider community that shoulders the burden of one's illness, whether emotionally in the case of the family or financially as in the case of, in Britain at least, the state) then lung cancer, cirrhosis of the liver and heart disease can all seem fitting 'punishments' for a life of smoking, drinking and gluttony. In the majority of these cases, however, 'punishment' is unlikely to be a description with which many would agree in all but the most general sense. Sympathy may be limited, but illness is not commonly seen as the *moral* consequence of an individual's actions.

There is, however, a second sense in which we may interpret such thought as, if not *being* an early form of medical ethics, then rather *informing* an early form of medical ethics. Such an interpretation depends, first of all, on our remembering that distinctions which come readily enough to the modern mind may not have been apparent or may even have seemed nonsensical to the ancients, and that in no medicine of Near Eastern antiquity do we find unambiguous evidence of a sharp divide between magical and/or religious elements on the one hand and empirical and/or rational elements on the other¹². Even in Egypt, where naturalistic elements of medicine developed further than in any culture prior to the Greeks, the approving (and seemingly empirical and/or rational) formula 'really excellent, *proved* many times' [my emphasis] is more often found appended to spells than it is to pharmacological prescriptions¹³.

For healers in such cultures, in which a distinction between the 'natural' and 'supernatural' has not yet been drawn, there is no reason *not* to count knowledge of incantations and right conduct as *at least* the equal of knowledge of pharmacology and anatomy in terms of the practical measures available for treating one's patient. Indeed, in the case of Persia at least, there is some evidence that the former were

counted as *superior* to the latter. In differentiating certain kinds of healer along lines common to many early cultures, the *Videvdad* or *Vendidad* notes that ‘one who heals with the holy word’ (that is, the incantation priest) and not ‘one who heals with the knife [or] one who heals with herbs... will best drive away sickness from the body of the faithful’¹⁴. Given such a state of affairs, we may wish to consider whether (to borrow Jonsen’s phrasing) what is ‘right’ and ‘good’ about a doctor’s practice can be conceived of as separate from what is ‘correct’.

In other words, questions of the doctor’s moral conduct may be seen to be intertwined with questions of *competence*: a healer must know and abide by proper forms of behaviour not only for their own sake but because doing so is important for successfully restoring the health of his patient. Again, in the case of Persia at least, circumstantial evidence for this view can be found in the description of the ‘ideal physician’ found in the *Dinkard*. Just as modern codes such as that of the American Medical Association compel doctors to ‘be dedicated to providing competent medical service’¹⁵ so the *Dinkard* describes how the doctor ‘should know the limbs of the body... remedies for disease... [and be] skilled to prepare health-giving plants medically’¹⁶. Yet the description also contains several elements explicitly related to character and conduct (‘respecting modesty, protecting good reputation, ready to listen; not acting for gain, but for a spiritual reward’¹⁷).

It is of course perfectly possible that this part of the *Dinkard* is simply concerned with a different set of qualities that were expected from a healer *in addition* to practical competence; the qualities Jonsen has termed ‘bedside manners’. However, as with the strikingly similar section of the Hippocratic *Oath* (‘remaining free of all intentional injustice... [whatever] I may see or hear in the course of the treatment or even outside of the treatment ... which on no account one must spread abroad, I will keep to myself’¹⁸) their presence in such a solemn context appears to suggest that they are ‘more grave matters’ at least co-equal in importance with knowledge of anatomy and pharmacology. Additionally, the doctor so described would have been not only a rational and/or empirical healer but also a Zoroastrian magician-priest¹⁹ and, as we have seen, it was in this aspect that his abilities were (sometimes, at the very least) conceived of as at their most potent.

Even if we are wrong to make such an inference in this case (although, as we shall see in Chapter 3, there may be other reasons why right conduct constitutes for the doctor a matter of practical competency) it remains difficult to dispute that, as soon as the healer is defined as an individual possessed of specialised skills and attributes, his competence in applying these for the benefit of the sick or injured becomes a moral issue. Of course, the nature of these skills and attributes, and of the benefits they confer, may (as we shall explore further in Chapter 2) themselves be open to question. Nevertheless, what list of virtues that the doctor should possess would not involve an aptitude for and conscientious development of applied medicine? Who could claim that competence is not a doctor's moral duty? And what greater sum total of good could be achieved by even the luckiest of unskilled doctors that could not be at least equalled by a skilled counterpart equally fortunate?

Possible Moral Concerns regarding Experimental and Surgical Elements of Medicine in the Ancient Near East

More concrete examples of concerns regarding doctors' competence can be found when we consider those elements of ancient medicine in which firstly, rational and/or empirical elements are present to a greater degree than the magical and/or religious and secondly, where there is a clear risk of the doctor causing direct harm to the patient. In Egypt, for example, we may note that pharmacological prescriptions become noticeably more exact when indicating the proportions of mineral ingredients that are likely to have been toxic²⁰. In Assyria, there is some indication from state letters that drugs were tested on slaves before being used to treat members of the royal family²¹. In Egypt, it seems from other ancient sources that doctors were discouraged from pursuing experimental treatment. Diodorus Siculus, writing in the 1st Century BC, claimed that if the Egyptian doctor lost a patient having 'deviated from the traditional practices and methods in any way' he was put to death; Aristotle, in the *Politics*, allows for slightly more leeway, claiming that this sanction did not apply to doctors who had followed traditional methods during the first four days of treatment²².

It is in surgical medicine, however, that these concerns are most in evidence. In Babylonia as early as the 17th Century BC, the *Code of Hammurabi* contained what

Carrick has described as a 'comprehensive system of legislative sanctions [concerning] surgical medicine'. Interestingly, considering Grodin's contention that concerns regarding the doctor's fee rose to prominence only in the Middle Ages, the *Code* also sets out a sliding scale of 'differential medical fees for surgery based on the socio-economic status of each patient'. More importantly for our current purpose, it also contained the 'first recorded attempt by any culture to protect patients from incompetent doctors'. With reference to surgery on the eye, the *Code* lays out several punishments for the doctor who causes the loss of either the affected organ, or his patient's life. In the case of a nobleman, the state is to punish either eventuality by cutting off the doctor's hand; in the case of a slave, loss of life is to be compensated by the doctor replacing the slave with one of equal value, and loss of an eye with payment equivalent to half the value of the slave²³.

There are several plausible reasons why surgery should be singled out for regulation. First of all, such interventions were, as Carrick has noted, 'perceived to carry more immediate and permanent risks to the patient compared to other forms of medicine... (including magic)²⁴. Moreover, risks and responsibilities would be easier to quantify. Whereas the causes of 'a stroke, or epilepsy... would be quite mysterious and their effect regarded as due to the patient's being possessed by some demon or other'²⁵ the cause of injuries requiring surgical treatment (or injuries inflicted as a result of such treatment) would in most cases be immediately obvious. For example, in what is far and away the most rational and empirical of the surviving Egyptian medical texts, the *Edwin Smith Papyrus*, the prevalence of head wounds that appear to have been caused by weapons seems to indicate that the anonymous author had at some point 'acted as an army surgeon'²⁶. It seems reasonable to conclude that, where the responsibility for an ailment is situated in human agency, responsibility for the success of a remedy is likewise shifted. It is much harder for a doctor to believe the failure of a treatment is the result (or blame the failure of a treatment on) the strength of a demon or divine displeasure when he is evidently responsible for inflicting fresh injuries as part of an intended cure.

Again, it is important to caution against drawing any but the most general conclusions and impressions from such cases. It is tempting to read Egyptian regulations that new treatments should not be tried until those which had been 'proved many times' had

been exhausted, or Babylonian punishments for botched surgery, primarily or exclusively in terms of a concern for patient welfare. However (and without claiming that what follows definitively excludes the possibility of such concerns *also* being present) we should remember that Egyptian medicine was ‘extraordinarily static’²⁷ and heavily prejudiced against the possibility of improving on older forms of knowledge²⁸. In Babylonia, in the case of slaves, we are reminded that these are laws concerned with damage to property at least as much as with harm to human beings. Likewise, the sliding scale of payments outlined in the *Code of Hammurabi* may be a way of ensuring wide access to medical treatment, yet it is equally possible that they are a literal expression of the relative value placed on the lives of different classes of people.

Possible Moral Concerns regarding Euthanasia and Abortion in the Ancient Near East

If moral concerns were raised, in some cases at least, by those situations in which a doctor might *inadvertently* hasten the end of life, what of those in which he might be seen to *intentionally* cause this to happen? In the case of moral positions surrounding what we would now understand as euthanasia, the evidence is, at best, ambiguous. It is known that the Egyptians, Persians, Assyrians and Babylonians all viewed *suicide* as taboo, an act which ‘irrevocably cut [the perpetrator] off from the Gods’. However, suicide is not necessarily analogous with euthanasia to the modern mind and there is no reason to suppose that this was always the case in the ancient world either. Similarly, although the religious elements of the doctor’s role in these cultures may be seen as likely to prohibit either assisting in or actively causing a patient’s death there is, as Carrick has suggested, no reason why we should suppose religious judgement may not have been in some cases tempered with religious compassion and mercy²⁹.

The *Edwin Smith Papyrus* suggests that the Egyptians gave serious thought to what the doctor should do when faced with seemingly hopeless cases. In the list of injuries and ailments, we find a threefold division of cases into those where the prognosis is good (‘an ailment which I will treat’), uncertain (‘an ailment with which I will contend’) or poor (‘an ailment not to be treated’)³⁰ which is echoed in another work, the *Ebers Papyrus*³¹. What the doctor might do in cases of the third type is not always

clear. In the case of the *Edwin Smith Papyrus*, Sigerist contends ‘that hopeless cases were not to be touched’ as part of which he rules out ‘endeavours to alleviate symptoms’³². With regards to the *Ebers Papyrus*, he is more inclined to agree with Carrick that ‘some of the cases explicitly reveal... steps to at least relieve... suffering’³³, allowing that the latter work provides examples of clearly hopeless cases in which incantations are prescribed to at least ‘relieve or cheer the sick man’³⁴. Nevertheless, even if we accept Carrick’s stronger contention, which can plausibly be extended to cover inducing a comfortable death, it remains the case that we have no explicit evidence of Egyptian doctors doing so.

In the case of abortion, on the other hand, there is clear evidence that abortive procedures were known in the ancient Near East and that, in Egypt at least, it is plausible to suggest that the survival of relevant prescriptions indicates that doctors were permitted to terminate pregnancies; there is, however, nothing to indicate when this was considered morally appropriate and/or medically necessary³⁵. Similarly, in Persia and Assyria, where there is evidence that some abortions were forbidden, it is far from conclusive that any restriction or taboo applied to all possible cases. Assyrian law, for example, mentions only the woman who procures an abortion for herself, remaining silent on abortions procured by her relatives or the social group to which she belonged³⁶. Similarly, whilst the Persian *Videvdad* does provide for anyone who helps a woman in procuring an abortion to be punished, along with the doctor or nurse who carries out the procedure³⁷, this still raises the possibility of permitting medical abortions prescribed or required by the doctor in cases of non-viable offspring, or where the life of the mother was threatened.

Carrick is surely right in noting that the severity of the Assyrian punishment for procuring an abortion (impalement on a stake, with the remains left unburied) constitutes plausible grounds for believing it to be considered morally repugnant³⁸. However, it is by no means certain that this repugnance means that abortion was here thought of as wrong because it constituted *killing* (it is, by contrast, explicitly described as such in the *Videvdad*). Certainly in some parts of ancient Mesopotamia, the killing or exposure of newborn children appears to have been considered acceptable³⁹ and, as we shall see in Chapter 2, abortion has been considered wrong for quite different reasons (principal among them matters of sexual and social control) in

cultures where this practice is widespread. It may be noteworthy in this context that in one later Mesopotamian law-code, that of the Hittites, murder, manslaughter and other crimes against the person were punishable by fines; sexual intercourse with cattle, however, was punishable by death⁴⁰.

Nevertheless, whether abortion was forbidden amongst the Assyrians as analogous to murder or manslaughter, or as a crime against the social order, and regardless of whether Egyptian doctors sometimes hastened the death of patients when they believed their position to be helpless, it is clear that not only the correct execution but also the proper use of the doctor's skills was at least in part a matter for regulation. Whatever the motivation, in the Egyptian prognosis 'an ailment not to be treated' there is a suggestion that there are times when the doctor should refrain from performing surgery; in Assyria it is clear that, in some cases at least, neither surgical (or more likely, pharmacological) means were to be used to terminate a pregnancy. From these examples, it seems reasonable to conclude that there existed in these cultures a recognition that, just as magical and/or religious powers bring with them the possibility of black magic or the 'evil eye', so the skills acquired by the doctor as medicine developed to include rational and/or empirical methods brought with them the potential for misuse.

Conclusions

Despite the limitations noted at the start of this chapter, then, we may draw several tentative conclusions regarding moral thought and medicine in the ancient Near East from the examples above. The first of these is that the emergence of the healer as a figure with a distinct social role raises moral questions as to their competence to carry out this role and that, for reasons anthropological or otherwise, this is bound up with concerns regarding the moral character of the healer themselves. The second is that these moral questions later extend to cover the mastery of a body of practical knowledge, especially those parts of it that involve practices such as surgery which (contrary to the intuitive role of the healer) risk or require causing harm to the patient. Finally, there is at least the possibility that moral questions eventually extend to the degree to which such skills can be employed, especially when there is the potential for them to be used to carry out actions which are morally prohibited or otherwise taboo.

However, whilst there is much in Egyptian, Assyrian and other ancient Near-Eastern medicine which seems familiar to the modern mind, it should also be emphasised that there remain significant differences. The first is that, as yet, we have not encountered a ‘medicine’ which is recognisably like our own: naturalistic, based wholly on rational argument and empirical evidence as opposed to supernatural intervention, and (perhaps) conceived of as a progressive struggle against disease. More importantly, though we have evidence of much that is ethical in the first sense in which we have elected to use the term (the codification and exposition of moral action-guides) we are left with little but speculation when considering the second (analysis of and debate about the reasoning which produces them). For the emergence of both these key elements, then, we must now look towards the Greeks.

¹ Carrick, P. *Medical Ethics in Antiquity* (Dordrecht: Kluwer, 1985) pp.59-60

² Ibid. p.61

³ Jonsen, A. *The Birth of Bioethics* p.325

⁴ Sigerist, H.E. *A History of Medicine (Vol. II: Early Greek, Hindu and Persian Medicine)* (Oxford: Oxford University Press 1987) p.84

⁵ Longrigg, J.L. *Greek Rational Medicine* (Abingdon: Routledge, 1993) p.8

⁶ Ibid. p.6

⁷ Ibid. pp.8-9

⁸ Jonsen, A. *The Birth of Bioethics* pp.4-5

⁹ Ibid. p.5

¹⁰ Ibid. p.5

¹¹ Longrigg, J.L. *Greek Rational Medicine* p.6

¹² Ibid. p.6

¹³ Sigerist, H.E. *A History of Medicine (Vol. I: Primitive and Archaic Medicine)* (New York: Oxford University Press/Galaxy Books, 1967) p.339

¹⁴ *Vendidad* tr. Darmester, J. and Mills L.H. in Muller, F.M. (ed.) *Sacred Books of the East* (Oxford: Oxford University Press, 1880) in Sigerist, H.E. *A History of Medicine (Vol. II)* p.202

¹⁵ American Medical Association *Principles of Medical Ethics (Revised 1980)* cited in Carrick, P. *Medical Ethics in Antiquity* (Dordrecht: Kluwer, 1985) p.188

¹⁶ *Dinkard* 157.19 tr. Ratanshan Erachsash Kohiyar in Peshotan Dastur Behramjee Sanjaner (ed.) *The Dinkard: The Original Pahlavi Text* (Bombay: Duftur Ashkara Press, 1891) in *ibid.* p.61

¹⁷ *Dinkard* 157.19 tr. Ratanshan Erachsash Kohiyar in *ibid.* p.61

¹⁸ [Hippocrates] *The Hippocratic Oath* tr. Edelstein, L. in Edelstein, L. tr. Temkin, C.L. and ed. Temkin C.L. *Ancient Medicine: Selected Papers of Ludwig Edelstein* (Baltimore: Johns Hopkins University Press, 1967) p.6

¹⁹ Carrick, P. *Medical Ethics in Antiquity* p.61

²⁰ Sigerist, H.E. *A History of Medicine (Vol. I)* p.337

²¹ Ibid. p.438

²² Carrick, P. *Medical Ethics in Antiquity* p.9

²³ Ibid. pp.60-1

²⁴ Ibid. p.61

²⁵ Longrigg, J.L. *Greek Rational Medicine* p.10

²⁶ Sigerist, H.E. *A History of Medicine (Vol. I)* p.310

²⁷ Longrigg, J.L. *Greek Rational Medicine* p.11

²⁸ Carrick, P. *Medical Ethics in Antiquity* p.9

²⁹ Ibid. p.62

³⁰ *The Edwin Smith Surgical Papyrus* tr. Breasted, J.H. (Chicago: University of Chicago Press, 1930) 6, 8a and 20 in *ibid.* p.62

³¹ Ibid. p.62

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- ³² Sigerist, H.E. *A History of Medicine (Vol. I)* p.306
³³ Carrick, P. *Medical Ethics in Antiquity* p.62
³⁴ Sigerist, H.E. *A History of Medicine (Vol. I)* p.315
³⁵ Carrick, P. *Medical Ethics in Antiquity* p.63
³⁶ Sigerist, H.E. *A History of Medicine (Vol. I)* p.429
³⁷ Sigerist, H.E. *A History of Medicine (Vol. II)* p.201
³⁸ Carrick, P. *Medical Ethics in Antiquity* p.63
³⁹ Sigerist, H.E. *A History of Medicine (Vol. I)* p.401
⁴⁰ *Ibid.* p.430

Chapter 2: Medicine and Ethics in Ancient Greece

Such evidence that exists as to the earliest forms of Greek medicine, in the form of references in the Homeric epics and the poetry of Hesiod, suggests that it was similar in form and content to that found elsewhere in the ancient world. Disease was seen as the result of divine displeasure: Apollo and Artemis in particular were believed to cause epidemic disease ‘by shooting their arrows at mortals’¹ (there is no doubt amongst the army besieging Troy at the start of the *Iliad*, for example, that the plague ravaging their camp has been sent by Apollo²). As Longrigg has noted, whilst less ‘heroic’ illnesses do not appear in the epics as the direct result of divine agency (as when Odysseus asks the shade of his mother the cause of her death in Book XI of the *Odyssey*³) it seems likely they were nevertheless ascribed an origin that was ultimately divine⁴. Hesiod, for example, portrays disease (the ‘[thousands] of troubles wandering the earth’) as Zeus’ punishment upon mankind for receiving Prometheus’ gift of fire⁵. Unsurprisingly, practices concerning the healing of illness and injury that appear in these sources are still bound up with magical and/or religious methods: in the *Iliad*, the obvious course of action to end the plague is to send for a soothsayer to discover what will placate the angry god⁶.

Despite Edelstein’s claims to the contrary⁷, rational and/or empirical elements do not appear in Homer as wholly distinct from magic and/or religion. It is true that, where the healing of battlefield injuries is not carried out by divine intervention, it takes the form of binding and cleansing wounds before applying healing drugs (‘a surgeon... can cut out an arrow and heal the wound with his ointments’⁸). Moreover, skilled surgeons could win renown for mastery of these arts (Machaon, son of Asclepius, is said to be ‘worth a regiment’⁹) suggesting that success or failure was seen as at least in part within the healer’s own compass rather than simply in the hands of the gods. However, such skills are explicitly identified as semi-divine in origin, ultimately derived from the centaur Chiron (whom Homer identifies as the teacher of both Achilles¹⁰ and Asclepius¹¹). Nor are they employed separately from magical and/or religious remedies: in the *Odyssey*, Odysseus’ hunting wounds are treated with both bandages *and* incantations¹² (much later, in the late 6th or early 5th Century, Pindar still describes Asclepius as having tended ‘some... with soft incantations [and] some

[with] the knife'¹³). Additionally, as Sigerist points out, the word used by Homer to describe drugs (*pharmakon*) is also used to denote any 'vegetable substance that had magic powers' (including that of turning men into pigs)¹⁴.

Yet Greek medicine, unlike that of surrounding cultures, did not remain static. Whilst the Egyptians may have developed many of the most strikingly rational and/or empirical elements of their medicine by the beginning of the 3rd millennium BC, they failed to ever fully divorce medicine from magic¹⁵. In Greece, by contrast, the conception of disease present in Hesiod's poetry, written in the 8th Century BC, had by the 5th been superseded by 'an approach to the problems of health and disease and, in general, a type of medicine such as the world had never seen before'¹⁶. The contents of the earliest surviving Greek medical texts, grouped together as the Hippocratic Corpus, are notable not only for the amount of medical knowledge (in terms of techniques, observations and evaluations) they record, but also for the repeated insistence that 'disease is... a natural process' and that there exists 'the possibility of understanding and controlling [it] through the art of medicine'¹⁷.

It is of course possible that the scope and pace of the changes in Greek attitudes to nature from the 6th Century onwards came about simply because the Greeks were lucky enough to be in some way innately intellectually superior to their neighbours, or to be blessed with a remarkable and inexplicable surfeit of individuals of genius. However, it is also clear that several factors existed which were likely either to drive such change or at least to enable such geni as undoubtedly did exist to flourish. First of all, the Greeks lacked the centralised political authority found in Egypt and Mesopotamia (perhaps since, unlike those regions, cultivation was possible without extensive irrigation and the 'strong power [and] disciplined population' required for it); even the *form* of governance varied from city-state to city-state¹⁸. Consequently, there was also a lack of strong religious authority to restrict inquiry: 'no professional priesthood jealous to preserve a dogmatic religious orthodoxy [or] inviolable dogmatic code'¹⁹. Miletus, the home of Thales²⁰ and Anaximander²¹, was also cosmopolitan, wealthy enough to support a population with enough leisure-time to engage in reflection and debate, and could boast recent achievements which were 'too obviously the product of human energy and initiative for there to be any need to acknowledge an indebtedness to the gods'²².

Longrigg has noted that the 'emancipation of (some) medicine from magic and superstition was the outcome of precisely the same attitude of mind which the Milesian natural philosophers were the first to apply to the world about them'²³. The absence of written medical records from the time of the first presocratic philosophers make it hard to quantify the exact relationship between the two²⁴. However, it seems unlikely that the impetus towards a wholly naturalistic medicine came entirely from healers themselves, in the main itinerant craftsmen who most likely passed on their skills through oral instruction from father to son and/or master to apprentice without the aid of written records²⁵. It is true that, unlike his counterpart elsewhere, the ancient Greek doctor was largely free from organised religious influence. Temple healing associated with the cult of Asclepius, once thought of as the wellspring of Hippocratic medicine, appears to have been a separate, contemporary development: archaeological evidence, for example, indicates that the temple of Asclepius on the island of Cos was constructed only *after* the island was 'already famous for its secular healers'²⁶. Nevertheless, and even allowing for Sigerist's suggestion that the Greeks inherited from Crete a world-view in which (compared to that of their Near Eastern contemporaries) gods, ghosts and demons were less likely to take a direct role in human affairs²⁷, the Greek doctor of the 8th to 6th Centuries most probably practised a folk-medicine 'not so different from that of their Egyptian and Babylonian colleagues'²⁸.

The Hippocratic doctor, however, was far closer to the philosopher than the folk healer. As both Longrigg²⁹ and Sigerist³⁰ point out, the texts of the Hippocratic Corpus are written, not in the Dorian dialect spoken in Cos and Cnidus, where they were most likely produced, but in the Ionian dialect that was the language of the cities of Asia Minor (of which Miletus was one) and thus of early Greek philosophy and science. Furthermore, just as the Ionian natural philosophers replaced Homeric descriptions of Poseidon and Zeus causing earthquakes and lightning with accounts in which 'rational causation supplanted supernatural explanation'³¹ so we may compare the account of epilepsy in the Babylonian *Sakikku* with that found in the Hippocratic *The Sacred Disease*. The empirical record of physical symptoms that may be present in a seizure are in each case strikingly similar. In the former text, however, differing symptoms are taken to indicate differing causes such as 'an [unfulfilled] vow made by [the patient's] father', 'hand of ghost' or 'hand of ghost who has died in a mass

killing'³². In the latter, by contrast, the author explicitly states that epilepsy 'is not in the least more divine than any other [disease], but has the same nature... and a similar cause'³³.

As this quotation illustrates, there was still room for the religious to co-exist with the naturalistic: after all, the writer does not argue that epilepsy is *in no way* divine, simply that it is not *more* divine than other illnesses. Especially in the case of plagues and epidemics for which there was neither a readily apparent natural cause nor any form of natural remedy it remained possible to ascribe illness to divine disfavour. The plague that struck Athens between 430-426 'led to some disillusionment with conventional religion' as it seemed to strike the devout as often as anyone else; nevertheless, it also led to the introduction of the cult of Asclepius³⁴. Ancient writers themselves do not seem to have seen religious and naturalistic viewpoints as mutually exclusive: as Longrigg points out, Diodorus was happy to follow Thucydides in viewing the Athenian plague as the result of 'breathing of corrupted air caused by overcrowded conditions' whilst attributing others to punishment for, for example, the sacking of temples³⁵. On the other hand, such a conception does not necessarily rule out naturalistic diagnosis and/or treatment of individuals; moreover, it is consistent with maintaining a separation between medical and religious approaches to illness, with the doctor attempting the former whilst leaving the latter to the priest.

Moral Concerns regarding Practical Competence in Naturalistic Medicine

The insights into the physical world that the Ionian natural philosophers hoped to gain do not seem to have been of interest to them merely as the subject of leisurely reflection, but rather as a source of practical knowledge. Whilst one apocryphal story mentioned by Plato has an unworldly Thales jeered at by a servant-girl for having fallen into a well whilst gazing at the stars³⁶, Herodotus describes him as an ingenious and practical thinker, able to plan and construct a culvert in order to divert the flow of a river and thus reduce it to a suitable level for an army to ford³⁷ and active in the political life of the city³⁸. Similarly, the author of *The Sacred Disease* is not interested in defending a naturalistic account of epilepsy for its own sake. Rather, in striving to understand the illness to be 'not in the least more divine than any other' he raises the possibility that 'it can be *cured* no less than other diseases [my emphasis]'. Equally,

such understanding makes it clear that certain treatments (notably magical remedies such as ‘[charms] buried in the ground, thrown into the sea, or carried off into the mountains where no-one may touch or tread on them’) have next to no chance of working³⁹ (although, as we might expect from the previous section, religious cures were less controversial, especially when conceived of as a last resort ‘when all human skills proved unavailing’⁴⁰).

The naturalistic turn taken by Hippocratic medicine thus had clear moral implications in terms of redefining and expanding the nature of what it meant for a doctor to be competent, something of which the author of *The Sacred Disease*, with his scathing attack on ‘witch-doctors, faith-healers, quacks and charlatans’⁴¹, seems well aware. Removing the supernatural elements from the doctor’s role did not lead to a concomitant reduction in the doctor’s responsibilities in this respect; far from it. Instead, to knowledge of anatomy and pharmacology was added that of dietetics and of the patient’s environment. The author of the treatise *Airs, Waters, Places*, for example, notes that only the doctor who has made a study of climate, situation and water-supply will ‘not be at a loss to treat diseases [in a new environment, nor] make mistakes as he would certainly do had he not thought about these things beforehand’⁴². An expanded body of knowledge, too large to pass on through an oral tradition alone, also requires that discoveries are correctly recorded so that they may be communicated to others, as attested by the surviving volumes of the *Epidemics*. Even concerns regarding the character of the doctor take on a new form, as indicated in the *Canon*, in which the most important elements of the prospective doctor’s nature are described as a ‘natural disposition’ for, and ‘prolonged industry’ in, study⁴³.

The extent to which those who chose *not* to pursue this naturalistic turn can be judged morally culpable for doing so is difficult to establish. Certainly, we may be tempted to agree with the author of *The Sacred Disease* when he castigates those who wilfully exploit superstition for personal gain and to escape responsibility for their actions (‘if the patient be cured, their reputation... is enhanced... if he dies, they can excuse themselves by explaining that the gods are to blame’⁴⁴). On the other hand, it should not be forgotten that the specific details of Hippocratic medicine were often every bit as wrong as an assumption of divine or demoniacal influence (epilepsy is not caused, as the author of *The Sacred Disease* asserted, by the blood-vessels that supply air to

the brain being shut off by the accumulation of phlegm⁴⁵). Also, whilst the belief that all diseases had a natural cause *turned out* to be the correct one, there was no way of knowing ahead of time that this was the case, that the progress it promised was indeed possible, or if a naturalistic turn was in fact the best way to go about it if so. The caution that rendered Egyptian medicine so static for so long is as explicable in terms of an evidently moral concern for the patient as it is of xenophobic prejudice or religious dogmatism (more probably, it was a combination of all three).

Eventually, however, the evidence in favour of Hippocratic medicine must have grown to the extent that refusal to adopt its naturalistic approach becomes difficult to explain in terms of anything other than dishonesty or (more charitably) either foolishness or wilful ignorance. Exactly when this change happened is impossible to say; nevertheless, it does not appear to have gone unnoticed, as the following story from Herodotus attests. Darius, the king of Persia, had dislocated his ankle whilst hunting and the staff of Egyptian doctors he kept on hand due to their ‘reputation for the highest eminence in their profession’ were unable to reduce the injury⁴⁶. However, it came to Darius’ attention that the Greek doctor Democedes (‘the most distinguished physician of his day’⁴⁷) was amongst the slaves of Oroetes, a nobleman he had recently had executed⁴⁸. Darius sent for Democedes, who ‘by using Greek methods and substituting milder remedies for the rough-and-ready treatments of the Egyptian doctors, enabled the king to get some sleep, and very soon cured him completely’⁴⁹. Democedes was appointed Darius’ court doctor, and interceded with the king to spare his Egyptian predecessors, who had been ordered to suffer death by impalement⁵⁰.

Whether Herodotus’ story recounts literal history is not particularly important for our purposes here, although it is known that the Persians, like the Greeks, held Egyptian medicine in high regard: records indicate that Darius provided for the restoration of the House of Life, an Egyptian medical school⁵¹, and his predecessor Cyrus is also reputed to have surrounded himself with Egyptian physicians⁵². Even if Herodotus is repeating or embellishing a folk-tale, however, we may see it as one which records either a contemporary or remembered realisation that Greek medicine at some point began to outstrip its forbears. Certainly, any employment of Egyptian doctors in the Persian court would suggest that the *Videvdad*’s claim that Zoroastrian incantation-priests made for the best healers was known (by some, at least) to be untrue. Their

own cultural influences notwithstanding, it is clear that at some point it became possible for the Persians to judge first Egyptian, then Greek medicine as superior to their own, and where judgement is shown to have become possible, so individuals become culpable for errors in exercising it.

Ethical Reflection in Ancient Greece

As we noted at the end of the previous chapter, such ethical codes and rule-systems as we have encountered so far have been presented as a *fait accompli*. On encountering the *Code of Hammurabi* or the *Videvdad*, one is put in mind of Nietzsche's description of the 'law-book [which] never tells of the utility of law, of the reason for it, of the casuistry which preceded it'⁵³. We have yet to encounter ethics in the sense of reflection, interpretation and debate: in such law-books, morality takes the form of *imperatives* and, prior to the Greeks, we have yet to encounter morality understood as a *problem*. We should, of course, be cautious of counting the absence of evidence for ethical debate in the ancient Near East as evidence of its absence. Indeed, it can be reasonably inferred (ruling out the possibility of divine inspiration or revelation) that such debate (or something like it) occurred in said cultures *at some stage* in order to provide the content of their moralities, laws, religions and so on. Nevertheless, not only are the 'reasons and casuistry' through which (some) Greeks interrogated their morality preserved for us in a form which remains sufficiently complete to render them intelligible, they also appear to have been prized as *contributing* to the force of moral imperatives. This role is quite incompatible with their being hidden or neglected, arguing that (as with the naturalistic turn in medicine) this attitude was a Greek innovation.

Given that knowledge of the physical world, as conceived in the ancient Near East and in Homeric Greece, was bound up with knowledge of the spiritual world and thus with morality we might expect that philosophers should eventually expand their concerns from the physical to the moral sphere. If thunderbolts and earthquakes (and, lest we forget, epidemic disease) are no longer thought of as the arbitrary whim of the gods, but rather as the result of some other process inherent in the world, then it is not too far an imaginative leap to begin to consider whether moral imperatives and prohibitions might not also have a similar origin. To some extent, the two remain

inextricably connected: Anaximander, perhaps metaphorically, gave an account of physical change in terms of a universal moral law ('according to necessity [things] pay penalty and retribution to each other for their injustice'⁵⁴) which seems to at least raise the possibility that there exists a moral law which is binding even on the gods. It is perhaps of interest to compare this insight with the contrasting portrayal of the plagues that afflict the Greek army in Book 1 of the *Iliad* and Thebes in Sophocles' *Oedipus the King*: both are manifestations of Apollo's wrath, but the first is sent to avenge a more-or-less personal slight against him⁵⁵ whilst in the second instance he is acting in accordance with the requirements of a universal moral taboo⁵⁶.

Fragments suggest that other philosophers may also have begun to ground positions regarding human conduct in their physical accounts of the world. Democritus, for example, appears to make reference to atomic theory when noting that a lack of moderation '[gives] rise to large movements within the soul'⁵⁷ although it is possible his meaning is metaphorical⁵⁸. Earlier, Heraclitus had described 'all the laws of men [as] nourished by one law, the divine law'⁵⁹, which as Kirk, Raven, and Schofield have noted, refers not to divine *commands* but rather 'the Logos [understood in this sense as] the formulaic constituent of the cosmos' and thus an understanding of 'the proper relation of men to the world'⁶⁰. That there were known examples of human law-givers (although both Lycurgus in Sparta and Solon in Athens were traditionally accorded reverence consistent with a belief they were divinely inspired⁶¹) and that laws and customs were known to vary between different peoples⁶² may also be seen to have prompted a realisation that, if a universal law did exist, it remained to be discovered.

In Plato's *Euthyphro*, for example, Socrates' interrogation of Euthyphro's conception of piety and his conclusion (that what is holy is what is approved of by all the gods, and that this cannot simply be because it is holy in itself but must be for some other reason, namely that it is just)⁶³ may be seen to place a moral principle above the gods in the same way that the Ionian presocratics placed a physical principle above them. The mention of legal proceedings also brings out another element of Greek culture which fostered the development of moral enquiry, what McKirahan has termed 'the beginnings of the practice of reaching decisions through public debate'⁶⁴, a process which reached an unprecedented level of sophistication in 5th Century Athens⁶⁵. Law

made in an Assembly and justice meted out by a jury are likely to require some form of moral argument; moreover they are likely to bring into focus questions regarding the potential for and/or nature of difference between human and 'divine' or 'natural' laws. Socrates may also be seen to underline the importance of rational enquiry in *upholding* piety through establishing its meaning (Socrates recognises that Euthyphro must be particularly sure that his actions will be approved by the gods since taking his own father to court would, conventionally, also be impious)⁶⁶.

As we noted above, the naturalistic turn in Greek medicine (though scathing of magical remedies) does not seem to have been antagonistic to religious healing. Similarly, any naturalistic turn in physics and ethics should not necessarily be seen to result in philosophers doing away with gods or with religion altogether. In some cases, as with Heraclitus' apparent equivalence of 'divine law' with the 'constituent of the cosmos', the Ionian presocratics tended to apply terminology previously reserved for the Olympian gods to the underlying causes of the natural world: Anaximander, for example, is described by Aristotle as regarding 'the infinite [as] the divine; for it [alone] is immortal and indestructible'⁶⁷. Other philosophers, including Empedocles and the Pythagoreans, remained religious in a way that we (although not the Greeks) may regard as more conventional⁶⁸. Nevertheless, as we shall explore in more detail below, from the 6th through to the 5th Centuries BC we find in Greece a move away from a morality known and willed through divine revelation and command to one established or uncovered through rational enquiry and argument.

As such, the Greeks preserved a record not only of different moral positions but of the arguments used to reach them, and thus provide us for the first time with evidence, not of moral differences between cultures, but of both an *awareness* of these differences and of moral debate within their own. The question of whether this increase in the *quantity* of moral debate in Greece in the 5th Century is also indicative of increase in the moral *quality* (or otherwise) of Greek culture is a rather more vexed one, as is the extent to which the conclusions of this debate could be regarded as applicable in other cultures and at other times. Plato himself, in the city where such debate was more prominent than anywhere else, appears to have doubted whether an increase in moral deliberation *per se* was sufficient to achieve moral understanding or ensure moral conduct: in the *Gorgias*, for example, Socrates takes pains not to be

mistaken for someone who engages in debate ‘not so much to elucidate the subject as to gain a verbal victory’⁶⁹. As McKirahan notes⁷⁰, this concern – that Athenians might become more concerned with (rhetorically) impressive arguments than (morally) correct judgements – is echoed in Aristophanes’ *The Clouds* (in which ‘Wrong’ trumps ‘Right’ in a mock-Sophistic debate⁷¹).

These criticisms however, together with the success of the Sophists in finding gainful employment and their (sincere or otherwise) deployment of provocative philosophical questions in doing so⁷², nevertheless point towards the extraordinary *seriousness* with which moral concerns and debates were taken in Athenian culture in general.

Moreover, this seriousness is displayed throughout the public sphere as a whole: ‘from the theatre, Assembly and law courts to the great festival of Olympia... the general public was exposed to and presumably understood and entered into... debate’⁷³. Sophocles’ *Antigone* for example, as Knox has perceptively argued, is a play which appears first to suggest its audience sympathise with both sides of a moral argument (both Antigone and Creon’s cases are persuasively put) and then deconstructs these arguments and their motivations in a way that resists endorsing either position as definitively stronger than the other⁷⁴. In other words it is a work which is both morally sophisticated (we may contrast the dispute with the more straightforward squabble between Agamemnon and Achilles in Book 1 of the *Iliad*, for example) and morally challenging, not in terms of inviting the audience to come to a judgement on who is right and who is wrong, but in inviting them to consider how such judgements may be made and whether they are possible.

Given the growth in moral debate throughout Greek culture as a whole we should not be surprised to find that this was accompanied by increased moral reflection regarding medicine and related matters. A further consequence is that such reflection is often intelligible to us in a way that is only possible with regards to earlier cultures by employing a certain amount of conjecture. For example, we may consider the case of abortion. As we saw in Chapter 1, this was certainly legally prohibited in Assyria and appears to have been considered morally repugnant, but it is difficult to establish *why*. On the other hand, with regards to (for example) the Pythagoreans, Edelstein argues that there are two reasonably clear grounds for their moral disapproval of the practice⁷⁵. Firstly, their (admittedly speculative) understanding of human physiology

with regards to how the soul was formed in terms of a zygote's physical development led them to believe that this must occur at the moment of conception ('The germ is a clot of brain containing hot vapour within it... when brought to the womb... soul and sense come from the vapour within'⁷⁶). Secondly, their religious beliefs held that the only permissible form of sexual intercourse was that in which the production of offspring was the intended consequence ('[they] forbade entirely intercourse that was unnatural, or resulting from wanton insolence, allowing only the natural and temperate forms, which occur in the course of chaste and recognised procreation of children'⁷⁷). The second part of Edelstein's argument has been echoed more recently by Gaca, whose own translation ('[intercourse] for the *purpose* of... reproduction [my emphasis]') underlines that this is not simply a reference to, for example, autoeroticism or homosexuality⁷⁸.

As a consequence it is possible, in contrast to the Assyrian position, both to *identify* on what grounds the Pythagoreans claimed abortion to be wrong and to *engage* with their argument by examining the premises on which it is based: we could, for example, challenge their views regarding souls, or the gods, or the duties humans owe them. Moreover, we have clear evidence in Greece where we do not in Assyria of both dissenting opinion and dissenting argument. So, for example, Aristotle did not accept Pythagorean views regarding the moment at which the zygote became 'besouled', holding that abortion was morally permissible (for some reasons) 'before the embryo has acquired life and sensation; the presence [of which] will be the mark of division between right and wrong'⁷⁹ (as Carrick notes, Aristotle does not specify exactly when this is supposed to occur, but within 40 days of conception seems likely given his position in the *History of Animals*⁸⁰). Plato, by contrast, mentions the embryonic soul not at all when advocating both abortion and infanticide. Rather, in the *Republic*⁸¹ (and perhaps in the reference to 'measures to check propagation' in the *Laws*⁸²) his arguments concentrate on what Aristotle kept as a defensible reason for the former⁸³: both practices are deemed necessary to keep the state optimally stocked with optimal individuals. Philip V of Macedon, by contrast, 'worried about his country's depopulation', would in later times use this same justification to *outlaw* 'wilful limitation of the family by contraception, abortion or infanticide'⁸⁴.

Again, it is possible that such engagement is not necessarily conducive to moral conduct. If one believes that, for example, abortion is always morally wrong because it is equivalent to murder, then it may be tempting to allow that Assyria, where (at least some) abortions were forbidden was (perhaps inadvertently) morally preferable to Greece and certainly superior to any state run along the lines suggested by Plato or Aristotle in which (at least some) abortions would be mandatory. On the other hand, one might also reflect that, just as the naturalistic turn in Greek medicine allowed for new possibilities to do both good (in terms of, for example, mastering and applying an increased range of knowledge in treatment of the sick and injured) and bad (in terms of being negligent in one's learning of these skills, of refusing to accept them because of some cultural prejudice, and so on) so an increase in moral debate allows for at least an increased *possibility* of moral progress (presumably exemplified, in the example above, in the position of the Pythagoreans) together with an increased *risk* of moral error (in this case, Plato and Aristotle). Furthermore, even if one did not accept this possibility, in the examples above *all* the positions appear to be in some way the consequence of scientific progress and social change; as such, it would seem that some engagement with them was inescapable.

The Relationship between Philosophy and Medicine in Ancient Greece

So far, we have shown that the ancient Greek philosopher could be concerned with medicine in two different respects which may both, in different ways, be seen to develop the moral concerns identified in Chapter 1. Firstly, medicine could be seen as a practical application of natural philosophy in which, as Carrick puts it, the philosopher 'sought... to plumb nature for some lasting insights into her universal laws [and] *to explain* phenomena through these laws' whilst the doctor sought '*to use* the practical consequences'⁸⁵. As a result, natural philosophy called into question the possible effectiveness of some treatments (notably magical remedies such as charms and incantations) and thus began to redefine the nature of medical competence. Secondly, medical practices, which had in earlier cultures been subject to moral judgement, now became the object of moral reflection. From this, we should perhaps expect that it does not seem to have gone unnoticed that this shared 'attitude of mind' with regard to the natural world meant that doctor and philosopher could each draw

conclusions that affected what the other was accustomed to thinking of as their own sphere of expertise.

In some respects this meant that philosophy and medicine were, amongst the Greeks, complementary activities. As Edelstein notes (quoting Burnet's opinion that 'it is impossible... to understand the development of philosophy without keeping the development of medicine constantly in view'⁸⁶) it has been suggested that the impetus towards naturalism in Greek thought was itself provided by medicine. Certainly, Plato appears to have borrowed certain concepts from Hippocratic works: in *Phaedrus*, his Socrates compares the knowledge of the underlying nature of the body that 'the Asclepiad doctor Hippocrates' insisted was essential to medicine with the knowledge of the underlying nature of the soul that is essential to rhetoric⁸⁷. Edelstein inverts this position, claiming instead that 'philosophy influenced medicine rather than being influenced by it' and that the itinerant Greek craftsman who 'knew medicine... was not a 'scientist' applying theoretical knowledge to the case at hand... biological and physiological enquiries were neither presupposed, nor were they actually made'⁸⁸. He also contends that, in so far as those few doctors who 'aspired to overcome the narrow limits of their craft'⁸⁹ were concerned, they either adapted existing philosophical positions⁹⁰ or, where they did 'contradict specific philosophical doctrines and... evolve new theories', did so as philosophers and not as doctors⁹¹.

Regardless of how much influence extended in either direction, Edelstein appears to be correct insofar as the application of theory was not, in general, a major part of widespread medical practice. Aristotle makes a passing reference in Book 3 of the *Politics* to doctors being divided between 'the ordinary practitioner and the master-craftsman'⁹² which Carrick interprets as elevating 'as masters of their craft [those who] could *explain* why their treatments worked' in contrast to those 'who acquired their skills mostly by imitation and rote'⁹³. This interpretation draws on a similar distinction, made by Plato in the *Laws*, between the 'free doctor' whose 'method is to construct an empirical case-history [and] in this way... learns something from the sick'⁹⁴ and the slave, 'innocent of theory'⁹⁵, who 'prescribes what he thinks best... *as if he had* precise knowledge' [my emphasis]⁹⁶. Likewise, it is apparent that those doctors who not only understood theories of nature but attempted to themselves develop these in distinctive and original ways were in doing so considered to be

engaged in philosophical work, at least by other philosophers. As Longrigg has noted, the earliest known Greek medical theories, those of Alcmaeon, were preserved by Theophrastus in his history of philosophy, not by Meno in his history of medicine⁹⁷. On the other hand, it is also clear that at least one of the works Edelstein treats as ‘philosophical’, the Hippocratic treatise *Tradition in Medicine* (or *On Ancient Medicine*) was conceived as a primarily medical text .

We may allow that *Tradition in Medicine* is *also* a philosophical text given that Edelstein is indisputably right that it is *concerned* with philosophical ideas: the author contrasts his own views with those of ‘doctors [whose] discourse... tends to philosophy’ and specifically with the influence of Empedocles ‘and all the others who have ever written about nature’⁹⁸. Equally, in opposing those who ‘have introduced arbitrary postulates into their arguments’⁹⁹ Edelstein is likely correct that the author was himself making use of philosophical scepticism¹⁰⁰. As Longrigg points out, he may be seen to employ in ‘his [own] theory of health a conception which can be traced back to Alcmaeon and ultimately to Anaximander’¹⁰¹. However, unlike Alcmaeon’s work, the inclusion of *Tradition in Medicine* in the Corpus suggests that it was regarded as a medical text in antiquity. More importantly, it is clearly primarily medical insofar as the arguments employed are intended to have relevance to medicine at least as much as they are to philosophy: in suggesting that medicine has grown to a science through empirical trial and error rather than rational deduction from ‘arbitrary postulates’¹⁰² the author’s purpose is not to use medical examples to advance a theory of knowledge *in general*, but rather to argue that this form of acquiring knowledge is proper to medicine *in particular*¹⁰³. Importantly, for our purposes, the author identifies his arguments as containing moral elements: doctors working from ‘arbitrary postulates’ not only deceive both themselves and their patients about the true (empirical) basis for their knowledge with ‘technical gibberish’¹⁰⁴ but do so in a ‘science... which all employ in a matter of the greatest importance’¹⁰⁵.

From this example we can see that, whilst medicine and natural philosophy could be considered a common enterprise in terms of an interest in what Longrigg describes as ‘[rational] modes of explanation... sought to account for the phenomena in an ordered world whose laws were discoverable’¹⁰⁶ this also brought them into competition with

each other. Furthermore, as the emphasis of the philosopher's role progressed from the study of nature to incorporate the study of how man should live his life (that is, from natural to moral philosophy) this competition became more pronounced. Medicine was useful to philosophers as a source of both knowledge about the (physical) nature of man and of analogies about proper human conduct (Aristotle provides us with a characteristic example in noting that '[as] both eating and drinking too much or too little destroy health... [thus] temperance and courage are destroyed by excess and deficiency'¹⁰⁷). Yet it was also antagonistic to philosophy in that, as Carrick has it, 'both sought to suggest right ways to live'¹⁰⁸.

We have noted already that, even in Homeric times, the doctor was accorded the status of an exceptionally skilled craftsman; nevertheless, this still saw him ranked behind 'musicians, mathematicians, poets *and* philosophers' [my emphasis] in terms of social standing¹⁰⁹. Given the emphasis which Greek culture placed on physical health, however, the 'more famous and successful physicians could wield significant power and authority... [when they] spoke, people were inclined to listen'¹¹⁰. Moreover, Greek medicine, with its emphasis on dietetics and 'health... considered [as] a balance of the various constituents of the human body, at every moment upset by man's actions... at every moment to be restored consciously' could through its very methodology and practice quickly become concerned with the totality of an individual life, leading to regimes to be followed 'not only [by] those who were ill, but [by] those who were healthy... in order to remain [so]'¹¹¹. Plato appears to have been well aware of this: in the *Republic*, Socrates describes the supposed inventor of dietetic medicine, Herodicus, as having 'proceeded to make... himself, and then many others after him, miserable by a combination of medicine and physical training... too busy to do anything other but doctor himself and... made wretched by any departure from his routine treatment'¹¹².

All this should be borne in mind when considering the recommendation of Plato's Socrates that, firstly, only emergency medical treatment should be allowed (and then only for those who are ordinarily of sound mind and body) and secondly that no doctor should be allowed to instruct his patient as to what course of action to take, restricting himself only to advising on what the outcome of such courses of action are likely to be¹¹³. It may be tempting to read a certain condescending professional

jealousy into Plato's cautionary note that the skilled doctor who operates scientifically is 'almost like a philosopher [my emphasis]',¹¹⁴ however, his argument that a preoccupation with physical health as an end in itself is both limiting (in that it leaves little time for anything else) and self-defeating (in that it is likely to make one a hypochondriac)¹¹⁵ is both cogent and perceptive. It is, as Edelstein notes, 'an odd way of achieving health and longevity'¹¹⁶; in fact, it does not seem a very 'healthy' existence at all.

Conclusions

From the examples above, we may draw several conclusions about the ways in which the elements of moral thought in medicine we encountered in Chapter 1 were further developed in ancient Greece. First of all, and most likely as the result of certain socio-historical factors not present in the Near East, Greek medicine took what we have described as a 'naturalistic turn' away from magical and/or religious methods towards the rational and/or empirical. This not only carried moral implications in its own right, in terms of expanding and redefining the practical competencies proper to the role of the doctor (which could, as in the case of Persia and Egypt, subsequently apply in cultures where this had not yet happened), it was also the product of an outlook of mind which itself led to an expansion of ethical thought into reflection and reasoned debate, including moral philosophy. The latter was applied to moral concerns in medicine, with the result that we encounter medical ethics for the first time in the sense of intelligible arguments with which we are able to engage.

Furthermore, the continued interaction of medicine and philosophy may be seen to lead to moral questions regarding practical competence being supplemented by similar questions regarding epistemology. Simply put, its having a direct bearing on the progress towards an effective medicine that the naturalistic turn seemed to offer meant that developing a method for obtaining the correct insights, and drawing the correct conclusions from them, itself became in some sense a moral matter. Equally, the possible consequence of this progress raised moral questions as to the proper goals of medicine, the proper authority of the doctor and, perhaps, the need to expand and redefine conceptions of 'health' itself. In addition to these, and perhaps not surprisingly when we consider the seriousness with which moral debate appears to

have been taken, it is in ancient Greece that we also find for the first time literature specifically devoted to the subject of medical ethics in the form of both some of the treatises found in the Hippocratic Corpus, and of the Hippocratic *Oath*. In the subsequent chapter, then, we will move on to consider how our understanding of these texts may be influenced by the general trends we have identified thus far.

¹ Sigerist, H.E. *A History of Medicine (Vol. II)* pp.20-1

² Homer tr. Rieu, E.V. *The Iliad* (Harmondsworth: Penguin, 1950) p.23

³ Homer tr. Rieu, E.V. rev. Rieu, D.C.H. and Jones P. *The Odyssey* (Harmondsworth: Penguin, 1991) p.164

⁴ Longrigg, J. *Greek Rational Medicine* pp.13-14

⁵ Hesiod *Works and Days* in Wender, D. (tr. and ed.) *Hesiod and Theognis* (Harmondsworth: Penguin, 1973) pp.60-2

⁶ Homer *The Iliad* p.24

⁷ Edelstein, L. 'The Distinctive Hellenism of Greek Medicine' in Edelstein, L. tr. Temkin C.L. and ed. Temkin, C.L. and Temkin, O. *Ancient Medicine* p.376

⁸ Homer *The Iliad* p.211

⁹ *Ibid.* p.211

¹⁰ *Ibid.* p.219

¹¹ *Ibid.* p.82

¹² Homer *The Odyssey* p.299

¹³ Pindar *Pythian Ode III* in Pindar tr. and ed. Bowra, C.M. *The Odes of Pindar* (Harmondsworth: Penguin, 1969) p.96

¹⁴ Sigerist, H.E. *A History of Medicine (Vol. II)* p.27

¹⁵ Carrick, P. *Medical Ethics in Antiquity* pp.7-8

¹⁶ Sigerist, H.E. *A History of Medicine (Vol. II)* p.84

¹⁷ Longrigg, J. *Greek Rational Medicine* p.14

¹⁸ Sigerist, H.E. *A History of Medicine (Vol. II)* p.13

¹⁹ Longrigg, J. *Greek Rational Medicine* p.29

²⁰ Sigerist, H.E. *A History of Medicine (Vol. II)* p.89

²¹ *Ibid.* p.91

²² Longrigg, J. *Greek Rational Medicine* p.29

²³ *Ibid.* p.27

²⁴ *Ibid.* p.33

²⁵ Sigerist, H.E. *A History of Medicine (Vol. II)* p.84

²⁶ Longrigg, J. *Greek Rational Medicine* p.22

²⁷ Sigerist, H.E. *A History of Medicine (Vol. II)* p.17

²⁸ *Ibid.* p.87

²⁹ *Ibid.* p.33

³⁰ Sigerist, H.E. *A History of Medicine (Vol. II)* p.88

³¹ Longrigg, J. *Greek Rational Medicine* p.30

³² Wilson, J.V.K. and Reynolds, E.H. 'Translation and analysis of a cuneiform text forming part of a Babylonian treatise on epilepsy' in *Medical History* (34: 185-98) in *ibid.* pp.7-8

³³ [Hippocrates] *The Sacred Disease* in [Hippocrates] tr. Chadwick, J. and Mann, W.N. and ed. Lloyd, G.E.R. *Hippocratic Writings* (Harmondsworth: Penguin, 1978) p.240

³⁴ Longrigg, J. *Greek Rational Medicine* p.18

³⁵ *Ibid.* p.34

³⁶ Plato tr. Kirk, G.S. and Raven, J.E. *Theatetus* in Kirk, G.S., Raven, J.E. and Schofield, M. *The Presocratic Philosophers (2nd Edition)* (Cambridge: Cambridge University Press, 1983) p.80

³⁷ Herodotus tr. de Selincourt, A. rev. Marincola, J.M. *The Histories* (Harmondsworth: Penguin, 1996) p.31

³⁸ *Ibid.* p.67

³⁹ [Hippocrates] *The Sacred Disease* p.240

⁴⁰ Longrigg, J. *Greek Rational Medicine* p.25

⁴¹ [Hippocrates] *The Sacred Disease* p.237

- ⁴² [Hippocrates] *Airs, Waters, Places* in [Hippocrates] tr. Chadwick, J. and Mann, W.N. and ed. Lloyd, G.E.R. *Hippocratic Writings* p.148
- ⁴³ [Hippocrates] *The Canon* in [Hippocrates] tr. Chadwick, J. and Mann, W.N. and ed. Lloyd, G.E.R. *Hippocratic Writings* p.68
- ⁴⁴ [Hippocrates] *The Sacred Disease* p.238
- ⁴⁵ *Ibid.* p.243
- ⁴⁶ Herodotus *The Histories* p.204
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- ⁶² *Ibid.* p.391
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Chapter 3: 'Outward Show', 'Inward Duty' and the Hippocratic *Oath*

Given our discussion in the previous chapter of the growth of moral reflection and debate amongst the Greeks it may seem surprising that the most well-known work of ancient Greek medical ethics contains no explicit evidence of these whatsoever. The Hippocratic *Oath* does not devote itself to the reasons behind the rules it lays down for governing doctors' conduct; moreover, as Edelstein points out, 'most of the statements contained in the document are worded in rather general terms [and contain] concepts which in themselves do not imply any distinct meaning but may be understood in various ways'¹. In addition, what apparently unambiguous guidance it *does* offer (regarding dietetics, use of the knife, and the provision of 'deadly drugs' to anyone and 'abortive remedies' to women) seems quite out of place with prevailing moral and medical opinion in Greece during the period (between the 6th and 3rd Centuries BC²) it was most likely written, which held, for example, that 'aiding a patient in suicide [and] abortion... were basically acceptable... neither religious nor legal sanctions, nor moral disapprobation typically forbade such conduct'³.

Several different explanations have been offered to account for the *Oath's* eventual standing given its departure from mainstream Greek medical practice, attempting in some cases to 'explain away various troublesome and otherwise irreconcilable features of the *Oath*', in others to show it to be wholly 'atypical of Greek medical literature' and the work of a group outside the mainstream⁴. This chapter will consider two of these explanations in particular. The first, Edelstein's, attempts to locate the *Oath* specifically within a (perhaps marginal) reformatory Pythagorean religious-philosophical sect. The second, Carrick's, places the *Oath* less precisely at the centre of a network of related social and ethical concerns surrounding the practice of medicine in Greece at the time it was written (although Carrick agrees that it was at least 'the product of a religiously-minded person with a particular fondness for cult rules and institutions')⁵. Though our argument is generally sympathetic to Carrick's more cautious and inclusive approach (and in some cases goes beyond it) it lies outside the scope of our present enquiry to definitively settle debate on the *Oath's* origins one way or the other. Nevertheless, if the *Oath's conclusions* are 'atypical' of

Greek medicine, it can be shown to be reasonably likely that its *concerns* are anything but.

The Hippocratic Oath: Text and Structure

Edelstein divides the *Oath* into two parts, with the first (P1-2) '[specifying] the duties of the pupil towards his teacher and his teacher's family and... obligations in transmitting medical knowledge' and the second (P3-8) 'rules to be observed in... treatment... medical ethics as it were'⁶. Carrick, following this lead, divides it into four: 'the *preamble* (P1)... the *covenant* (P2)... the *ethical code* (P3-P7)... and the *peroration* (P8)'⁷, although P1 and P8, concerning the invocation of the appropriate gods and goddesses to witness the oath and the appropriate rewards and punishments for the observance or breaking thereof, need not concern us here. The full text is as follows:

The Hippocratic Oath

P1 I swear by Apollo Physician and Asclepius and Hygieia and Panacea and all the gods and goddesses, making them my witnesses, that I will fulfil according to my ability and judgment this oath and this covenant.

P2 To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art – if they desire to learn it – without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him that has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else.

P3 I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

P4 I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

P5 I will not use the knife, not even on sufferers from stone, but will withdraw in favour of such men as are engaged in this work.

P6 Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

P7 Whatever I hear in the course of my treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things to be shameful to be spoken about.

P8 If I fulfil this oath and do not violate it, may it be granted to me to enjoy life and art, being honoured with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.⁸

Though Edelstein is most likely correct that the first half of the *Oath* is not '[merely] superficially connected' to the whole⁹, he is also (as we shall see) most likely correct that this connection is best revealed by considering first the possible origins of the second. Initially, then, our enquiry will focus on the third of Carrick's sections (P3-7). For the sake of clarity, we will divide this into three further categories: the rules concerning *drugs* (P4), or more specifically the giving of 'deadly drugs and abortive remedies' (literally, 'poisonous pessaries'¹⁰) to those who request them; the rules concerning *practice* (P3 and P5), that is, those concerning the methods it is considered appropriate or permissible for the doctor to employ in the course of treatment; and the rules concerning *conduct* (P6 and P7), particularly with regards to secrecy and sexual probity.

The Rules Concerning Drugs

Edelstein's case for the Pythagorean origins of the *Oath* rest largely on his interpretation of the rules contained in P4 and in particular on three conclusions that he draws regarding them. First of all, that they can only represent straightforward prohibitions of two traditionally controversial acts, physician-assisted suicide¹¹ and abortion¹², and are of a religious nature ('[in] purity and holiness I will guard my life and my art') admitting no exceptions¹³. Secondly, that in ancient Greece (and for several centuries after in the wider Mediterranean) these acts not only fell within the scope of the doctor's role but were regarded as a normal and morally uncontroversial part of his practice: '[suicide] was not censured in antiquity... [and abortion] in Greek times no less than in the Roman era... was resorted to without scruple'¹⁴. Finally, he argues that in the period in which the *Oath* was written it is in Pythagorean thought alone that we can find a 'philosophical dogma that can possibly account for [these attitudes]'¹⁵. With regards to all three of these arguments, however, his interpretation is open to objection.

It is true that Pythagorean thought not only condemned abortion (as noted in Chapter 2) but also viewed suicide as an unacceptable transgression of divine law (as Plato has it in the *Phaedo*: 'mystics... say that we men are put in a sort of lock-up, from which one must not release oneself or run away'¹⁶). However, we may agree with Carrick that the fact that 'the Greeks... were generally sympathetic provided that the deed was done *for the right sorts of reasons*'¹⁷ also indicates neither suicide nor abortion carried *unqualified* acceptance. In the *Laws*, for example, Plato outlines legal penalties to apply to any suicide whose act is not motivated by either 'any legal decision of his state', 'the pressure of some excruciating and unavoidable misfortune' or 'some irredeemable disgrace that he cannot live with'¹⁸. Remembering Plato's views on how far it is proper for a doctor to instruct his patient as discussed in Chapter 2 we may also question whether he would view this as a proper thing for a doctor to 'suggest'. In cases of abortion, too, it hardly fair to say that the Greeks acted 'without scruple' no matter how common abortion and infanticide may have been (we may think of the shepherd in Sophocles' *Oedipus the King* who finds himself unable to fatally expose the infant Oedipus¹⁹). Furthermore, Sigerist suggests that, in Athens and Sparta at least, abortion was illegal without the consent of the father²⁰.

As to whether this part of the *Oath* is intended to impose to a blanket ban on *all* cases of physician-assisted suicide and on *all* abortions, its phrasing, as we found to be the case in Chapter 1 with regards to the Assyrian prohibition of abortion, does not seem to unambiguously rule out all instances of either practice. The *Oath* does not make explicit the context of the purpose for which ‘deadly drugs’ are sought, and the doctor is forbidden only to ‘give’ them to an individual; furthermore, he is only specifically forbidden from ‘giving’ abortive remedies to women. In each instance ‘give’ can be read in one of two senses. Edelstein’s case is strengthened if we read it (as he seems to think we should²¹) as ‘administer’. However, it is clear the ambiguity is also present in the Greek: Chadwick and Mann render the second part of the prohibition ‘[neither] will I give a woman *the means to procure an abortion* [my emphasis]’²² which would once more allow for the doctor to perform medical abortions or for abortions to be carried out at the behest of, or in conjunction with, a woman’s family.

As the second translation suggests, even if ‘give’ is intended to mean ‘administer’ in the first part of the prohibition it would not necessarily follow that it is in the second. Edelstein is insistent that it is used in the same sense in both parts, which he argues strengthens his case that it refers in both cases to drugs the doctor prescribes rather than those he merely dispenses²³. However, even if we were to accept this, it can in fact be used in just the opposite way, to argue for a conclusion that he emphatically rejects: if a doctor will not ‘give a deadly drug to anybody if asked’ in the same sense that he will not help a woman ‘procure an abortion’ then the first part may refer (as Carrick suggests) not to physician-assisted suicide but to the doctor’s possible ‘involvement in any murder plot as the supplier of effective poisons’²⁴. Edelstein presents two objections to this suggestion, the first being that to insert such a clause into a medical *Oath* would prove ‘a useless duplication of the existing laws’²⁵ and the second that ‘[there] is no evidence... that the *Oath* refers to anybody except patient and physician’ (clearly, ‘the patient himself certainly would not ask the doctor for the poison with which he is to be murdered’)²⁶.

To deal with these objections in reverse order, whilst it is clear that the *Oath*’s ethical code deals with conduct towards the *layman* (as opposed to the covenant, which concerns conduct towards other doctors) it is far from clear that it refers only to *patients*: P7, in particular, makes reference to things heard ‘outside of the treatment’.

Indeed, P4 may itself make reference to someone other than the patient (women seeking to procure abortions); since it is the meaning of this part of the *Oath* that is under discussion Edelstein can hardly cite this as supporting evidence. In terms of ‘useless duplication’, we may suggest this would *also* be the case were a Pythagorean to swear an oath to refrain from practices he already found to be morally objectionable to the highest degree. Moreover, as Carrick points out, there *did* exist a widespread prejudice amongst the Greeks that ‘the physician who is skilful at curing was, in virtue of this knowledge, also peculiarly well suited to kill’²⁷: in Book 1 of the *Republic* for example, the correct answer to Socrates’ question ‘who then is best able to benefit his friends and *harm his enemies* in matters of health? [my emphasis]’ is ‘a doctor’²⁸. Furthermore, in the *Laws* Plato does in fact suggest that the criminal sanction regarding poisoning (even in non-fatal cases) be supplemented in the case of the doctor: unlike the layman, the doctor, if found guilty of such an offence, ‘*must be punished by death* [my emphasis]’ since, unlike the layman, he does not ‘act in ignorance of the effect he will have on the body’²⁹.

This need to address popular prejudices also argues for an interpretation of the second part of the prohibition as referring to supplying women with the means to procure an abortion. For just as doctors may fall under suspicion of acting as the purveyors of murderous poisons, so midwives (who, as both Carrick³⁰ and Sigerist³¹ note, were in the ancient world the primary care-giver during pregnancy and childbirth) could (and we may note that is the word used in the *Oath* itself to link the prohibitions together) similarly find themselves suspected of selling abortive remedies (in the words of Soranus) ‘wickedly [that is, in cases of the sort described above] for payment’³². Moreover, it is lent further plausibility by the particular position occupied by the doctor in Greek society. As we noted in Chapter 2, the doctor was generally regarded as a craftsman and his craft as an entirely secular, naturalistic one. This meant, however, that unlike his predecessors and contemporaries in the Near East he was neither licensed nor endorsed by a religious tradition. Equally, the Greek doctor was free from state regulation in the manner of his Egyptian counterpart: as Carrick puts it ‘[anyone] could practice medicine, and many who did were quacks and charlatans’³³.

Whatever dividends this may have paid in terms of allowing the Greek doctor latitude in developing experimental treatments, it also meant that his reputation was of

extraordinary importance, not least in terms of securing a living, something reflected in several works of the Corpus: *Prognosis*, for example, notes that the doctor who '[increases] his reputation as a medical practitioner [will find] people will have no qualms about putting themselves in his care'³⁴. It may be that this seems too mercenary a motive for a solemn oath undertaken in 'purity and holiness', in which case we may also remember that it is likely any doctor who swore the *Oath* would be at least as disapproving of these practices as society in general. Indeed, it is highly likely that he would be *more* disapproving, since it was his own conduct that the behaviour of quacks, charlatans and poison-peddlers called into question. In the Corpus, we may note that the author of the *Canon* blames 'ignorant professors' of medicine as much as its 'rash critics' as the cause of medicine's poor reputation, something he clearly intends to work towards repairing (he also uses 'holiness' to refer to the importance of bestowing medical knowledge only on those properly suited to it³⁵). Beyond this, it is also possible that reputation might have been of further importance to the ancient Greek doctor for other reasons; something we shall consider in more detail below.

The Rules Concerning Practice

The *Oath* contains both two rules explicitly governing the methods by which those swearing it may practice medicine. The first is positive: the doctor is sworn to use 'dietetic measures' to treat his patients. The second is negative: the doctor is to abstain from 'use of the knife' (that is, from surgical measures) under all circumstances, although he may refer his patients to other doctors not similarly sworn. Historically, it is the second of these rules which has drawn the most attention for, as with physician-assisted suicide and abortion, surgery with the knife (as opposed to cautery) was not an uncommon practice in ancient Greece. From the Renaissance onwards, it was supposed that the *Oath* was intended to 'draw a line between the practice of internal medicine and that of surgery'³⁶; however, as both Carrick³⁷ and Edelstein³⁸ attest, the ancient Greek doctor is now commonly accepted to have typically acted as both physician and surgeon. The Corpus contains several works dealing with surgery, and these 'are generally regarded to be the most medically precise and useful parts of the Collection'³⁹. If surgery were widely proscribed it is difficult to see how this could be the case: one cannot become expert in such a

complex and dangerous area of medicine without engaging in a fair degree of practical experience.

Thus, those wishing to reconcile the *Oath* with mainstream Greek medical practice have sought to find a way of interpreting the prohibition so as to exclude the majority of surgical procedures where the knife was very much involved. Some early 20th Century attempts to effect such a reconciliation contended that ‘the knife’ in this sense is in fact an oblique reference not to surgery in general but to either intentional castration⁴⁰ or to lithotomies (hence ‘sufferers from stone’) in which castration was a possible unintentional side-effect, an outcome which, it is argued, doctors felt to be morally repugnant⁴¹. There are two main problems with this view. First of all, lithotomies seem to have been a common and by most accounts fairly successful form of surgical procedure at the time⁴². Furthermore, if doctors were morally repulsed by such use of the knife it is difficult to explain why they would ‘withdraw in favour of such men as are engaged in this work’. Nittis attempted to avoid this issue by translating the passage to read ‘*keep apart* from such men...’ but this is dependant on reading the original Greek in a speculative and unusual sense⁴³ evidence for which is lacking elsewhere⁴⁴.

Edelstein, by contrast, is free to hold to a more usual interpretation since he makes no such claim for the *Oath*’s adherence to values and practices common in mainstream Greek medicine. Rather, he links the prohibition of surgery to the positive rule to treat the sick with dietetic measures and argues that both are characteristic of Pythagorean approaches to medicine⁴⁵. For example, he notes that Plato does not mention surgery (or cautery) at all when giving an outline of medicine in the *Timaeus*⁴⁶, and that Aristoxenus attests that the Pythagoreans ranked dietetic methods ahead of pharmacology and surgery (in that order) as a result of their account of the causation of disease, which interpreted most illness as the result of immoderate living⁴⁷. Furthermore, Edelstein allows that this is consistent with ‘withdrawing in favour’ of another as ‘the Pythagoreans recognised that men in general could not observe any elaborate rules of purity’ and would thus have no objection to patients seeking out another doctor for such purposes⁴⁸. Edelstein concedes that none of the above explains why Pythagoreans should refrain from surgery *entirely*, but defends his ‘conjecture’ that the prohibition developed from an abhorrence of blood sacrifice by

arguing that it is ‘*only* in connection with Pythagorean medicine that the injunction acquires any meaning and plausibility *at all*’ [my emphasis]⁴⁹.

As Carrick points out, however, this last claim is highly questionable⁵⁰. For one, the Pythagoreans were hardly unique amongst the Greeks in viewing dietetic remedies as the principal treatment to be employed by the doctor. Plato, for example, presupposes that the work of the doctor is primarily of this nature in the passages from the *Republic* dealing with medicine referred to in Chapter 2 and the author of *Tradition in Medicine* deals exclusively with dietetics when describing medical practice⁵¹. *Tradition in Medicine* also espouses a causal theory of disease which would suggest dietetics as the most promising method of treatment: ‘[each] one of the substances of a man’s diet acts upon his body and changes it in some way and upon these changes his whole life depends’⁵². Similar views are also found elsewhere in the Corpus, for example in the Book 3 of the *Epidemics* in which a young man’s fever is identified as the result of ‘sexual indulgence and drinking’⁵³. Moreover, as Carrick points out, the *Aphorisms* suggest that surgery was ‘not resorted to as a treatment of first choice’⁵⁴: ‘[what] drugs will not cure, the knife will; what the knife will not cure, the cautery will; what the cautery will not cure must be considered incurable’⁵⁵.

Plato’s views in the *Republic* notwithstanding, it is clear that Greek thought in general regarded surgery as the least preferable form of treatment available, something of which Edelstein is well aware (‘in antiquity popular opposition to ‘cutting and cauterisation’ was strong indeed’⁵⁶). Indeed, as Carrick goes on to argue, surgery (as the most dramatic, dangerous and painful recourse open to the ancient doctor) was widely feared and mistrusted and ‘it is possible that the [Oath’s] prohibition represents a reaction on the part of *some non-Pythagorean* physicians against [this] [my emphasis]’⁵⁷. Once more, we should not forget the extraordinary sway that reputation, and hence wider opinion, held over the doctor in the unregulated world of ancient Greek medicine. Carrick is right to commend Edelstein for the comprehensive nature of his account⁵⁸; unlike Nittis’ arguments regarding surgery, for example, it can offer a clear explanation of why dietetic measures are endorsed. However, an account based on the need to uphold the reputation of the doctor in the face of popular prejudice appears plausible: the doctor who swears the *Oath* will employ in the first instance what seems to have been generally regarded as the most appropriate and

effective form of medicine; he will use his knowledge to benefit the sick, not to enrich himself by selling poisons and abortive remedies; and he is not, as Heraclitus put it, amongst those ‘physicians who cut and burn [and then] demand pay, but deserve nothing, since they do these things’⁵⁹.

The Rules Concerning Conduct

The rules concerning conduct, prohibiting ‘mischief’ and sexual congress with patients or members of their household, and committing the doctor to secrecy about what ‘no-one must spread abroad’ (and not only, as we noted above, about such things that are learnt of during the execution of his duties) are obviously the least controversial of the *Oath*’s strictures. Unlike the rules concerning drugs and practice, they are not contradicted by any part of the Hippocratic Corpus or what is known of doctors’ general conduct at the time; indeed, it is difficult to imagine how they *could* be: the idea that anyone recommend a doctor pursue a career filled with mischief-making, sexual impropriety and indiscretion seems frankly absurd. Equally, however, they do not seem to concern such weighty matters as the rules that come before them: Carrick is happy to term them ‘medical etiquette’⁶⁰ and, indeed, they do seem to fit more naturally into what Jonsen terms ‘bedside manners’ than into the ‘more grave’ morality he sees as typified by the *Oath* as a whole⁶¹.

Given these circumstances, we may wish to ask how such concerns could move from the former sense to the latter and become the matter of such a solemn undertaking as the swearing of an oath. Further, we may also ask (much like Edelstein does when questioning the prohibition against the giving of a deadly drug in the light of pre-existing laws) why the *Oath* would formally prescribe what seems to be obvious common-sense on the part of the doctor. Edelstein, of course, has a ready-made answer to this: the *Oath* includes these elements alongside its other rules because, for the Pythagoreans, such matters *were* regarded as part of a ‘more grave’ morality. We mentioned in Chapter 2 his contention that sexual intercourse was viewed by them as permissible only the context of procreation. To this, he adds a preoccupation with justice as a primary virtue present in all social relations beyond mere adherence to social, political or legal norms, explaining its presence alongside chastity at this point⁶². With regards to the entreaty to silence, he notes that this too was of

importance to the Pythagoreans more so than to other groups⁶³ (Porphyrius' *Life of Pythagoras*, for example, notes that 'silence with them was of no ordinary kind')⁶⁴.

Yet this is not the only plausible explanation for how these rules may have gained the moral weight that seems required for their presence in as solemn a document as the *Oath*. As both Edelstein and Carrick are aware, similar pronouncements can be found elsewhere in the Corpus: the treatise known as *The Physician*, for example, contains a similar injunction against the sexual exploitation of those (notably women and maidens) who the doctor is likely to encounter in the execution of his duties⁶⁵ whilst in the *Decorum*, the ideal doctor is praised for his 'reserve'⁶⁶. Of course, as Edelstein argues, it may be that their presence is accounted for by such rules being both 'self-evident' and 'compatible with any ethical standard to which a doctor may subscribe'⁶⁷. This does not necessarily mean that they hold the same moral force as the rules found in the *Oath*: indeed, he concludes that they do not⁶⁸. Carrick concurs with this judgement, arguing that where the *Oath* is concerned with an 'inward duty' in regard to the doctor's conduct (the Greek *ethika*), the treatises in the Corpus appear instead to be concerned with the 'outward show' of right conduct (the Greek *euchemosyne*) which bears little regards to the doctors' actual motives, character or intentions⁶⁹.

An account of the *Oath* which attempts to explain the entirety of the ethical code in terms of the doctor's reputation may be seen to be attempting the reverse of the task that Edelstein sets himself. His account seeks to find elsewhere in Greek thought an account of chastity, justice and reticence as inward duties to match the more obviously 'grave' concerns he identifies elsewhere, and finds what he is looking for in Pythagoreanism. In contrast, an emphasis on the importance to the Greek doctor of his reputation may seem to argue that we should interpret these 'grave' concerns simply as an expedient 'outward show' of conduct liable to enrich the itinerant craftsman who professes them. This would, however, be a mistake, for it discounts the possibility, quite evident in the works of the Hippocratic Corpus, that an adherence to the 'outward show' of etiquette can be *demand*ed by the 'inward duty' of ethics.

First of all, as Carrick notes, the Greeks were aware to some degree at least of the placebo effect, in that a patient's recovery was often greatly helped by his trust in the

doctor; similarly, a good reputation would encourage the patient to confide the truth to his doctor on medical matters, to hold nothing back and be prepared to follow his instructions⁷⁰. Secondly, there is the question of the reputation not only of the individual, but of medicine *as a whole*, a question that recurs throughout the *Corpus* (for example in *The Science of Medicine*⁷¹) and is clearly of importance in ensuring that patients come to Hippocratic doctors for advice rather than consulting ‘witch-doctors, faith-healers, quacks and charlatans’. The author of the *Canon*, for example, does not appear to bemoan the poor reputation of medicine simply because it is preventing him making a decent living. Rather, he shows evident concern for what he considers both ‘holy’ and ‘the most noble of all the arts’ (we may note that this kind of language, also echoed in the closing remarks of the *Decorum*⁷² is, contrary to Edelstein and Carrick’s contentions, redolent of the solemn language of the *Oath*). Arguing that this is the result of medicine being ‘the only science for which states have laid down no penalties for malpractice’, the *Canon*’s author appears to be putting the case for self-regulation⁷³ (given which we may also consider how such concerns are addressed in the *Oath*’s covenant, and in the doctor’s promise to ‘guard my life and my art [my emphasis]’).

Conclusions

In assessing what particular developments (if any) are displayed in such treatises on medical ethics as the Greeks produced, we may return for a moment to consider Jonsen’s tripartite division of the discipline in *The Birth of Bioethics* which (we may recall from the introduction to this thesis) is as follows. Firstly arise questions as to the doctor’s behaviour when attending upon his patient, or ‘bedside manners’ as Jonsen puts it. Second are the matters of ‘more grave morality’ of which the *Oath* (even allowing for its disputed and controversial status within the ancient world, as Jonsen does⁷⁴) is held up as the ‘paradigm’ example. Finally, there are the ‘social ethics’ Jonsen contends emerged in the Middle Ages, when doctors were called upon to justify their social standing, the legal recognition of their monopoly over healing (and consequently their control of the licensure of new doctors) and their right to charge a fee for their services (not to mention, of course, how large or small said fee should be). To begin with, we may now pause to question in the light of our own interpretation the status given by Jonsen to the *Oath*.

First of all, the *Oath* may be considered ‘paradigmatic’ in at least one, weak sense of the word in that subsequent codes and declarations have consciously or otherwise aped its form, language and (to a degree) its content. We may instructively compare the *Oath*’s second clause (‘[to] hold him who has taught me this art as equal to my parents and to live my life in partnership with him’) with its counterpart in the Declaration of Geneva (‘I will give my teachers the respect and gratitude which is their due’). Similarly, we may note that the latter also shares with the *Oath* a solemn injunction against breaking a patient’s confidence which is limited neither to medical matters nor only to things disclosed during the course of treatment⁷⁵. As we have noted above, however, the second of these clauses can easily be conflated with concerns of the type Jonsen groups under ‘bedside manners’, whilst the former seems to be more a matter of professional regulation and thus part of the ‘social ethics’ to which Jonsen contends ‘scant attention’ was paid in the ancient world⁷⁶.

Yet we may reclaim for the *Oath* the standing Jonsen accords it, not by examining its form, its content or indeed its standing in Greek society but instead by considering the degree of emphasis it places on the moral content of the doctor’s entire behaviour and methodology. For the *Oath* does not only instruct those doctors who swear it to uphold a particular religious and/or philosophical cult morality (which is not to say it does not do that *as well*). It can also be seen, when read against the context of wider Greek culture, as a first tentative step towards formally recognising the ‘more grave’ moral aspects of both ‘bedside manners’ and ‘social ethics’ or, to coin a phrase, to recognise that medicine is *morally saturated*. On this reading, the ethical code of the *Oath* and its analogues elsewhere in the Corpus (for example in the *Decorum*) represent moral concerns in medicine coming full circle: once again, conduct is recognised as a therapeutic tool available to the doctor *along with* dietetics, pharmacology and surgery, albeit for very different reasons than was the case in the Near East as described in Chapter 1. Moreover, in the covenant and *its* analogues (for example the *Canon*) we can discern a growing recognition that these concerns extend not only to the conduct, epistemology and practical competence of the *individual* doctor, but also to the nature and organisation of medicine as a discipline.

¹ Edelstein, L. ‘The Hippocratic Oath: Text, Translation and Interpretation’ p.8

² Carrick, P. *Medical Ethics in Antiquity* p.87

³ *Ibid* p.70

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- ⁴ Ibid. pp.70-1
- ⁵ Ibid. p.87
- ⁶ Edelstein, L. 'The Hippocratic Oath: Text, Translation and Interpretation' p.7
- ⁷ Carrick, P. *Medical Ethics in Antiquity* p.70
- ⁸ [Hippocrates] *The Hippocratic Oath* tr. Edelstein, L. rev. Carrick, P. in *ibid.* pp. 69-70 (please note there have been minor amendments in the form of converting spellings from US to UK English)
- ⁹ Edelstein, L. 'The Hippocratic Oath: Text, Translation and Interpretation' p.7
- ¹⁰ Carrick, P. *Medical Ethics in Antiquity* p.84
- ¹¹ Edelstein, L. 'The Hippocratic Oath: Text, Translation and Interpretation' p.10
- ¹² Ibid. p.14
- ¹³ Ibid. p.15
- ¹⁴ Ibid. p.13
- ¹⁵ Ibid. p.17
- ¹⁶ Plato *Phaedo* in Plato tr. Tredennick, H. and Tarrant, H. and ed. Tarrant, H. *The Last Days of Socrates* (Harmondsworth: Penguin, 1993) p.114
- ¹⁷ Carrick, P. *Medical Ethics in Antiquity* p.129
- ¹⁸ Plato *The Laws* p.391
- ¹⁹ Sophocles *Oedipus the King* in Sophocles tr. Fagles, R. and ed. Knox, B.A. *The Three Theban Plays* p.232
- ²⁰ Sigerist, H.E. *A History of Medicine (Vol. II)* p.230
- ²¹ Edelstein, L. 'The Hippocratic Oath: Text, Translation and Interpretation' p.9
- ²² [Hippocrates] *The Oath* in [Hippocrates] tr. Chadwick, J. and Mann, W.N. in ed. Lloyd, G.E.R. *Hippocratic Writings* p.67
- ²³ Edelstein, L. 'The Hippocratic Oath: Text, Translation and Interpretation' p.9 n.8
- ²⁴ Carrick, P. *Medical Ethics in Antiquity* p.82
- ²⁵ Edelstein, L. 'The Hippocratic Oath: Text, Translation and Interpretation' p.10 n.11
- ²⁶ Ibid. p.10
- ²⁷ Carrick, P. *Medical Ethics in Antiquity* p.83
- ²⁸ Plato *The Republic* p.68
- ²⁹ Plato *The Laws* p.480
- ³⁰ Carrick, P. *Medical Ethics in Antiquity* p.109
- ³¹ Sigerist, H.E. *A History of Medicine (Vol. II)* p.232
- ³² Soranus *Gynaecology* tr. Temkin, O. (Baltimore: Johns Hopkins University Press, 1956) p.xl in Carrick, P. *Medical Ethics in Antiquity* p.109
- ³³ Ibid. p.84
- ³⁴ [Hippocrates] *Prognosis* in [Hippocrates] tr. Chadwick, J. and Mann, W.N. and ed. Lloyd, G.E.R. *Hippocratic Writings* p.170
- ³⁵ [Hippocrates] *The Canon* pp.68-9
- ³⁶ Edelstein, L. 'The Hippocratic Oath: Text, Translation and Interpretation' p.26
- ³⁷ Carrick, P. *Medical Ethics in Antiquity* p.71
- ³⁸ Edelstein, L. 'The Hippocratic Oath: Text, Translation and Interpretation' p.27
- ³⁹ Ibid. p.70
- ⁴⁰ Edelstein, L. 'The Hippocratic Oath: Text, Translation and Interpretation' p.27
- ⁴¹ Carrick, P. *Medical Ethics in Antiquity* p.73
- ⁴² Ibid. p.73
- ⁴³ Ibid. p.74 n.11
- ⁴⁴ Edelstein, L. 'The Hippocratic Oath: Text, Translation and Interpretation' p.27 n.80
- ⁴⁵ Ibid. pp.30-1
- ⁴⁶ Plato *Timaeus* in Plato tr. and ed. Lee, D. *Timaeus and Critias* (Harmondsworth: Penguin, 1971) pp.109-15
- ⁴⁷ Edelstein, L. 'The Hippocratic Oath: Text, Translation and Interpretation' pp.21-2 n.54
- ⁴⁸ Ibid. p.32
- ⁴⁹ Ibid. pp.32-3
- ⁵⁰ Carrick, P. *Medical Ethics in Antiquity* p.75
- ⁵¹ [Hippocrates] *Tradition in Medicine* pp.73-7
- ⁵² Ibid. p.78
- ⁵³ [Hippocrates] *Epidemics, Book III* in [Hippocrates] tr. Chadwick, J. and Mann, W.N. and ed. Lloyd, G.E.R. *Hippocratic Writings* p.134
- ⁵⁴ Carrick, P. *Medical Ethics in Antiquity* p.76

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- ⁵⁵ [Hippocrates] *Aphorisms* in [Hippocrates] tr. Chadwick, J. and Mann, W.N. and ed. Lloyd, G.E.R. *Hippocratic Writings* p.236
- ⁵⁶ Edelstein, L. 'The Hippocratic Oath: Text, Translation and Interpretation' p.31 n.96
- ⁵⁷ Carrick, P. *Medical Ethics in Antiquity* p.76
- ⁵⁸ Ibid. p.74
- ⁵⁹ Heraclitus fr.58 tr. McKirahan, R.D. in McKirahan, R.D. *Philosophy Before Socrates* p.122 n.17
- ⁶⁰ Carrick, P. *Medical Ethics in Antiquity* p.88
- ⁶¹ Jonsen, A.R. *The Birth of Bioethics* p.6
- ⁶² Edelstein, L. 'The Hippocratic Oath: Text, Translation and Interpretation' pp.36-7
- ⁶³ Ibid. p.38
- ⁶⁴ Porphyrius *Life of Pythagoras* tr. Kirk, G.S. and Raven, J.E. in Kirk, G.S., Raven, J.E. and Schofield, M. *The Presocratic Philosophers (2nd Edition)* p.238
- ⁶⁵ [Hippocrates] *The Physician* in [Hippocrates] tr. Jones, W.H.S. and ed. Jones R.H.S. *Hippocrates (Vol. II)* (London: William Heinemann, 1923) p.313
- ⁶⁶ [Hippocrates] *Decorum* in *ibid.* p.287
- ⁶⁷ Edelstein, L. 'The Hippocratic Oath: Text, Translation and Interpretation' p.33
- ⁶⁸ Ibid. p.37
- ⁶⁹ Carrick, P. *Medical Ethics in Antiquity* p.89
- ⁷⁰ Ibid. p.92
- ⁷¹ [Hippocrates] *The Science of Medicine* in [Hippocrates] tr. Chadwick, J. and Mann, W.N. and ed. Lloyd, G.E.R. *Hippocratic Writings* p.139
- ⁷² [Hippocrates] *Decorum* p.301
- ⁷³ [Hippocrates] *The Canon* pp.68-9
- ⁷⁴ Jonsen, A.R. *The Birth of Bioethics* p.6
- ⁷⁵ World Medical Association *Declaration of Geneva (Amended 1983)* in Carrick, P. *Medical Ethics in Antiquity* p.193
- ⁷⁶ Jonsen, A.R. *The Birth of Bioethics* p.7

Chapter 4: Moral Concerns in Medicine from Galen to Percival

The reader of many histories of medical ethics could be forgiven for assuming that the Middle Ages, Renaissance and Enlightenment were periods of little importance in human affairs. For Jonsen the Medieval period is notable mainly as a time during which medicine once more came under religious authority, with the obscure prohibitions of the *Oath* specified and made explicit through its adoption by the Christian religious tradition¹. Similarly, Grodin highlights the importance of Christian, Jewish and Islamic traditions in which the goal of the ‘ideal physician... was to serve the sick under God’². Histories of medicine as a whole tend to regard the Middle Ages as moribund: ‘the Church arrested medical progress, for instance, by supposedly banning dissection’³ whilst learned doctors were preoccupied with ‘abstract disputation topics’⁴ and ‘hindered by the quibbles of scholasticism’⁵. Whilst such histories may devote more space to the Renaissance and Enlightenment, histories of medical ethics, on the whole, do not: Grodin ignores them entirely⁶ whilst Jonsen covers the several hundred years from the first establishment of medicine in ‘universities, guilds and colleges’ to 1803 (and the publication of Percival’s *Medical Ethics*) in three and half sentences⁷.

Nor would it seem, at first glance, that philosophers throughout these periods took very much interest in medicine, and certainly not from an ethical point of view. In this respect, a browse through the index of one representative work on the history of medicine (Porter’s *The Greatest Benefit to Mankind*) paints an interesting picture. For the five chapters covering the Middle Ages, Renaissance and Enlightenment (191 pages) ‘ethics’ is referenced once⁸ and ‘philosophy’ six times⁹. By contrast, ‘philosophy’ is referenced nine times in the chapter concerning antiquity (38 pages)¹⁰ and ‘ethics’ ten times over the two chapters covering medicine in the late 20th and early 21st Centuries (41 pages)¹¹. A similar picture exists with regard to the interest of philosophers in specific ethical problems. To take abortion as an example, in contrast to some of the positions we have examined in Chapters 2 and 3, moral philosophers from the Renaissance onwards seem, as Jonsen notes, to have paid little attention to the issue, regarding it instead as a theological or legal matter¹²: ‘detailed analysis of

problems [were] rare and the elaborate reasoning of moral philosophy almost nonexistent'¹³.

This apparent gap may be seen to be of interest for two reasons. First of all, there is the puzzle of why it should be there at all: as we have seen, moral thought in medicine had deepened and broadened throughout antiquity, and medicine was itself of great interest to philosophers. Why then should this (apparently) cease for several centuries to be the case? Secondly, there is the matter of Percival's *Medical Ethics* itself. For Grodin, this 'first modern code of medical ethics' ushered in a new era (exemplified by works such as the American Medical Association's *Code of Medical Ethics*, published in 1848) that lasted nearly a century and a half until the dawn of modern bioethics in the mid-20th Century¹⁴. However, as we have attempted to demonstrate in the previous three chapters, the moral concerns faced by Hippocratic medicine (and the manner in which it attempted to deal with them) were shaped by social and historical factors: again, it seems at least possible that that our understanding of this 'new era' of 'modern medical ethics' can be illuminated through comparison with what had gone before.

The Recovery of Hippocrates and Galen: Moral Concerns Regarding Theory and Practice in Medicine in the Medieval West

At the beginning of the Christian era in the West, neither the doctor nor any element of the Hippocratic tradition (the *Oath* included) were held in high regard by Christian writers. At best, Christian attitudes displayed a degree of ambiguity towards doctors; often, the relationship was antagonistic: as Nutton has pointed out: 'the average doctor and all that he stands for is a stock opponent in a variety of lives of the saints'¹⁵. It is possible this attitude stems in part from a confusion of secular non-Christian doctors with the practitioners of pagan rites at the temples of deities such as Asclepius and Isis, who were in direct competition at a religious level with Christian miracle cures¹⁶. Equally, it appears to have been fed by a more subtle opposition provided by secular doctors such as Galen who, after the fashion of Hippocratic treatises such as *The Sacred Disease*, frowned upon the use of ritual practices in medicine. Such views could plausibly be extended to regard Christian faith in miraculous healing as logically deficient: indeed, in late antiquity, students of

Christian theology at Nisibis in Syria were forbidden from associating with secular doctors¹⁷.

Whilst it is true that anti-medical attitudes persisted amongst some Church authorities well into the Middle Ages (in the 11th Century AD, for example, St. Bernard of Clairvaux remained of the declared opinion that consulting doctors and taking medicine was contrary to religious purity¹⁸) by the time learned medicine was revived in Europe at the school of Salerno¹⁹, it was in the form of a 'Christianised Galenism'²⁰ and both Galen and Hippocrates eventually came to be regarded as virtuous pagans and paradigms of the healer's art²¹. In spite of initial tensions it proved possible to reconcile both figures with Christian teaching. In Galen's case, this was thanks in part to his account of the natural world, heavily indebted to the natural philosophy of Plato and Aristotle²² that had already been subsumed into the doctrine of the Roman Church²³. In addition to his endorsement of a physiology and cosmology which formed the basis of established dogma, his repeated insistence that medicine provided irrefutable evidence of the Creator's hand in the natural world helped to ensure his emergence as the pre-eminent doctor of antiquity in the eyes of the medieval religious and scholarly community²⁴.

Hippocrates' status was enhanced by Galen's high regard for his Athenian predecessor (he 'claimed always to be the most faithful and scrupulous interpreter of Hippocrates'²⁵) and through the *Oath's* apparent condemnation of abortion and euthanasia, and its emphasis on the doctor's chastity. As Jonsen notes, Christian attitudes to sexuality from St. Paul²⁶ to St. Augustine²⁷ had included the implication that sexual congress was an inherently sinful activity redeemed only by the prospect of conception, and that one of the chief purposes of marriage was to direct and limit such behaviour as far as possible given the inherent weaknesses of the flesh (in these respects, their views were similar to those Edelstein ascribes to the Pythagoreans, as discussed in Chapters 2 and 3). Equally, Christianity had, from Augustine onwards, subjected any form of suicide, for any reason, to 'a powerful and exceptionless condemnation': in the 13th Century, Thomas Aquinas held that suicide should be considered the most serious of mortal sins as it precludes the possibility of repentance (and thus of any possibility of redemption)²⁸.

The views ascribed to Hippocrates through this reading of the *Oath*, however, were not the main focus of moral concern in medieval medicine. Whilst the Church was undoubtedly concerned with the possibility of medical knowledge being misused (often insisting on the ecclesiastical licensure of midwives, for example, ‘on the grounds that their morals needed to be impeccable’²⁹) the chief moral concern facing medicine in the medieval West was the need to recover the medical knowledge that had been lost through ‘[barbarian] invasions, the collapse of the western Roman empire, and the rise of warrior fiefdoms [that had] spelt catastrophe for civilisation’³⁰. The Church was in the forefront of this recovery: ‘medical manuscripts were... copied, preserved and studied [within] abbeys and cathedral schools’³¹. To the fragmentary records preserved in the abbeys and cathedrals were added further translations into Latin from Greek, Hebrew and Arabic authors, first of all at Salerno and again a century later throughout Spain and Italy³². Indeed, Jacquart has argued that the pace of translating showed ‘no break... between the 11th and 14th Centuries’³³. At Salerno, debates took place as to the proper classification of medicine amongst other spheres of learning, and as to what methods of teaching were appropriate, with the result that medicine became organised around a set ‘of authoritative texts... that could be subjected to exegesis and discussion’³⁴.

It is of course possible to view the Church’s adoption of Galenism as motivated by either necessity or self-interest. For Christianity to hold the dominant position over European thought that it came to during the period, it would seem important for it to find a way to accommodate such important practical information. Moreover, as Hippocrates, the *Oath* and Galen gained authority and legitimacy through their compatibility with Church doctrine, so Church doctrine was able to call upon the two most famed figures of ancient medicine (Galen’s achievements, for example, were popularly regarded as approaching the miraculous³⁵) for intellectual support. Such a reading, however, may seem to be overly cynical given the moral obligation many Christians felt to care for the sick: already in late antiquity wealthy Christians had provided for charitable hospitals unlike any previously found in the West³⁶. In the Middle Ages, the Benedictine rule held attending to the infirm a direct service to Christ³⁷ and hospitals were invariably religious institutions³⁸. Generally the Church was sympathetic to medicine and the need for medical advancement: as both Porter³⁹ and Jacquart⁴⁰ have pointed out, the Church did not in fact at any time prohibit the

dissection of human corpses and by 1482 Pope Sixtus IV explicitly endorsed the practice, provided the corpses were those of executed criminals and were afforded Christian burial afterwards⁴¹.

That figures such as Grodin and Jonsen see an apparent absence of moral and/or ethical thought in medicine throughout the Middle Ages, then, appears due to their failure to identify the moral concerns we have shown to accompany matters of practical competence, especially since (as we have previously argued) other kinds of moral concern in medicine tend to arise either as a corollary or consequence of these. Medieval scholars in the West, on the other hand, appear to have realised this and as it happens were quite right to focus their attention on repairing the state of medical knowledge: throughout the Dark Ages ‘[the] medical thread’ may have remained ‘unbroken [but] it [had] frayed and threatened to snap’ and the medicine that the monasteries and cathedral schools had ‘kept alive was... a shadow of its brilliance in Galen’s day’⁴². The chief moral concern of learned medicine under such conditions was to recover or rediscover such knowledge as had been lost: questions regarding the proper conduct of doctors and organisation of medicine are of little importance if there is no medicine to organise and no doctors to ask them of.

As we saw in Chapter 2, however, the Hippocratic tradition was concerned not only with establishing practical competence but also with epistemology; that is, with establishing the best way to go about obtaining and organising medical knowledge. A perceived overreliance on a set of authoritative works and on scholastic techniques of logical argumentation has led to the learned medicine of the Middle Ages being castigated by historians from the Renaissance onwards for what Porter has termed ‘Galenolatry’: a slavish adherence to a small canon of ancient texts whose authority was considered to be beyond question⁴³. On this view, for example, Mondino de’ Liuzzi (an early pioneer of human dissection for teaching purposes at the University of Bologna⁴⁴) was ‘blinkerered by limitless faith in the observations of Galen [and thus] saw nothing’, failing to realise that the master had his anatomy wrong⁴⁵. This would seem to establish the medieval doctor as akin to those of his Persian and Egyptian counterparts in the ancient world who persisted with the chanting of incantations and ancient wisdom rather than adopting naturalistic Greek methods after it became apparent that the latter were demonstrably more effective.

Such criticism is manifestly unfair. It is true that the 9th Century Persian doctor al-Razi had drawn from *his* reading of Galen the need to criticise and improve upon earlier works: in his *Doubts About Galen* he declared himself the Roman's disciple, but he also emphasised that this meant 'neither [renouncing] criticism nor... worshipping the dead' and extolled the possibility of the progress of scientific knowledge⁴⁶. Al-Razi, however, had access to sources his Western counterparts did not (we may note that the Ancient Egyptian doctors who had held it hard to improve on earlier wisdom could at least be sure, where the medieval doctor in many cases could not, what that earlier wisdom *was*). Doctors in the medieval West did sometimes tend to frame medical questions in terms, not of asking what *was* the case, but of which of Galen or Aristotle was *right* about the case⁴⁷ and records of the medical debates of the period sometimes show an 'excessive penchant for logical argumentation'⁴⁸. On the other hand, these debates also led, as Jacquart points out, to 'an increased depth in Western epistemological thought'⁴⁹.

First of all, disagreements between the two ancient authorities gave doctors 'an opportunity to redefine the meaning that they attributed to their art' for example by considering whether the chief concern of learned medicine was to be found in therapeutic measures or in natural philosophy⁵⁰. Establishing a logical framework was necessary in 'adapting [medicine] to the university context' (Roger Bacon's criticisms of medical learning on these grounds, for example, were made at the time this process was taking place in Paris, a city in which he had lived more than once); at other times, learned doctors wrote 'extensively' on the importance of experience⁵¹. Moreover, it was not simply a question of overcoming theoretical barriers: a far greater impediment than any 'Galenic 'dogma'' was the 'real obstacle' posed by the lack of accurate methods for obtaining and organising data: from the 14th to the 15th Century 'physicians declared, on countless occasions, that it was impossible to obtain [the] reliable and accurate measurements'⁵² on which experienced-based learned medicine (as opposed to 'blind empirical procedure'⁵³) could hope to build.

If medicine in the medieval West can be excused for not building further on the epistemological concerns advanced by Hippocratic medicine, however, it may be seen to be more culpable (and the influence of the Church as more pernicious) in failing to continue the tradition of moral reflection so evident in ancient Greece. Of course, as

we have noted above, such reflection depends to an extent on the state to which medicine has been advanced and we should not expect this to have been a matter of primary concern. Nevertheless, it is clear that medieval scholarship produced and recovered works that challenged the assumptions on which certain doctrinal moral positions were based. For example, building on the Galenic assumption that the regulation of sexual ‘evacuations’ was necessary for health⁵⁴ some medieval doctors articulated the idea of the need for sexual pleasure being a natural and proper element of the human condition⁵⁵, whilst Pseudo-Aristotle’s *Problems* was known to explore the possibility of a natural causes for homosexuality⁵⁶. Such positions were, of course, expressly contrary to the views of Ss. Paul and Augustine as noted above.

Moreover, it is clear that there existed in addition to contrary evidence some (at least) implicit arguments against certain of the Church’s moral positions. Abortion, for example, was condemned in all cases by the early church authorities⁵⁷ (and in the Middle Ages, following Aristotle, past the point of ‘quickening’ at which the soul was supposed to enter the body⁵⁸) as an excommunicable offence analogous to murder. However, what evidence we have suggests that those found guilty of helping to procure abortions were *not* regarded as murderers in the eyes of the law. Jacquart and Thomasset, for example, note the case of a German woman convicted in Sélestat of inducing miscarriages: her sentence was three years exile, which could be revoked under ‘special authorisation’, a punishment they describe as ‘extremely lenient’⁵⁹. The Church and Church scholars, however, did not attempt to refute positions contrary to official doctrine; their response was a mixture of suppression and self-censorship. Medieval doctors writing on homosexuality, for example, were careful to do so only within the moral boundaries established by religion⁶⁰. ‘Quickening’ remained the chief focus of debates concerning abortion until the 17th Century (and, in the case of the Catholic Church, until the second half of the 19th⁶¹), whilst a ‘personalist’ view of sexual activity as possessing a natural good aside from the possibility of conception was not considered (and formally rejected) by the Church until 1968⁶².

We may illuminate this account of the lack of ethical debate in the medieval West as something that can be judged at least in part an error rather than an unavoidable limitation imposed on (in this case) moral (rather than medical) thought by social and

historical circumstances by considering Rachel's account of what he sees to be a similar error in ancient philosophy, namely Aristotle's defence of the institution of slavery. On this account, the 'bare outline' of arguments against slavery is as follows: 'it is unjust to set some people apart for different treatment unless there is a relevant difference between them that justifies the difference in treatment', a view that Rachels contends Aristotle 'plainly' accepted. Aristotle thus attempts to justify slavery by offering the argument that some people are by nature slavish (in that they lack rationality) and are thus suited to a corresponding station in life. However, this is an argument that runs contrary to Aristotle's own actions: he provided in his will for the manumission of his slaves, something which (Rachels argues) would not make sense if his 'slaves [were] fitted for their station by nature itself'. In other words, this account allows for the possibility of Aristotle having made the judgement that slavery was wrong without our 'transporting our [20th Century] standards of rationality back into a culture that was 'different''⁶³.

What Rachels wishes to demonstrate is that Aristotle's claim about the nature of slaves 'can be shown to be false by evidence that should be counted as evidence as much by Aristotle as by us'⁶⁴ and, whether he is right in this particular instance or not (we should note that Aristotle's arguments need not mean that all people who currently are slaves should be, nor that all people currently free might not be better off enslaved) a similar argument can be applied to the examples above. Church doctrine held that moral questions could be answered from a proper study of God's creation insofar as the proper (moral) purpose of the human body could be defined 'in terms of the apparent physical structure and purpose of [its] functions'. So, for example, the position of Ss. Paul and Augustine was justified by the "'natural orientation' of the sexual act to effect reproduction'⁶⁵. Yet contemporary medical scholarship suggested that God's creation might 'naturally' include homosexuality, that homosexuality might in some cases have a purpose (the Muslim doctor Avicenna held that female homosexuality increased fertility⁶⁶, although we should note that this has historically met with less moral opprobrium than male homosexuality) and that the natural orientation of the sexual act might also be to help maintain the body in healthy equilibrium⁶⁷. Whether or not such scholarship was correct (and clearly in some cases it was not) it was no more speculative than that which the Church was happy to endorse; as such, it surely merited detailed attention, if not assent.

Moral Concerns Regarding Epistemology, Organisation and Conduct from the Renaissance to Enlightenment

Notwithstanding the above, it remains the case that consideration of those measures available to the doctor that he or others might feel qualms about his employing was simply not as important as securing effective medical knowledge. Whilst it is clear that abortions were performed in the Middle Ages, that concerns regarding physician-assisted suicide were laid to one side may be as much the result of the era hardly having been conducive either to long life or to survival in a state of serious chronic illness as of a religious taboo on suicide. Medicine must, in general, be useful before the potential arises for its possible *misuse* and, as the Middle Ages gave way to the Renaissance, it became clear that there were three main obstacles to establishing medicine on a sound practical footing. First of all, it was becoming increasingly apparent that even the recovered wisdom of the ancients had its limitations. In the mid-14th Century, '[a] Europe which had been relatively epidemic-free turned into a crucible of pestilences'⁶⁸ with the onset of the Black Death, which learned doctors found impossible to incorporate into the scholastic structures of learned medicine⁶⁹.

The Black Death was followed by further outbreaks of bubonic plague and, in the late 15th Century, by the first recorded outbreak of the 'French Disease' (syphilis), possibly returned from the New World with Columbus' sailors and 'typical of the new plagues of an age of conquest and turbulence... spread by international warfare, rising population density, changed lifestyles and sexual behaviour... migrations of soldiers... traders... refugees and peasants'⁷⁰. Through the spread of these 'two great epidemics' it became apparent that the 'approach [of a disease] could be charted, from city to city' and that it could be 'spread from person to person... by clothes or merchandise' as well as direct contact; this undermined a medicine 'centred on the individual and his constitution and circumstances' and 'traditional elementary qualities, which were part of an individual's environment and acted directly on him'⁷¹. Moreover, neither disease could be found in the ancient texts: they eluded classification, without which learned doctors could not agree on even a possible course of treatment⁷². Galenism was not abandoned entirely: '[the] dream of Renaissance humanists was to restore medicine to its Greek purity'⁷³ (many blamed 'the barbarity of the Middle Ages for the loss of the name and description of

[syphilis]⁷⁴) and it remained the basis of accepted medical theory in Spanish universities into the 18th Century⁷⁵, but learned medicine ‘was not quite the same afterwards’⁷⁶. By the 17th Century, some medical theorists began to advance the view that ‘medicine could thrive only if the deadweight of the past were cast off’⁷⁷.

If we remember that this concern is as much a moral as it is a scientific one, then philosophers’ apparent lack of interest in moral concerns in medicine throughout this period (especially puzzling given its gradual re-emergence as an endeavour distinct from theology⁷⁸) can be seen as an error brought about by a reliance on foreground evaluations. The most pressing questions were ones we are no longer accustomed to thinking of as moral at all and continued to be centred, not on the conduct of the doctor, but on matters of natural philosophy. In this respect it is clear that philosophers of the time did in fact take a great deal of interest in medicine. Francis Bacon cited medicine as one example of a science which was ‘professed’ more than ‘laboured’, and ‘laboured’ more than ‘advanced’⁷⁹ in order to underline the importance of adopting a new method of natural philosophy in order to develop practical knowledge⁸⁰. Descartes regarded medicine as ‘a key to the natural world’ and was a keen dissector of animals. He wrote extensively on the nervous system and anatomy, and was heavily involved in promoting a mechanistic view of both human and animal bodies⁸¹. In his *Discourse on Method*, he both defended and enlisted as support for his own natural philosophy Harvey’s account of the circulation of the blood⁸² in what French has described as an ‘unusually confident and forthright’⁸³ manner.

As Bacon himself realised, however, in insisting that the new science must be composed of ‘tribes not hostile to each other, but bound together through mutual services’⁸⁴, there was a second barrier to establishing an effective medicine in addition to the inadequacy of current theory: the lack of any form of centralised professional organisation. The collapse of a more or less universally accepted system of natural philosophy had been hastened in part by the Reformation: Martin Luther himself had voiced concerns that the medical departments of universities in Germany were ‘dominated by Aristotelian scholasticism and therefore... opposed to true Scripture-based knowledge’⁸⁵. Catholic theologians and doctors tended to view any criticism of Galenism as an attack on the Church itself⁸⁶ and attacked ideas such as

Harvey's as 'modern nonsense'⁸⁷. The problems that could result did not go unnoticed even by those proposing radical revisions of doctrine: Harvey, whose model of circulation undermined several key tenets of Galenic medicine⁸⁸ was unperturbed by attacks from the Continent, accepting that his detractors were officially obliged to do so and acknowledging that it was 'fitting... to keep Galen's medicine in good repair'⁸⁹. In 1678, when the viceroy of Naples asked the profession for advice following the accidental poisoning of a favourite by his (Galenic) doctor, they were forced to admit that theory had become so 'confused ' as to make the regulation of medicine essentially impossible⁹⁰.

Learned medicine was not only divided, but also under pressure from without. University-educated doctors were in competition with a range of craft practitioners whose medicine was rooted in experience rather than theory: 'surgeons, apothecaries, empirics and irregulars' many of whom began to draw support from the medical chemistry pioneered by Paracelsus⁹¹. Learned doctors tended to be scathing of such practitioners (Harvey, according to one account, habitually referred to them as 'shitt-breeches'⁹²). Nevertheless, they gained governmental support: '[in] England, monarchs from Elizabeth to Charles II supported unlicensed practitioners against the College of Physicians, while in France the court afforded shelter to [Paracelsans]... against the hidebound Paris faculty'⁹³. Eventually, many traditional institutions came to incorporate new ideas. Daniel Sennert, appointed professor of medicine at Wittenberg in 1602, drew inspiration from Paracelsus⁹⁴ and the London College of Physicians formally repudiated Galenism around 1680⁹⁵. Nevertheless, well into the 18th Century, '[rival] camps proliferated' and 'traditional... centres of excellence were challenged by Halle, Leiden, London, Edinburgh, Vienna and Philadelphia, each with its own school'⁹⁶.

If the unity that had been offered by Galenism was increasingly broken, with the Roman now an 'arch-enemy... supposed to have sterilized medicine with his sophistry' his Greek predecessor remained an inspiration: 'Hippocrates maintained his Olympian status as the champion of bedside experience'⁹⁷. Gabrielle de Zerbi, a 16th Century Paduan doctor, wrote works on medical ethics which explicitly dealt with many of the concerns we have previously identified in the Hippocratic Corpus. French has dismissed de Zerbi's work as 'rules designed as much for the benefit of doctors as

of the patient', although he concedes that they are 'not wholly cynical'⁹⁸. Certainly, some of his suggestions (for example, that the doctor should avoid going shopping or playing games) can seem somewhat frivolous. On the other hand his injunction that theoretical disagreements be aired in private seems to have derived from his realising, like Harvey, that 'the vulgar and the plebeians... could cause immense damage to the reputation of all properly trained physicians by showing that, since they disagreed in their learning [they] could not be trusted' and from realising, like his ancient Greek counterparts, that this trust was an important part of his treatments' effectiveness⁹⁹. Even his superficially self-interested insistence on 'expensive remedies' was prompted at least in part by a belief that they 'acted more surely than cheap ones'.

Regaining some sense of unity was important since, aside from the growing theoretical divisions amongst themselves, all sincerely naturalistic doctors (whether craft- or theory-driven) faced a second difficulty: competition from religious, superstitious and/or traditional remedies and, increasing, the products peddled as part of what has been termed 'the golden age of quackery'¹⁰⁰. Since the dawn of the Christian era, the Church had maintained alongside a Christianised natural medicine versions of the old pagan healing cults reattributed to particular saints¹⁰¹. Following the Reformation the Catholic Church 'upheld familiar healing rituals: holy water and wells, shrines [and] saints' relics'; in Protestant nations 'seventh sons of seventh sons and 'stokers' might claim 'miracle' cures'¹⁰². Various cultish practices abounded, such as the belief that the royal touch could cure scrofula: in France this continued until the reign of Charles X in the mid-19th Century (although whether it was still widely believed in by then is debatable)¹⁰³ whilst Frazer reports that William III of England was forced to bribe the subjects gathered outside his palace, begging him to exercise healing powers he did not believe in, to get them to go away (he also relates the story that, when finally unable to avoid the entreaties of one such supplicant, the king laid hands upon him with the benediction: 'God give you better health and more sense'¹⁰⁴).

The popularity of such remedies depended to a large extent on the third obstacle facing the establishment of an effective medicine: widespread public ignorance of medical matters. In the 17th Century, '[magic] still underlay much vernacular healing' and, as with medicine in the ancient Near East, it can sometimes be hard to

distinguish the rational and/or empirical cure from the product of superstition. For example, a chicken or pigeon butchered live and applied to the forehead was commonly recommended for ‘inflammation of the brain’: as Porter asks, ‘was this a medical therapy drawing upon the virtue of heat, or did its efficacy lie in the blood sacrifice’¹⁰⁵? By the 18th Century, some doctors appear to have recognised the need to address the situation, leading to the publication of several populist works. Wesley’s *Primitive Physick* of 1747 ‘taught common folks how to treat their ills with the aid of simple kitchen ingredients’ whilst Buchan’s *Domestic Medicine* of 1769 attempted to ‘lay open’ medicine to the general public (the latter would later espouse ideas of ‘medical democracy’ under which access to proper medical knowledge, especially simple practices of ‘diet, hygiene and temperance’ was a natural right of man analogous to those proclaimed by the French Revolution¹⁰⁶).

The Birth of the Clinic and the Politicisation of Medicine in the 18th Century

From the 14th Century onwards, Europe continued to be beset by epidemics: ‘plague bounced from the Balkans to Britain, malaria was on the increase, smallpox grew more virulent, while typhus and [dysentery] became camp-followers of every army’¹⁰⁷. Beyond the vast death tolls they exacted, these various plagues served not only to loosen the hold of scholastic thought on learned medicine but to tighten the grip of civic authorities on public health. Prior to the 15th Century, ‘[public] health boards, composed of nobles and officials, were *ad hoc* creations’; in 1410, however, Milan established a permanent board, followed by Venice in 1486, Florence in 1527 and Lucca in 1549, with northern Europe gradually catching up over the course of the following century¹⁰⁸. As Porter notes, doctors did not act ‘as full members of such boards but as advisers’; nevertheless, they became ‘more involved in public administration’¹⁰⁹. Doctors and midwives were called on to provide the state with information (for example, by registering births)¹¹⁰ and by the 18th Century works such as Hoffman’s *The State Doctor* appeared in an attempt ‘define the role of medicine within legal procedures’¹¹¹.

The relationship between medicine and politics worked in both directions. In the case of syphilis, as French points out, that ‘there was little [he] could do in the case of the French Disease... detracted from the authority of the learned doctor’; after all ‘[it]

was religious charity that built hospitals [and] the city authorities who organised quarantine or turned people from the walls'¹¹². Learned medicine in universities depended on civic recognition 'that their philosophical medicine was the best and deserved a monopoly'¹¹³, and in the face of epidemic disease, civic authorities expected learned medicine to make good on its obligations. When Galenic medicine could not, and 'civil administrations ultimately came to see plague as an entity that travelled from town to town, often along trade routes' this weakened its authority 'and opened further opportunities for... the empirics'¹¹⁴. On the other hand, as 'the devastating effects of plague, epidemics and social unrest heightened the problem of the management of the urban masses', any medicine which *could* win the backing of civic authorities stood to gain along with it significant political influence.

To illustrate this relationship more clearly, we may consider the example offered by Foucault in *The Birth of the Clinic* with regards to the period in French history from the late 18th Century onwards when the 'botanical model' of disease¹¹⁵ (a 'medicine of species' defined by a 'classificatory rule [that dominated] medical theory in practice', dated 'from the *Nosologie* of Sauvages (1761) to the *Nosographie* of Pinel (1798)'¹¹⁶) was eventually supplanted by a new 'medicine of epidemics'¹¹⁷. For Foucault, each of these 'medicines' is based on a different set of ontological claims regarding the nature of disease, 'opposed [to one another] at every point'¹¹⁸. The 'medicine of species' placed its emphasis on disease as the result of discrete entities with their own 'natural histories'. By contrast, the 'medicine of epidemics' placed emphasis on 'a sort of historical individuality' which, like Hippocratic and Galenic medicine, takes into account particular temporal and geographical features¹¹⁹. In this respect, *The Birth of the Clinic* paints a picture in which the continuity of medical practice is an illusion, with the continued use of the term obscuring a fundamental shift in the content, not only of medicine, but of related terms such as 'health'. Equally important for Foucault, however, is that the dominance enjoyed by one conception over the other is not a simple matter of truth and/or 'progress' (in which a simpler and less accurate conception of disease is succeeded by a more complex and more accurate one) but is intimately associated with economic, social and political pressures.

Foucault explicitly associates the growth of the new 'medicine of epidemics' with political intervention, namely the establishment 'of the Société Royale de Médecine...

for the study of epidemic and epizootic phenomena that had increased considerably in recent years', in particular an outbreak of 'disease affecting livestock' which had caused 'fairly serious' economic disruption in the affected region¹²⁰. Additionally, however, this new medicine itself called for the nature of political intervention to be modified. Its effectiveness was dependent on control over temporal and geographical elements and as such it gradually arrogated to itself the power to do so: 'medical space can coincide with social space, or, rather, traverse it and wholly penetrate it'¹²¹. Furthermore, it necessitated 'a complex method of observation' achievable only through a collective response which ultimately sanctions or requires intervention in public health at the level of the state¹²². On such a reading, Buchan's comparison between medicine and the rights enshrined in the French Revolution is no mere analogy; rather, they are parts of the same totalising whole. 'Medicine' enshrines a particular view of how the world is and how human beings should act in accordance with it: 'the struggle against disease must begin with a struggle against bad government'¹²³.

In addition, the adoption of a 'medicine of epidemics' brought about a change in the relationship between patient and doctor: unlike Hippocratic and Galenic medicine it did not have at its centre the individual patient, or at least, an individual person. Under the 'medicine of species', '[in] order to know the truth of the pathological fact, the doctor must abstract the patient... in relation to that which he is suffering from, the patient is only an external fact; the medical reading must take him into account only to place him in parentheses'¹²⁴. Under the 'medicine of epidemics', the abstraction of disease from the patient is supplanted by the elimination of the patient as a separate entity; as particular historical and geographical circumstances become incorporated into a disease, so the patient disappears entirely: 'not so much a sick person, as the endlessly reproducible pathological fact'¹²⁵. The individual is reduced to the body over which medicine exercises power, and the economic, social and political nature of this power is concealed behind the veil of 'objective' fact: 'the clinician's gaze becomes the... equivalent of fire in chemical combustion... the separating agent of truths'¹²⁶.

Such an account is both revealing and limiting. Revealing, because it lays bare forces which were undeniably in operation on the theory, practice and organisation of

medicine during the late 18th Century. Limiting, first of all, because if one ‘medicine’ is adopted because it achieves certain ends better than another, then the dislocation in methodology Foucault describes may itself be a distraction from recognising a continuity, not of method, but of the *objective* of a method (that is, the effective care of the patient through the proper study of disease). Moreover, Foucault’s approach also fails to acknowledge that such interpretations may be useful for reasons other than those which lead to their widespread adoption, or perhaps that this adoption occurs for reasons other than (or in addition to) those that he describes. First of all, we may note that the ‘medicine of epidemics’ having a higher use-value than that of the ‘medicine of species’ is not necessarily a bar to the former also being a ‘truer’ account (perhaps, indeed, it was more useful *because* it was more ‘true’). Secondly, we may note that the economic benefits brought by a medicine’s being able to deal with epidemic outbreaks is not necessarily a bar to it bringing other benefits as well, especially when those ‘economic’ benefits are often ultimately calculated in human lives.

What was wrong with *both* the ‘medicine of species’ and the ‘medicine of epidemics’ was not that they were ‘incorrect’ but that both held ontological pretensions to which they had no right. As long as their status as abstractions was remembered then both could remain useful and objections to them, trivial (we should also note that their use-value seems to rely on their having some kind of relationship with how things ‘really are’). However, as Foucault’s account makes clear, this tended to be obscured. Increasingly in the 18th Century ‘Enlightenment thinkers looked to science for their...models of social order’¹²⁷. Doctors, in the vanguard of the triumphant march towards ‘a better future [in which] science and technology... would enhance man’s control over Nature [and] the conquest of disease would follow’¹²⁸, were to become ‘anatomists and doctors of society itself’¹²⁹. Yet the route this march would take concealed traps for the unwary, and hidden though they may have been, many had already been sprung by the time Foucault uncovered them in the 1970s. As we shall see in Chapter 6, this had not gone unnoticed. Indeed, it is highly unlikely that it could have been missed.

Conclusions

The underlying moral concerns associated with medicine during the Middle Ages, Renaissance and Enlightenment are familiar from our previous three chapters, given new shape by the historical and social context of the times. Primarily, the chief focus of medical thought (and of philosophical thought regarding medicine) lay in making medicine effective, firstly through recovering knowledge lost following the collapse of the Roman Empire in the West and, subsequently and in the wake of devastating outbreaks of epidemic disease, in forging ahead with the attempted discovery of new knowledge and new cures. To these may be added, as the centuries wore on, fresh questions regarding the organisation of medicine as a discipline and with regards to the political and social order. On the other hand, partly as a result of the urgent need to address these concerns, but partly also as a result of religious restrictions on the scope of moral reflection, questions as to the doctor's conduct and as to those practices which ran counter to received morality were neglected. It is in the light of this state of affairs that we will now turn our attention towards specific works produced in response to it: Percival's *Medical Ethics* and the first *Code* of the American Medical Association.

¹ Jonsen, A.R. *The Birth of Bioethics* p.7

² Grodin, M.A. 'Introduction: The Historical and Philosophical Roots of Bioethics' p.3

³ Porter, R. *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present* (London: Fontana Press, 1999) p.110

⁴ *Ibid.* p.115

⁵ Jacquart, D. 'Medical Scholasticism' in Grmek, M.D. (ed.) *Western Medical Thought from Antiquity to the Middle Ages* (London: Harvard University Press, 1998) p.224

⁶ Grodin, M.A. 'Introduction: The Historical and Philosophical Roots of Bioethics' pp.2-3

⁷ Jonsen, A.R. *The Birth of Bioethics* p.7

⁸ Porter, R. *The Greatest Benefit to Mankind* p.786

⁹ *Ibid.* p.814

¹⁰ *Ibid.* p.814

¹¹ *Ibid.* p.786

¹² Jonsen, A.R. *The Birth of Bioethics* pps.292-4

¹³ *Ibid.* p.11

¹⁴ Grodin, M.A. 'Introduction: The Historical and Philosophical Roots of Bioethics' p.3

¹⁵ Nutton, V. 'God, Galen and the Depaganization of Ancient Medicine' in Biller, P. and Ziegler, J. (eds.) *Religion and Medicine in the Middle Ages* (York: York Medieval Press, 2001) pp.19-20

¹⁶ *Ibid.* p.21

¹⁷ *Ibid.* p.20

¹⁸ Porter, R. *The Greatest Benefit to Mankind* p.110

¹⁹ *Ibid.* p.106

²⁰ *Ibid.* pp.106-7

²¹ Nutton, V. 'God, Galen and the Depaganization of Ancient Medicine' p.18

²² Porter, R. *The Greatest Benefit to Mankind* p.74

²³ Nutton, V. 'God, Galen and the Depaganization of Ancient Medicine' p.19

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- ²⁴ Carrick, P. *Medical Ethics in Antiquity* p.24
- ²⁵ Ibid. p.24
- ²⁶ Jonsen, A.R. *The Birth of Bioethics* p.283
- ²⁷ Porter, R. *The Greatest Benefit to Mankind* p.284
- ²⁸ Ibid. p.262
- ²⁹ Ibid. p.120
- ³⁰ Ibid. p.106
- ³¹ Ibid. p.106
- ³² Ibid. pp.108-9
- ³³ Jacquart, D. 'Medical Scholasticism' pp.214-5
- ³⁴ Ibid. pp.208-10
- ³⁵ Nutton, V. 'God, Galen and the Depaganization of Ancient Medicine' p.23
- ³⁶ Porter, R. *The Greatest Benefit to Mankind* p.88
- ³⁷ Ibid. p.111
- ³⁸ Ibid. p.112
- ³⁹ Ibid. p.110
- ⁴⁰ Jacquart, D. 'Medical Scholasticism' p.224
- ⁴¹ Porter, R. *The Greatest Benefit to Mankind* p.111
- ⁴² Ibid. p.106
- ⁴³ Ibid. p.115
- ⁴⁴ French, R. *Medicine Before Science: The Rational and Learned Doctor from the Middle Ages to the Enlightenment* (Cambridge: Cambridge University Press, 2003) p.113
- ⁴⁵ Jacquart, D. 'Medical Scholasticism' p.224
- ⁴⁶ Porter, R. *The Greatest Benefit to Mankind* p.96
- ⁴⁷ Jacquart, D. 'Medical Scholasticism' p.216
- ⁴⁸ Ibid. p.220
- ⁴⁹ Ibid. p.220
- ⁵⁰ Ibid. p.218
- ⁵¹ Ibid. pp.220-1
- ⁵² Ibid. p.223
- ⁵³ Ibid. p.221
- ⁵⁴ Porter, R. *The Greatest Benefit to Mankind* p.107
- ⁵⁵ Jacquart, D. 'Moses, Galen and Jacques Despars' in Biller, P. and Ziegler, J. (eds.) *Religion and Medicine in The Middle Ages* p.39
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- ⁵⁸ Ibid. p.288
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- ⁶² Ibid. p.301
- ⁶³ Rachels, J. 'Moral Philosophy as a Subversive Activity' in Winkler, E.R. and Coombs, J.R. (eds.) *Applied Ethics: A Reader* (Oxford: Blackwell, 1993) pp.123-4
- ⁶⁴ Ibid. p.124
- ⁶⁵ Jonsen, A.R. *The Birth of Bioethics* p.36
- ⁶⁶ Jacquart, D. 'Moses, Galen and Jacques Despars' p.41
- ⁶⁷ Porter, R. *The Greatest Benefit to Mankind* p.129
- ⁶⁸ Ibid. p.123
- ⁶⁹ French, R. *Medicine Before Science* p.130
- ⁷⁰ Porter, R. *The Greatest Benefit to Mankind* p.167
- ⁷¹ French, R. *Medicine Before Science* p.158
- ⁷² Ibid. p.152
- ⁷³ Porter, R. *The Greatest Benefit to Mankind* p.201
- ⁷⁴ French, R. *Medicine Before Science* p.152
- ⁷⁵ Ibid. p.185
- ⁷⁶ Ibid. p.127
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- ⁹⁶ Porter, R. *The Greatest Benefit to Mankind* p.247
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- ¹²⁹ Ibid. p.302

Chapter 5: Percival, the BMA and the AMA: ‘Professional Ethics’ or ‘Medical Etiquette’?

Given the challenges described in the previous chapter, it is perhaps unsurprising that the ethical literature produced by 19th Century medicine should both proceed from and focus on the new social and institutional settings within which doctors were beginning to operate. Thomas Percival’s *Medical Ethics*, for example, was begun not from a desire to reform medicine as a whole but from the need to establish a regulatory framework in hospitals, which in Britain had from the 18th Century onwards taken on a growing role not only in caring for the sick but in educating professional doctors¹. Specifically, it was written in response to a request from the Manchester Infirmary, and the first chapter came to form ‘the code of laws, by which the practice of this comprehensive institution [was] governed’². The work itself, however, went beyond this original intention and attempted to extend these regulations into a framework for professional medicine in general (three of its four chapters have titles beginning ‘Of Professional Conduct...’; two make reference to specific areas of practice: ‘hospitals, or other medical charities’³ and ‘private or general practice’⁴) with the aim of what Jonsen has described as establishing ‘professional cohesion around the goal of an effective medicine’⁵.

The American Medical Association *Code* of 1848 (although, as we shall see below, drawing heavily upon Percival’s work of nearly five decades before) was, by contrast, designed to fulfil this role from the start: it explicitly identifies the establishment of a unified professional standard of proper practice as the chief and most important goal of medical ethics: ‘[by] union alone can medical men hope to sustain the dignity and extend the usefulness of their profession’⁶. These concerns would dominate medical ethics for the following century: the ethical committee structure and Central Ethical Committee established in 1902 by the British Medical Association concerned itself almost entirely with maintaining accepted standards of professional behaviour⁷ and was ‘responsible for presenting cases for expulsion from the Association, under the general rubric of conduct ‘contrary’ or ‘detrimental to the honour and interests of the medical profession’⁸. In all three cases, the chief content of 19th Century medical ethics as conceived by 19th Century medical men consisted of describing the proper

behaviour expected of them in their social and professional dealings, grouped together under the umbrella term 'consultation ethics'.

'Consultation' in this sense refers to three different sets of rules covering three different kinds of interaction. First of all are the rules concerning doctors' interaction with each other in a clinical setting, between more and less experienced doctors and (in the case of Percival at least) between different branches of the profession (chiefly between physicians and surgeons). We may refer to these as the *rules concerning clinical consultation*. Next come the rules concerning those cases in which a patient usually treated by one doctor either chooses to employ or is forced by circumstances to consult another. Following the terminology of the time, we may refer to these as the *rules concerning interference*. Finally, there are those rules that attempt to regulate the relationship between doctors on the one hand and, on the other, those providers of healthcare situated outside the immediate profession, whether 'medical' in some recognisably modern sense (such as apothecaries, dentists and opticians) or not (for example, homeopaths, bonesetters and chiropractors). These may be grouped together as the *rules concerning consultation with non-professional practitioners*. We may now move on to consider examples of each of these categories in more detail.

Rules Concerning Clinical Consultation

For Percival, the purpose of clinical consultation between doctors was twofold. First of all, it was often necessary for resolving difficult cases; moreover, it also helped to ensure the widest possible dissemination of skills throughout the profession.

Consultation with one's more experienced colleagues when faced with a problematic case and offering advice in turn to more junior colleagues can thus be seen in his work as an ethical duty in itself: '[giving] rise to confidence, energy and more enlarged views in practice'⁹, words echoed almost verbatim by the 1848 *AMA Code*¹⁰. Yet Percival was also aware of the potential difficulties attendant on such a process. These ranged from the personal (he cautions that '[on] such occasions no rivalry or jealousy should be indulged'¹¹) to the straightforwardly practical (for example, in deciding where the consultation should take place, and how it should proceed). Unsurprisingly, much of both *Medical Ethics* and the *Code* are given over to delineating a framework within which such consultations are to take place.

Some of these rules seem to be simple extensions of common courtesy. For example, Percival stresses the importance of timekeeping for those involved in consultation¹²; the *Code*, in slightly stronger terms, states that '[the] utmost punctuality should be observed' (we may note, however, that in the same passage the *Code* seems to indicate these responsibilities are rather weightier than simple good manners, and reminds doctors that their obligation to the profession overrides all other claims: leaving a prior social engagement to ensure prompt arrival at a consultation 'is generally practicable, for society has been considerate enough to allow the plea of a professional engagement to take precedence of all others'¹³). Both works give instructions for ensuring the primary doctor is treated with a degree of politeness in front of his patients by those called in. The *Code*, for example, instructs that the attending doctor still be the first to question the patient in all cases¹⁴ and whilst Percival, by contrast, recommends that the most senior doctor fulfil this role, he arguably goes further to ensure the continuing esteem of the attending doctor in the patient's eyes by instructing that they be the one to inform the patient as to the course of action decided upon¹⁵.

Other rules are more directly concerned with particular aspects of consultation and may be divided into two further groups. The first type outline the framework within which a consultation progresses and the roles which each participant is to take. For example, both works give a clear order in which the individuals involved are to state their opinion prior to discussion: in both cases it is recommended the attending doctor give their opinion first, with others following either in the order in which they were called into consultation (according to the *Code*¹⁶) or of seniority, with the most junior going first (according to Percival¹⁷). Percival calls for a simple majority vote between those in attendance to decide upon which course of action is to be followed, although he also allows for the attending doctor to make amendments to the treatment as the circumstances of the case may dictate¹⁸. The *Code* follows Percival's wording almost to the letter, further recommending that any changes to treatment are scrupulously recorded for discussion in any subsequent consultation¹⁹.

The second type of rules are found in those parts of both *Medical Ethics* and the *Code* which govern the interaction between doctors involved in consultation and the patients whose cases form the basis of their deliberations. We have already noted

above that both works recommend that the majority of contact with the patient be restricted to one practitioner (either the attending doctor in the case of the AMA, or the most senior in the case of Percival). Beyond this, both works require consultations to be held away from patients: Percival plainly states that ‘no discussion concerning the nature of the case should be entered into before the patients’²⁰ whilst the *Code* recommends that ‘physicians [involved] should... retire to a private place for deliberation’²¹. Also, it is recommended that theoretical discussion is avoided wherever possible; the language employed by the *Code* on this point²² differs in punctuation only from that used by Percival²³.

Rules Concerning Interference

Dealings with another doctor’s patients outside of the consultation process defined above are generally discouraged by both Percival and the *Code*. Percival couches this primarily in terms of ensuring the continuing respect of patients towards their usual doctor: ‘[no] meddling enquiries should be made concerning the patient, no unnecessary hints given relative to the nature or treatment of his disorder... that may directly or indirectly tend to diminish the trust reposed in the Physician or Surgeon employed’²⁴. The *Code* again borrows Percival’s language in proscribing such behaviour, prefacing it with an injunction to ‘observe the strictest caution and reserve’ when dealing with ‘a patient under the care of another physician’²⁵ and discouraging taking on cases where the patient has recently been under the care of another doctor²⁶. Furthermore, the *Code* also places a responsibility upon the *patient* to avoid discussion of medical matters with those doctors they have dealings with in other capacities, warning to ‘avoid even *the friendly visits of a physician* who is not attending them [my emphasis]’ in case conversation with such a visitor inadvertently results in a loss of confidence in the treatment prescribed²⁷.

The *Code* goes in to more detail than Percival when considering those situations in which interference is unavoidable or may otherwise be considered permissible. Chiefly, these may occur when a patient’s usual doctor is unavailable, most obviously ‘in cases of sudden emergency’ and ‘in cases of sickness or absence’. At such times, caution is to be exercised by the attending doctor: in emergency situations, although the first to attend should take charge of the patient, they should also send for the usual

doctor if this has not already been done and ‘resign the care of the patient to the latter immediately upon his arrival’ (the importance of this is underlined by the fact that an extremely similar form of words is repeated twice within the space of two paragraphs). Even where a patient has discharged one doctor from his service and employed another, the new doctor is reminded to refrain from ‘unjust and illiberal insinuations... in relation to the conduct or practice previously pursued’²⁸.

As with the rules concerning clinical consultation, which established clear roles and procedures to be followed by those involved, the *Code* also provides guidance for how to act in cases where some permissible degree of interference has taken place. These extend to cover what treatment can be given: for example, in a case where a patient with a pre-existing condition’s symptoms have suddenly changed or worsened, the ‘interfering’ party is to follow treatments that as far as possible fit those already prescribed, and to avoid discussing what treatment may be followed in future. They also establish when a case is to be passed back to the usual doctor: for example, where a doctor engaged to deliver a baby is not available, another who performs the delivery in their stead is not to take over the care of the mother and her newborn infant. Generally speaking, the ‘interfering’ party is to perform only such care as is absolutely necessary before the arrival of the latter, who again is in all cases to be sent for as soon as possible and to whom the case is to be resigned²⁹.

Rules Concerning Consultation With Non-Professional Practitioners

The rules we have examined so far were to be followed by all members of the medical profession (or professions, in the case of Percival, where the distinction between physician³⁰ and surgeon³¹ is still rigorously made). Yet the business of healthcare in the 19th Century was not restricted to the clinical sphere; medical men did not operate in a vacuum. Competing theories or professions may have been fraudulent (as in the case of quacks and snake-oil salesmen), deluded or quasi-scientific (as in the case of homeopaths) or recognisably ‘medical’ in the modern sense of the word (for example, opticians or dentists). Establishing ‘professional cohesion’ amongst doctors also meant establishing where the profession was to stand in relation to these others, and, given professional doctors’ pursuit of ‘a professional monopoly over healthcare’³² this relationship was often antagonistic.

The *Code* not only expressly bars from the profession any individual not in possession of a 'regular medical education' but also notes that 'no-one can be considered... a fit associate in consultation, whose practice is based on an exclusive dogma, to the rejection of the accumulated experience of the profession'³³. To be a part of the profession was not only to embrace a certain standard of scientific medicine in its entirety but to refrain from consulting those who rejected all or part of it : Jonsen cites as examples homeopaths, naturopaths and hydropaths³⁴. In Britain, the GMC was prohibited from '[enforcing] any particular theory of medicine or system of therapeutics'. However, the Central Ethical Committee of the BMA could remove doctors from the statutory *Register of Medical Practitioners* for associating with those outside the profession: Morrice gives as an example the case of Dr. Axham: 'erased... for anaesthetising patients for the famous bonesetter Herbert Barker'³⁵.

This prohibition was not restricted to non- or quasi-medical practitioners. Removal from the *Register* could occur for a variety of reasons, initially left unspecified under the catch-all term of 'infamous conduct in a professional respect'³⁶. This did not necessarily prevent an individual from practising medicine: those in possession of a university doctorate could still describe themselves as a doctor and could continue to practice provided they did not claim to be registered. However, by the mid-20th century 'new laws and statutes allowed only registered practitioners to do certain things, and occasionally prevented unregistered practitioners from doing others'. More importantly, unregistered surgeons and physicians were cut off from the profession, as registered practitioners were forbidden from including them in consultation³⁷. As a result, such measures effectively excluded these individuals from 'professional' status and reduced the unregistered practitioner to the same status as bonesetters and homeopaths.

Whilst 'infamous conduct' could include behaviour which would be recognisably unethical to present-day eyes ('crimes or felonies', for example³⁸) doctors could find themselves removed from the profession for other reasons. Aside from association with non-medical practitioners, individuals could be sanctioned for failing to recognise the authority of the BMA in taking up posts where the local Division had made a decision to withdraw medical services. Individuals refusing to comply with the 'Warning Notice' listing such disputed posts in the *British Medical Journal* 'were

reclassified as outsiders and excluded from professional and social intercourse', with the 'Notice' being 'legally appraised as a 'black list''³⁹. Such official sanctions reinforced existing practice: even prior to the creation of the 'Warning Notice' in 1903 those who 'broke ranks' with the profession (for example by taking up contract positions boycotted by local colleagues) 'were often ostracised by their fellows'⁴⁰.

Contemporary Criticism of Professional Ethics in Medicine

The 'professional cohesion' which Percival, the *Code* and the Central Ethics Committee attempted to establish and enforce was not universally popular from the viewpoint of either medical practitioners or the general public. Morrice has described the purpose of such an ethic as twofold: 'to strengthen and patrol the boundary of the profession (stating who could and could not join in 'the game') [and to regulate] the space within it (the way the game was played)'⁴¹. By the early 20th Century, in Britain and America, the way in which the 'medical ethics' established by the profession attempted to achieve its goals had come under criticism on several fronts and from varied sources. An ethic which was seen to be focused on the 'honour and interests' of the medical profession 'increasingly came to be seen to have failed to pay enough attention to what the patient's interests may be'⁴². Certainly, by the beginning of the 20th Century it was felt both within and without the profession that works such as *Medical Ethics* and the *Code* had given rise to a situation in which 'ethics' had become synonymous with a closed, inward looking medical establishment pursuing, sometimes aggressively, the interests of its members above all else.

In Britain, both unregistered and unorthodox practitioners remained popular with the public. For example, the Dr. Axham whose removal from the *Register* was mentioned in the previous section was the subject of a popular campaign for his reinstatement, led by George Bernard Shaw, which characterised the BMA as 'self-interested and anti-social'⁴³. The public were also wary of the profession's motives in regulating consultation between registered practitioners. By the early 20th Century, strict rules covering a patient's freedom to approach other practitioners were responsible for creating a situation in which 'patients often complained that their choice was being restricted, and suspected they were being exploited'⁴⁴. Within the medical sphere

itself the damages for ‘libel, slander and conspiracy’ awarded to a group of doctors ‘blacklisted’ by the BMA for taking up disputed positions can be seen as an implicit criticism of those ‘ethical’ rules relating to the organisation of the profession⁴⁵. In America ‘two unconventional figures’ were, as Jonsen has it, to ‘[introduce] novelty into [the] traditional patterns of medical ethics’⁴⁶ from within the profession itself. The first of these was Dr. Richard Cabot who, unconcerned with whether ‘the practitioner went to church on Sunday, knew the “Star Spangled Banner”, swore the Hippocratic Oath, or adhered to... the AMA Code of Ethics’⁴⁷ sought instead to establish (as Jonsen puts it) ‘clinical competence... [as] the centre of medical education and even of medical ethics’⁴⁸. This clinical competence was to embrace mastery of both scientific medicine and of the more ‘humanistic’ aspects of the medical profession: an ‘appreciation of the personal and social needs of a patient’⁴⁹. Jonsen argues this ‘ethic of competence’ is a ‘particularly modern view of medical ethics’⁵⁰ and claims its very absence, following Cabot’s work, from official rules and codes as evidence that it had become wholly subsumed into the ethos of medicine as a whole, with ‘physicians [assuming] a professional persona that was shaped by scientifically dictated duties’⁵¹.

The second of these ‘unconventional figures’ was Dr. Chauncey Leake who, in preparing a new edition of Percival’s *Medical Ethics*, came to consider the established approach as ‘misconceived... from the beginning’⁵². Leake was one of the first to offer the now commonplace criticism that Percival and the *Code* were not, in fact, ‘ethical’ works at all but rather ‘rules of etiquette developed in the profession to regulate the professional contacts of its members with each other’⁵³. By way of contrast, he proposed a three-tiered system of ethical education for doctors of medicine, beginning with a course in moral philosophy, followed by ‘a historical survey of ethics in medicine’ and concluding with the discussion of actual, ethically problematic, cases with more experienced colleagues⁵⁴. The aim of this education would be to create an ethic ‘concerned with the ultimate consequences of the conduct of physicians toward their individual patients and toward society as a whole’⁵⁵. Again, for Jonsen, Leake is an early forerunner of later trends; the ‘perplexity before moral dilemmas’ he sees in Leake’s work is for him the key distinction between traditional and modern works of medical ethics⁵⁶.

Professional Ethics in Medicine Reconsidered

Despite Jonsen's contentions, it is far from clear that Cabot and Leake's arguments (though certainly valid in themselves) were either entirely novel or opposed to the aims of professional ethics as envisaged by Percival and the *Code*. We have already seen these aims characterised as unifying medicine around a common goal, and of determining who was to be allowed (in Morrice's terms) to 'play the game'. Yet we may ask whether these aims were ends in themselves, or (much like the Hippocratic works such as *Decorum*) themselves means in pursuit of other goals. On a closer reading, and bearing in mind the social and scientific context in which both *Medical Ethics* and the *Code* were written, it becomes clear that neither Percival nor the AMA can truly be accused of prioritising the needs of the medical establishment over those of the patient, nor of being ignorant of the deeper ethical concerns involved in medical practice. Percival, for example, seems to have been aware that what he proposed could seem to be more an organisational than ethical framework; he very nearly entitled his work *Medical Jurisprudence*⁵⁷. That he did not reflects an understanding that the rules contained within the work were an expression of underlying moral concerns: in the author's own terms, 'according to the definition of Justinian... Jurisprudence may be *understood to include moral injunctions* [my emphasis]',⁵⁸.

Indeed, to borrow Leake's phrasing, a concern for the ultimate consequences of the conduct of physicians toward their individual patients and toward society as a whole runs continuously through both works. Similarly, Cabot's description of a medical ethic driven by competence in both the scientific and personal spheres is strikingly similar to the very first paragraph of the very first chapter of *Medical Ethics* in which doctors are entreated to:

...minister to the sick with due impressions of the importance of their office; reflecting that... the lives of those committed to their charge depend on their skill... They should study, also, in their deportment, so to unite tenderness with steadiness, and condescension with authority, as to inspire the minds of their patients with gratitude, respect and confidence.⁵⁹

In attempting to codify the requirements of the medical profession Percival, the *Code* and many of the actions of the Central Medical Committee can be seen to share in the aims of Cabot and Leake. What should not be forgotten is that they were often operating in very different circumstances. This can be shown through an examination of several of the stated aims behind the kinds of rules we have already discussed.

With regards to the primacy of consultation ethics, the frequent references in both *Medical Ethics* and the *Code* to courteous behaviour with regards to ones colleagues and injunctions to refrain from ‘rivalship’, ‘jealousy’ and ‘meddling enquiries’ can be seen to serve a twofold purpose. First of all, they are essential in encouraging doctors to engage in consultation in the first place. The importance both works place on consultation as an essential element of ‘good medicine’ (both in specific instances and in order to share knowledge and best practice in general) has already been noted. For an individual practitioner still reliant in many cases on his reputation to earn a living, it is not difficult to see the value of some guarantee that one’s skills would not be publicly called into question in cases where the assistance of a more experienced colleague was required. Secondly, there is the question of maintaining confidence in the medical profession as a whole. We have already mentioned parallels with the status of Hippocratic medicine in antiquity; again, the need to ensure patients’ continued faith in scientific medicine here has a deeper ethical dimension. Loss of such faith could lead to patients seeking out non-professional practitioners, something that members of the medical establishment would have felt detrimental to their welfare.

This dual concern for the immediate welfare of the individual patient and for the wider need to both advance medical science and ‘win patients over’ to it can be seen in other aspects of consultation ethics. That discussions as to possible diagnoses or courses of treatment are to be held away from patients is explicitly identified with the former by Percival in terms (‘misapprehension may magnify real evils, or create imaginary ones’⁶⁰) which echo the ancient Greeks’ understanding that confidence in one’s doctor is itself an important element of medical care. The *Code*, in noting why discussions of theory should be avoided, seems to give examples of both concerns. First of all, it is noted that such discussions may delay effective treatment; secondly,

they may in any case be redundant in terms of bringing about a successful resolution since ‘experience and observation’ are as important as ‘hypothesis’ in determining a course of treatment⁶¹. When, regardless of apparent differences in theory, an effective treatment can be decided upon it is not difficult to see (as de Zerbi had noted) how the layperson may come to the conclusion that doctors do not understand what they are doing.

The rules governing relationships with other practitioners may also share these underlying concerns. That, in Britain, the GMC was not allowed to endorse a particular theory of medicine does not mean that such an endorsement was not necessary. This is not to imply that all alternative practitioners were charlatans: it is unlikely that homeopaths, for example, agreed with the BMA’s judgement of their ‘uselessness’⁶². Nor does it mean that all such remedies were *immediately* harmful. For example, during an outbreak of cholera in London in 1854, patients at the London Homeopathic Hospital had a survival rate nearly 40% higher than those at the Middlesex Hospital nearby⁶³. As scientific medicine advanced, however, it was able to grow in effectiveness where homeopathy, tied to mistaken premises, was not. This growth did not only take the form of new treatments: a great number of the deaths at the Middlesex Hospital are likely to have been due to poor hospital hygiene and/or poor initial health amongst impoverished patients who could not afford expensive (if specious) homeopathic remedies⁶⁴. The eventual recognition of the importance of both immediate and social environment to patient health (for example with regards to cholera) was made possible by scientific medicine, not homeopathy, which made no contribution to the growing understanding of the causes of disease throughout the 19th Century⁶⁵.

In addition, were traditional medical ethics motivated by any self-interest on behalf of the profession it would be difficult to account for those cases where work with individuals other than physicians and surgeons *was* recommended, or even required. Percival, to take one example, devotes a whole chapter to the subject of dealing with Apothecaries, in which he is quick to emphasise their importance to patient welfare, and to raise the importance of consulting with them to the level of a ‘moral duty’ (on the grounds, it should be noted, that ‘when health or life are at stake’ expediency becomes such). The injunction to consult with Apothecaries is a result of both their

close relationship with many patients (which makes them ‘in almost every instance the precursor of the Physician’) and their own level of professional skill and its relation to successful diagnosis and treatment: ‘on the knowledge, skill and fidelity of the Apothecary depend in a very considerable degree the reputation, the success and the usefulness of the physician’⁶⁶. There seems to be little question of professional jealousy here. Rather, it was ethical to associate with and even endorse certain kinds of practitioner (and unethical to associate with others) because their work was conducive to the health of the patient.

The response of the Central Ethical Committee (though, as noted, unpopular) can also be seen as a necessary response to a void left by legislation. Rules concerning interference and the Central Ethics Committee’s actions in ostracising those who took up disputed positions can also be seen to have a bearing on the wider needs of the profession as a whole. For it should not be forgotten that, for the profession to continue in existence, doctors had to be able to make a living. Although (in the Western world at least) it has become customary to think of doctors as well-off financially, it should be remembered that this was not always the case. In the 17th Century, it was not unknown for learned doctors to die in debtors’ prisons having failed to attract and/or retain patients⁶⁷ and Cabot, writing in the early 20th Century, still saw fit to warn his audience that while he had ‘known few physicians fail to get a living in medicine... the number who make comfortable incomes is equally few’⁶⁸. Under such circumstances, the *Code*’s injunction for wealthy physicians not to deprive more junior colleagues of income by offering free advice to their social peers⁶⁹ or the BMA’s concern that wealthy patients could avoid paying fees by joining mutual-aid ‘Friendly Societies’⁷⁰ can be seen as having vital importance to the preservation of organised medicine itself.

In a similar vein, rules designed to protect the reputation of the medical profession can be seen as necessary to protect continued confidence in medicine as a whole, rather than the more singular interests of individual doctors. It is true that when Cabot brought to public attention high error rates in diagnosis at the Massachusetts General Hospital by comparing the pathological findings of autopsies with clinical judgements made before the patients’ deaths⁷¹, his actions were regarded as a betrayal by many of his peers⁷², but it is also true that this does not necessarily reflect a desire to privilege

the standing of the doctor over the needs of the patient; indeed, any such desire is noticeably absent from the works we have discussed. When offering various injunctions against interference in the cases of another, Percival makes quite clear that this does not extend to tolerating negligence or incompetence: on the contrary, in such cases the physician should 'justly regard interference as his duty'. That Percival recommends for the 'interfering' party to begin by consulting the patient's present doctor seems more a question of caution than anything else⁷³. The potential in such cases for causing undue distress to the patient and their family, or undue damage to the reputation of an individual colleague or the profession as a whole is plain to see.

That establishing professional medicine on a sure footing has important moral implications can also be illustrated by returning to the criticisms offered by Cabot and Leake. The latter, as we have seen, proposed a new way for educating doctors in ethical matters; the former insisted on establishing standards of clinical competence. In some cases, their ideas are based on evidence and advances not available to Percival or the founders of the AMA: Cabot's work, for example, was based on advances in statistical analysis unknown at the start of the 19th Century⁷⁴. More often, they depend for their implementation on the state of affairs that professional ethics made possible. It is worth asking where Cabot's statistics would have come from, and where and from whom Leake's doctors would receive their education, in the absence of a professional medical establishment and/or a cohesive, effective medical science. Certainly implementing such ideas would not have been possible given the state of medical knowledge and organisation in the late 18th Century. It is also worth asking what the point of such an establishment would be if its members were unable to make a living, or content to allow or encourage their patients to see their work as no more effective than that of homeopaths, witch-doctors or faith healers.

Conclusions

Medical Ethics, the *Code* and the work of bodies such as the Central Ethical Committee shaped medicine and medical ethics in accordance with the social and scientific status of medicine at the time; in their concern with epistemology, practical competence and the social and professional structures required to develop these they can also be seen as a revival (or, perhaps, culmination) of the primary aims of the

Hippocratic tradition as described in Chapter 3. This is not to say that professional medical ethics was a complete success, that the 19th Century profession was universally to be admired, or that the achievement of these aims should be regarded as the completion of medical ethics as a whole. As Cabot's work demonstrated, even advances in such apparently unconnected fields as statistics could bring fresh moral challenges for the nascent medical profession. Over the 20th Century, pressure from both social changes outside medicine and, in some respects, the very success of scientific medicine itself would pose further questions, and it is to an examination of such challenges that our attention will now turn.

¹ Porter, R. *The Greatest Benefit to Mankind* p.292

² Percival, T. *Medical Ethics* Available at <http://books.google.co.uk/books> [first retrieved 08 February 2008] p.21

³ Ibid. p.27

⁴ Ibid. p.47

⁵ Jonsen, A.R. p.7

⁶ American Medical Association *Original Code of Medical Ethics* Available at <http://www.ama-assn.org> [first retrieved 08 May 2008] p.89

⁷ Morrice, A.A.G. 'Honour and Interests' p.20

⁸ Ibid. p.18

⁹ Percival, T. *Medical Ethics* p.51

¹⁰ American Medical Association *Original Code of Medical Ethics* p.94

¹¹ Percival, T. *Medical Ethics* p.51

¹² Ibid. p.54

¹³ American Medical Association *Original Code of Medical Ethics* p.101

¹⁴ Ibid. p.100

¹⁵ Percival, T. *Medical Ethics* pp.51-2

¹⁶ American Medical Association *Original Code of Medical Ethics* p.100

¹⁷ Percival, T. *Medical Ethics* pp.36-7

¹⁸ Ibid. p.37

¹⁹ American Medical Association *Original Code of Medical Ethics* p.100

²⁰ Percival, T. *Medical Ethics* p.29

²¹ American Medical Association *Original Code of Medical Ethics* p.100

²² Ibid. p.100

²³ Percival, T. *Medical Ethics* p.53

²⁴ Ibid. p.49

²⁵ American Medical Association *Original Code of Medical Ethics* p.102

²⁶ Ibid. p.103

²⁷ Ibid. p.96

²⁸ Ibid. p.103

²⁹ Ibid. pps.102-3

³⁰ Percival, T. *Medical Ethics* p.32

³¹ Ibid. pp.50-1

³² Ibid. p.7

³³ American Medical Association *Original Code of Medical Ethics* pp.99-100

³⁴ Jonsen, A.R. *The Birth of Bioethics* p.7

³⁵ Morrice, A.A.G. 'Honour and Interests' p.23

³⁶ Ibid. p.17

³⁷ Ibid. p.17

³⁸ Ibid. p.16

³⁹ Ibid. p.21

⁴⁰ Ibid. p.17

⁴¹ Ibid. p.28

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- ⁴² Ibid. p.27
⁴³ Ibid. pp.23-4
⁴⁴ Ibid. p.23
⁴⁵ Ibid. p.21
⁴⁶ Jonsen, A.R. *The Birth of Bioethics* p.8
⁴⁷ Burns, C.R. 'Richard Clarke Cabot (1868-1939) and Reformation in American Medical Ethics' in *Bulletin of the History of Medicine* 1977; 51 (3) 353-368 p.357
⁴⁸ Jonsen, A.R. *The Birth of Bioethics* p.9
⁴⁹ Ibid.p.9
⁵⁰ Ibid. p.8
⁵¹ Ibid. p.10
⁵² Ibid. p.9
⁵³ Leake, C.D. *Percival's Medical Ethics* (Baltimore: Williams and Wilkins, 1927) p.18 in *ibid.* p.9
⁵⁴ Ibid. p.9
⁵⁵ Leake, C.D. *Percival's Medical Ethics* p.18 in *ibid.*p.9
⁵⁶ Ibid. pp.10-11
⁵⁷ Morrice, A.A.G. 'Honour and Interests' p.13
⁵⁸ Percival, T. *Medical Ethics* p.26
⁵⁹ Ibid. p.27
⁶⁰ Ibid. ps.28-9
⁶¹ American Medical Association *Original Code of Medical Ethics* p.101
⁶² Morrice, A.A.G. 'Honour and Interests' p.23
⁶³ Singh, S. and Ernst, E. *Trick or Treatment: Alternative Medicine on Trial* (London: Corgi, 2009) p.133
⁶⁴ Ibid.p.134
⁶⁵ Ibid. pp.139-40
⁶⁶ Percival, T. *Medical Ethics* pp.69-70
⁶⁷ French, R. *Medicine Before Science* p. 198
⁶⁸ Cabot, R.C. *Training and Rewards of the Physician* (Philadelphia: J.P. Lippincott Company, 1918) p.136 in Jonsen, A.R. *The Birth of Bioethics* p.10
⁶⁹ American Medical Association *Original Code of Medical Ethics* p.104
⁷⁰ Morrice, A.A.G. 'Honour and Interests' p.17
⁷¹ Burns, C.R. 'Richard Clarke Cabot (1868-1939) and Reformation in American Medical Ethics' p.358
⁷² Jonsen, A.R. *The Birth of Bioethics* p.9
⁷³ Percival, T. *Medical Ethics* pps.49-50
⁷⁴ Jonsen, A.R. *The Birth of Bioethics* pp.8-9

Part Two:
Medical Ethics in the 20th Century

Chapter 6: New Medicine, New Ethics? The Changing Face of Medicine and Medical Ethics in the 20th Century

In the preceding chapters, we established that initial moral concerns regarding medicine ultimately derive from questions regarding practical competence. Prior to the 19th Century, there had been three main obstacles to overcome in addressing these concerns and establishing an effective medicine. Firstly, there was the lack of scientific knowledge with regards to the causes and nature of disease. Secondly was the general absence of any centralised regulation (state-sanctioned or otherwise) of doctors' abilities and conduct and/or structures for the systematic dissemination and enlargement of knowledge. Finally, there was the preponderance of superstitious or (increasingly) pseudoscientific alternatives allowed to compete with 'scientific' or professional medicine on a more or less level footing. As we have seen, by the end of the 19th Century, the cohesion provided by bodies such as the BMA and AMA had begun to address all of these concerns. Whether, once these goals had been achieved, doctors would face other moral challenges seems not to have been considered (we may consider Dewey and Leake as possible exceptions to this). By the 1960s, however, it was becoming increasingly clear that social changes and the rapid advance of the science of medicine *were* raising difficult moral questions for which 'professional ethics' had no clear answers.

The following chapter will seek to examine five different ways in which the creation of a medical establishment, effective medical science and changing social conditions presented fresh moral concerns for medical ethics in the mid-20th Century. Firstly, we will consider the effect of advances in scientific medicine on traditional conceptions of health and the 'good' of the patient. We will then move on to consider two important elements of scientific medicine in particular: the use of human trials for experimentation, and the effect of the increasingly scientific nature of medicine on conceptions of the doctor-patient relationship. Following that, we will consider one further important area of social change: the emerging social and political debate as to how an increasingly expensive scientifically-based system of healthcare should be provided and paid for. Finally, we will examine perceptions of the doctor as a paternalistic or coercive figure and the growth of the 'patients' rights' movement. In doing so, we will hope to achieve three aims: to illuminate the key questions with

which mid-20th Century medical ethics was faced, to explore the ways in which these questions reflect an ongoing response to underlying concerns, and to consider why traditional medical ethics found them so difficult to cope with.

Moral Concerns Regarding Advances in Medical Knowledge and Life-Sustaining Treatments

At the time Percival was writing *Medical Ethics*, the pathology of disease was still far from understood; over the course of the 18th and 19th Centuries, however, rapid advances were being made. In 1750, techniques were established for mass inoculation against smallpox with cowpox (the effect had been popularly known for some time prior to this), laying the groundwork for widespread vaccination programs¹. In post-revolutionary France, the study of particular tissues began to supersede that of the organs in importance; at the same time, increasing study of the body post-mortem provided an impetus towards explaining internal disease, leading to the invention of the stethoscope². In Germany, advances in lens-making technology enabled the development of cell theory, which was applied to a range of biological and medical fields such as embryology³. Similar technical progress allowed for greater accuracy in monitoring patients' physical states and importance began to be accorded to comparing the effects of disease on such states with 'normal function'⁴. Study of the pharmacopeia was brought into the scientific sphere, allowing for advances in the effectiveness of drug treatment⁵. Chloroform and cocaine were developed for general and local anaesthesia during surgery⁶. Beginning with Semmelweiss in Austria⁷ and continuing with Lister in Scotland⁸, recognition of the importance of hygiene in preventing the transmission of disease started to reduce the rate of post-operative and obstetric infections (although at first it was believed that dirt or 'putrid matter' itself was the problem, rather than any pathological agent⁹, a position maintained by some doctors well into the 1880s¹⁰).

In the wake of such dramatic and rapid successes throughout the 19th Century there came to exist 'a virtually utopian belief' in the possibilities of applying scientific discoveries to medicine¹¹. As the 20th Century passed its halfway point, there seemed little reason to doubt such optimism and the 1950s 'revelled in the progress of medicine'. The Second World War had 'spurred [an] effort to improve military

medicine', an effort which had 'spilled over' into peacetime. In the twenty years from 1945 to 1965 the advances for the doctor were the most dramatic yet: streptomycin was introduced to treat tuberculosis; penicillin had been synthesised and its use in treating infections became more widespread; and other drugs were developed for a wide range of physical and mental health problems. These were paralleled by the development of new surgical techniques such as open-heart surgery and organ transplantation, and new technologies such as the cardiac pacemaker and haemodialysis. Vaccines were developed for illnesses such as polio, raising the possibility that infectious disease could be wiped out altogether¹². Yet beneath this widespread confidence lay growing concerns.

As we saw in Chapter 1, from the Egyptians onward healers had always recognised in their prognoses the existence of certain diseases which simply could not be treated and accepted this as a part of their duties. As scientific medicine progressed throughout the 19th Century, attitudes began to shift: death was no longer 'seen... as the Hippocratic taught, [as] a natural terminus' but as the *failure* of life¹³. Medicine became a struggle against death and, in the utopian climate of the day, a struggle that it seemed might some day be won. Yet as Plato's Socrates had noted with regards to Herodotus, the very efforts involved in an attempt to prevail in such a struggle may mean that it is not one *worth* winning. The populist writer M. Scott Peck recounts how, in 1965, as a junior doctor at a San Francisco hospital, he became responsible for the care of an Air Force sergeant who had developed an inoperable brain tumour. The man's condition had deteriorated rapidly to the point at which he had passed into a coma and been placed on a respirator. As the tumour began to affect the part of his brain controlling blood pressure, Peck had, in line with accepted practice, resuscitated him. The patient's life was saved (an act of which Peck's supervisor approved) but to no apparent end: he did not regain consciousness and his body began to rot.

Since the patient was not 'dead', Peck was not permitted to cease administering treatment or life support. Privately, and against the express instructions of his Chief of Medicine, he nevertheless ended the patient's life by twisting the line intravenously supplying him with fluids. In doing so he defied both accepted practice and the instructions of a superior; yet he also felt he was 'halting an abomination'¹⁴. His dilemma was not unique. Jonsen, in describing one of the encounters that drew him to

be involved in medical ethics, offers another example. In 1967, a colleague offered to show him a 'real ethical problem' and introduced him to certain haemodialysis patients who wished to be allowed to 'turn off the machine' and die. Nothing in this colleague's medical education had prepared him for such a dilemma. Would the patients' actions be suicide? Would he, as a physician, be considered an accomplice¹⁵? The established medical profession, as with many of the issues we will examine in this chapter, was accustomed to keeping discussion of such matters 'in house'¹⁶. Throughout the 1960s, however, it was becoming increasingly apparent that medical advances were leading to doctors being placed in situations where the obligation to prolong life enshrined in both professional ethics and the law could seem inhumane, and that this was placing a great strain on both doctors and their patients.

Moral Concerns Regarding Human Experimentation

As we have already seen in Chapter 1, moral problems associated with subjecting patients to untried and possibly harmful practices had been recognised since before the naturalistic turn in Greek medicine. From antiquity onwards the incomplete state of medical knowledge also meant that it was sometimes difficult to distinguish medicine from experimentation. The Hippocratic tradition had established that '[the] untried and the unusual always had to be placed within a therapeutic attempt' (that is, experimentation was only to be pursued in the context of a course of treatment, preferably where other methods had proved ineffective). In the Middle Ages, both Avicenna and Maimonides advanced a similar position and cautioned against the use of patients as a 'mere means for learning'¹⁷. Additionally, whilst there is evidence that certain individuals may have pursued non-therapeutic research at certain times (under the Ptolemies, Alexandrian physicians were 'permitted... to perform vivisection on criminals') the medical value of such experimentation was also a matter of debate. Galen, for example, maintained that experimentation on human subjects was not only unethical due to the risks involved but of little value 'because the precise cause of [effects] cannot be isolated with certainty'¹⁸.

With the growth of scientific medicine from the 18th Century onwards, however, the use of human subjects to test potentially dangerous techniques became more common. King George II, whilst still Prince of Wales, only had his daughters inoculated against

smallpox following ‘[experiments]... with condemned felons’¹⁹; later in the century, Queen Caroline, wife of George IV had the vaccination ‘tested’ on orphan children before allowing it to be given to her own²⁰ (Queen Victoria, by contrast, took a more personal lead with her use of chloroform during childbirth in 1853²¹). The use of condemned felons or terminally ill patients for the testing of new cures or to observe the effects of parasites or infections became more widespread in the 19th Century. The French physiologist Claude Bernard approvingly notes an experiment in which a condemned woman was, without her knowledge, given worm larvae to swallow in order to see if they would develop in her intestines post mortem. His justification for this (that it would cause the woman no additional harm given her impending execution) may well have been true (although it was perhaps fortunate for her doctor that the woman was not granted clemency at the last minute). As Jonsen notes, however, such an attitude represents a significant shift away from a conception of the doctor as acting only in the individual patient’s interests: the worms may not have been in a position to cause harm, but they were of no possible *benefit* to the woman herself²².

Such activities were not uncontroversial within the profession. By the early 20th Century the Russian doctor V.V. Smidovich felt compelled to pseudonymously attack 19th Century practices including deliberately infecting patients (some hopelessly ill, others merely chronically so or ‘unfortunate enough to find themselves confined to a medical institution’) with biological agents relating to gonorrhoea and syphilis. Yet later, successful, experiments in determining the cause of yellow fever carried out in Cuba seemed to prove the value of non-therapeutic research. The American doctor William Osler, who wrote defending the practice, justified such experiments before both Congress in the United States and a Royal Commission in Britain by citing the consent given by the healthy test subjects, which he viewed as the chief moral issue at stake²³. Other doctors emphasised the importance of obtaining consent even in therapeutic research, especially where the treatment might prove painful or distressing: the pioneering American gynaecologist J Marion Sims insisted on obtaining it not only from slave-owners but from slave women themselves when developing invasive and painful techniques for curing a particular urinary problem²⁴. The first steps towards enshrining this importance in law were taken in Germany, where from 1900 research was only permitted in cases where the test subject had

given consent based on a thorough understanding of the risks involved in the experiment²⁵.

As Jonsen notes, history has rendered this development grimly ironic²⁶. The Nazi death camps of the Second World War numbered among their myriad horrors a whole catalogue of 'research experiments' carried out on unwilling subjects. Some of these were driven by an effort to improve military medicine: '[camp] doctors used inmates to study the effects of mustard gas, gangrene, freezing, and typhus... [children] were injected with petrol, frozen to death, drowned or simply slain for dissection purposes'²⁷. Others bore a eugenic stamp or reflected doctors' own interests. Josef Mengele, for example, carried out a range of experiments on twins: he 'performed cross-transfusions... [and] used his twin collection for comparative studies, infecting one child and then killing both for autopsy'. He also made his own 'artificial' conjoined twins²⁸. When the doctors involved in the Nazi camps were brought to trial at Nuremberg in 1947, charges were brought under 'standards that their prosecutors had devised precisely to try them'. Whilst such *ex post facto* standards are usually considered 'a legal impropriety' it was felt that they were justified in this case as an expression of 'moral imperatives that should be known to all civilised humans'²⁹. These imperatives were collected into the *Nuremberg Code* with the intention of governing all future human research:

Nuremberg Code:

1. The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the

experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonable to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment. The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.

2. The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.

3. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study that the anticipated results will justify the performance of the experiment.

4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.

5. No experiment should be conducted where there is a prior reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.

6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.

7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.

8. The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.
9. During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.
10. During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill and careful judgment required of him that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.³⁰

The *Nuremberg Code* was largely formulated by a medical man, Dr. Andrew C. Ivy, who believed that the principles it embodied represented what had long been established through the tradition of professional ethics (although, unlike many others, he was not entirely confident that these were widely known or reflected on³¹). It is certainly worth noting that the profession identified a distinction not made in the *Nuremberg Code* when, in 1964, the World Medical Association's Helsinki Declaration distinguished between research that is expected to benefit a patient ('clinical research') and research that is not ('nonclinical research')³². Given the almost unspeakably vile nature of wartime atrocities, it was perhaps a comfort to think that they were an aberration, a temporary blip caused by a tragic lapse in professional rectitude. And perhaps they were, if only in terms of the sheer gory horror of their extent. However, it was soon to be apparent that they were not as atypical as the medical establishment may have liked to think.

Germany had not been alone in carrying out experiments in biological warfare during the Second World War. Japan carried out research on prisoners of war at Pingfan in Manchuria to test the effectiveness of biological weapons³³; The United States,

working on the assumption that Nazi Germany would develop such weapons, had manufactured anthrax and botulin bombs; and Great Britain carried out military testing of anthrax in both Scotland and Dorset³⁴. During the Cold War, under the looming prospect of having to deal with the consequences of a nuclear exchange³⁵, members of the United States armed forces were subjected to secret radiation tests. As Porter argues, it is possible that the physicians involved believed they were acting in highly exceptional circumstances³⁶. Jonsen notes that the use of unwitting subjects may even have been the result of administrative error: in a grim irony, a declaration from the Secretary of Defence stating that such trials should be subjected to the *Nuremberg Code* remained classified as Top Secret until 1975, long after the tests had finished³⁷. What he fails to acknowledge is the damage this does to the widespread contention that the *Code* merely expressed what the 'good' doctor already knew³⁸: were this the case, such an error would have been merely a humorous irrelevance as those involved would presumably, whether guided by their own consciences or professional ethics, have followed the protocols anyway.

If such experiments can be excused as having taken place under the shadow of the atomic bomb (and it is by no means certain that this is the case) others were even harder to justify. The infamous Tuskegee Experiment, in which 600 black men from the eponymous town in Alabama who had been diagnosed with syphilis were unwillingly used as guinea-pigs to observe the effect of the disease was one. 400 of the subjects were left untreated (the remaining subjects formed the control group). All were instructed, on false premises, to report for periodic medical examination. Begun in 1932, the study was not shut down until forty years later, following revelations in *The New York Times*, and long after effective treatment had become available in the form of penicillin. There was an obvious racial element to the experiment, but perhaps more damning for the medical profession as a whole was that it 'had not been kept a secret within the Public Health Service nor within the wider scientific and medical community, since many articles reporting its data were published'. It was not until 1966 that a Public Health Service employee began pressing for attention to be paid to the moral aspects of the study. Even then, his efforts were initially ignored: when the Service *did* finally examine the case, they did not find it problematic³⁹.

In cases where the likely harm to patients was minimal and effective therapies were produced, the medical profession as a whole appears to have been divided as to the relevance of consent, especially in cases where the patient was incapable of giving it. In researching a vaccine for infectious hepatitis, two doctors deliberately infected handicapped children admitted to New York's Willowbrook State Hospital. Under the Helsinki declaration, hospitals had the power to give consent on behalf of 'incompetents', but how far this consent allowed for them to place patients at risk had not been defined. The test subjects were not in significant danger: in children the illness 'is a mild, flu-like condition... [besides,] almost all children eventually contracted hepatitis in... the institution and... the induced infection would subsequently immunise them'. Although the doctors were able to synthesise a vaccine, when their work was published in 1958 the result was public outcry and they were equated with Nazis. Though the *Journal of the American Medical Association* defended them, correspondents to and the editors of the British journal *The Lancet* were strongly critical⁴⁰.

Though the profession largely remained wary of outside regulation of research⁴¹, it was becoming apparent that the moral issues involved were too complex to be left to the investigator alone. Some doctors began to express concerns that work as a researcher was incompatible with the traditional role of the doctor as healer. The German doctor Otto Guttentag, who had emigrated to the United States in 1935 and returned with the American Army following the Second World War, had noted that in the case of research the traditional physician-patient relationship had been fundamentally altered. He drew a distinction between the traditional concept of 'physician-friend' and the emerging 'physician-researcher', which, though influential amongst some medical researchers, was not translated into regulation⁴². Moreover, it was not only with regards to research that some doctors and patients began to wonder if a key part of the medical profession's ethos was being lost.

Moral Concerns Regarding Advances in Medical Technology and Changing Perceptions of the Doctor

As we saw with regards to Avicenna and Maimonides' thoughts on experimental treatments, the fear that doctors could become concerned more with medicine as an

academic science than with medicine as the care of individual patients was not new to the 20th Century. Nevertheless, the 'utopian' view of medicine as a 'miracle of science' owed much to advances, not only in the biological sciences, but also in medical technology (better quality lenses for microscopes are one example we have already encountered). There was, of course much more to medical science than this: John Snow's epidemiological work on cholera in 1854 (which had shown that the disease spread through contaminated water) highlighted the impact of environment on public health and prompted the British government to address the squalid, poverty-stricken environment of the industrialised urban poor through 'massive improvements in drainage and sewerage'⁴³. Yet such works, however impressive as feats of engineering, were not noticeably medical in character and as such it is hardly surprising that, as Blume has argued, more eye-catching devices such as the X-Ray machine (introduced in 1896) inspired the public to think of medicine as miraculous and technological rather than a matter of 'hygiene and social improvement'⁴⁴.

To begin with, the X-Ray had not been thought of as a primarily medical device, although surgeons with suitable cases (a needle lodged in a patient's hand or foot, for example) would sometimes seek out those in possession of X-Ray machines⁴⁵. Its acceptance as a medical technology was driven in part by manufacturers seeking to market the practical applications of technology⁴⁶ and in part by the experience of its utility by army doctors in the trenches of the First World War⁴⁷. The profession was initially resistant to the idea of doctors specialising in the use of X-Ray technology: in the United States, the 'roentgenologist' was seldom a trained medical professional and although 'in the larger [British] hospitals, a medical man was in charge of X-Ray work' they were typically regarded as a technician and not accepted as a consultant. As Blume suggests, it is possible that doctors felt such advances called into question their clinical judgement⁴⁸. By the mid-20th Century, however, further developments such as the electrocardiogram (a prototype of which was loaned to the eminent London cardiologist Sir Thomas Lewis⁴⁹) shifted medicine further toward the technical and technological.

The 'technological successes of the Second World War'⁵⁰ and the search for 'new applications... for the technical and scientific skills [that had been] developed'⁵¹ during it accelerated this process. In some cases the utopian spirit of the 19th Century

lingered on: in the 1950s, the chairman of the Radio Corporation of America speculated excitedly on the prospect of building miniaturised electronic organs and publicly declared that the creation of a 'bionic man' living on with several artificial parts was no longer a remote possibility⁵². But this optimism was not universally shared: the 19th Century public had often viewed the medical profession with suspicion, sometimes regarding the doctor as a figure more concerned with himself than the patient. Public faith in the medical profession, already shaken by the discovery of Nazi experiments and about to be shaken further by the exposure of Tuskegee and Willowbrook, was coming to fear that the increasingly scientific and technical nature of medicine was making the doctor a cold and impersonal figure⁵³. As Porter notes, as 'doctors became therapeutically more potent, in large measure they ceased to give the patients what they wanted... they tended to forget the significance and benefit of the doctor-patient relationship'⁵⁴; in the United States there was growing disquiet at the possibility that the need for doctors trained in increasingly technical specialisations was to the detriment of general practice and that 'the family doctor was becoming extinct'⁵⁵. Moreover, as medical successes drove a change in disease patterns from acute to chronic conditions⁵⁶, it became apparent that these were much harder to treat; it seems unlikely that the haemodialysis patients encountered by Jonsen would regard the prospect of a 'bionic man' with any great enthusiasm.

Medicine was increasingly the subject of public unease, something we may illustrate by considering some fictional examples of the practitioners and 'beneficiaries' of technological medicine produced in the late 20th Century. First of all, one may think of the stereotypical 'Nazi doctor' such as the fictionalised version of Josef Mengele plotting to clone Adolf Hitler in *The Boys From Brazil*⁵⁷ or his close analogue Dr. Hans Glaub, creator of the blond-haired and blue-eyed 'Aryan superman' Max Zorin in the James Bond film *A View To A Kill*⁵⁸. Whilst this stereotype was undeniably linked to a wider association in the public mind between Nazi Germany and eugenics, it is also one that connects both Nazism and eugenics with a certain kind of medical thought and a certain kind of medical man. Such a doctor is a twisted inversion of the 'ideal physician': 'scientific' rather than 'humane', prepared to sacrifice the interests of the individual patient in pursuit of some 'higher' goal (we may note that other fictional Nazi medical men, for example the Auschwitz camp *dentist* who is the chief

antagonist of *Marathon Man*⁵⁹, share these latter traits whilst displaying no explicit attachment to eugenic ideals).

With regards to examples regarding the patient a few, for example the ‘bionic’ hero of the television series *The Six Million Dollar Man*, are positive⁶⁰ whilst others, such as the superhero Iron Man⁶¹ or the protagonist of the 1987 film *Robocop*, are satirical or ambivalent⁶². Many more, however, are negative or even terrifying. The villain of the *Star Wars* films, Darth Vader, wears a suit of armour that doubles as a walking life support machine. This alone is cited as a reason for the futility of appealing to any remaining traces of his moral sensibility: he is described as ‘more machine than man... twisted and evil’ as though the very measures taken to preserve his life have themselves robbed him of his humanity⁶³. The 1939 novel *Johnny Got His Gun* describes the nightmarish experience of a soldier kept alive by machines: a ‘new curiosity’ confined to his bed, unable to see, hear or communicate⁶⁴. The novel and its 1971 film adaptation formed the basis for the 1989 single and music video *One* by the American heavy metal group Metallica, sung from the soldier’s perspective as he tries to commit suicide by holding his breath⁶⁵. Both novel and song are often felt to represent an attack on the horrors of war; it may perhaps be more accurate to say they represent a fear of the horrors of medicine.

Moral Concerns Regarding Social and Economic Issues in the Provision of Healthcare

In the early part of the 20th Century, the organisation of medical services in Great Britain might charitably be described as haphazard. As Webster has noted, in the 1930s there existed ‘two rival hospital systems, the public sector and the voluntary hospitals’. The latter, numbering around 1,000 institutions, jealously guarded their independence and were only loosely associated with each other; the former, numbering around 3,000, were nominally governed by ‘hundreds of local authorities only remotely regulated by the health departments’⁶⁶. In the United States, by contrast, medicine had taken on the guise of a slickly-run private business. Individual practitioners ‘discovered the benefits of behaving like lawyers or businessmen, setting up offices in downtown medical buildings [and were] forward-looking in the use of secretaries’. Hospitals, meanwhile, which had been set up by ‘doctors [as well as]

religious, ethnic and other groups' were being transformed 'from refuges for the poor into institutions for all'. As Porter notes, the predominant attitude was one in which '[medicine] seemed good for business and business good for medicine'⁶⁷. Throughout the 20th Century medical, socio-historical and economic changes were to call both systems into question.

In Britain by the 1920s it had become apparent that '[in] comparison with many other advanced Western economies, including the white dominions, the UK's health services were falling behind, and these deficiencies showed up in the international league tables of health indices'⁶⁸. Worse, the chaotic state of healthcare provision resulted in 'dangerous lapses', such as that which contributed to an outbreak of typhoid in Croydon in 1937⁶⁹. Some medical experts began to argue for the central organisation of medicine, not only to remedy such problems but also to provide greater opportunities for training and consultation⁷⁰. This need became more urgent with the outbreak of war as government planners discovered that existing medical services were grossly inadequate to deal with the expected casualties. As a result, an Emergency Medical Service was established and with 'remarkable speed and efficiency' set about organising and reforming the whole structure of British medicine. A regional structure was set up which 'supervised the training and distribution of professional personnel [and] organised for the first time a regional blood transfusion service, a national public laboratory service and regional special facilities for... rehabilitation, fractures, plastic surgery, neurology and psychiatry'. The system met with such success that there were calls for it to be permanently transformed into a National Hospital Service⁷¹.

Pragmatic arguments for a national service based on clinical need and convenience were supplemented with political arguments based on concerns of social justice. In 1942, a Government report by civil servant Sir William Beveridge proposed as a post-war aim the creation of 'a new health service... available to everyone according to need, free at the point of service, without payment or insurance contributions'⁷². Beveridge's proposal faced opposition on political grounds⁷³ and from some sectors of the medical profession (doctors had already proved antagonistic to National Insurance, fearing that it would reduce their status to that of 'petty civil servants'⁷⁴, a fear now shared by workers in the voluntary sector⁷⁵). Though enjoying widespread

support amongst the public and securing the cautious backing of even the right-wing press⁷⁶, skilful negotiation was required to put plans for a National Health Service into action. The voluntary sector was mollified by the service's national character and 'relieved to have escaped control by local government'⁷⁷. The BMA were brought round when concessions were granted in terms of increased compensation and the ruling out of salaried service⁷⁸. Although the cost of the Health Service was far in excess of projected figures, it remained 'by international standards, exceptionally cheap'⁷⁹.

This last point highlights another factor that played a part in a trend throughout the West towards some form of social provision of healthcare: medicine was becoming increasingly costly. The governments of France and West Germany, in adopting state control of medical development in the 1960s and 1970s respectively, were prompted at least in part by 'skyrocketing' levels of medical expenditure⁸⁰. As Jonsen has noted, ongoing technical and scientific advances, whilst providing exciting possibilities for treatment, were largely reliant on ever-more expensive technology and drugs⁸¹. The changes to the structure of medicine demanded by its increasingly technical and scientific nature also contributed: one of the reasons that increased specialisation is attractive to the practitioner is, as Porter has pointed out, the opportunity it affords for increased remuneration⁸² whilst the ever-increasing amount of space required for technological devices 'began to constrain the very architecture of the hospital'⁸³. Although attention had been paid to the matter of the doctor's fee since the Renaissance⁸⁴ and professional ethics had sought to a degree to insulate the doctor from economic pressures, these traditions were badly in need of revision.

The situation was somewhat different in the United States, which in contrast to the majority of Western governments, 'went its own way'. In the climate of an increasingly frosty Cold War, plans for Federal involvement in medicine mooted under the New Deal came to be regarded as unacceptably socialist. Furthermore, the AMA opposed them on grounds of efficiency, arguing that 'the best form of medical insurance' was not to provide 'socialised' medicine but to make government funding available for research⁸⁵. The AMA's position served to worsen further the popular perception of doctors, now seen as 'uncaring, greedy and self-interested'⁸⁶. Moreover, professional and political arguments against socialised medicine and in favour of

alternative investment in research did not match up to economic reality. As a result ‘the [Federal] Government became committed to shouldering a growing proportion of health care’⁸⁷ through state-sponsored assistance for medical programs and insurance. The limited nature of these programs meant they were unable to exercise monopoly powers to drive down costs; instead, these escalated further, with healthcare becoming ‘one of the major growth industries in America’⁸⁸. To the increasingly common question ‘Who shall live? Who shall die?’ was added a further dilemma: ‘Who shall *pay?*’.

Moral Concerns Regarding Medical Paternalism

Morrice has argued that an emphasis on patient autonomy in late 20th Century medical ethics is a direct consequence of the legal monopoly that the professional doctor established over medicine in the 19th⁸⁹. This is something of an oversimplification: whilst wealth and/or social standing had always allowed certain patients who did not like the treatments prescribed them to simply take their business elsewhere, a lack of either could result in patients being dictated to. Percival, for example, noted that a greater degree of authority could be exercised over poor patients in charity hospitals than was practical when attending the wealthy in general practice⁹⁰. It is probably more accurate to say that, as medicine changed over the course of the 19th and 20th Centuries, so the *kinds* of issue regarding patient autonomy that it presented changed with them or at least (as for example with regards to obtaining informed consent in experimentation) became more frequent. Whilst the greater social and legal authority afforded the doctor were probably a part of this, change in patients’ perceptions of medicine, of doctors and of themselves may be seen to have played the more decisive role.

Although, as we saw in the previous chapter, the early-20th Century public did not always have the highest opinion of the medical profession, patients had nevertheless on the whole been happy to trust that their doctors ‘knew best’ and acquiesce to their wishes⁹¹. By the mid-20th Century, however, this trust had been significantly eroded. In part, this may have been the result of wider social change: as Grodin has noted, the decades following the Second World War were marked by better education, the growth of mass movements demanding a variety of individual rights (be they civil,

womens', consumers' or disabled), leading eventually to 'a decline in shared communal values and a general distrust of authority and institutions'⁹². However, it is also the case that doctors' own behaviour both during this period and (especially) in the decades leading up to the War had done little to help. The 'Nazi doctor' stereotype discussed above was not, after all, entirely the product of writers' imaginations: it had its real-world counterparts (the *actual* Dr. Josef Mengele being one example). Furthermore, the Tuskegee Experiment and others like it had further emphasised that doctors could not always be relied upon to police themselves.

The complicity of doctors in some American states' eugenic sterilisation programs from 1907 onwards had also shown that doctors were far from infallible in deciding what was best for their patients. Although these programs were primarily targeted at the mentally ill, many of whom may rightly have been considered incompetent to determine what treatment was in their best interests, in California mental patients were sterilised 'on their *release* from the asylum [my emphasis]' at which point many were presumably considered capable enough of making their own decisions, whilst in Indiana the program extended to include criminals. It was also clear that supposedly 'clinical' decisions had been tainted by doctors' own prejudices. Foreign-born citizens were both more likely 'to be admitted to state mental institutions and to be sterilised once there': in California in 1930 around one-fifth of the population had been born outside the United States, but this group accounted for around one-third of those sterilised⁹³. In Germany during the 1930s and 1940s the situation had, unsurprisingly, been even worse: 'in Kiel a girl who had cheated in school had been sterilised... zealots in Freiburg were going after 'moral defectives' as though they were psychopaths' and there were calls for the program to be extended to include diabetics⁹⁴.

The relationship between medicine and eugenics had never been a matter of straightforward acceptance: the *British Medical Journal* for example, maintained a 'consistent hostility to eugenics over a period of years'⁹⁵ whilst the BMA refused to endorse proposals legalising even *voluntary* sterilisation⁹⁶. Nevertheless, if one was, in the post-war era, to envision a society entrusted to medical science, recent history suggested it was likely to be eugenic and perhaps totalitarian (and, as we shall see in the subsequent chapter, if some scientists of the day had had their way, this would

indeed have been the likely outcome). This played into increasing concerns about the new and increasingly technological medicine: with improved life-support, clinical decisions as to what *could* be done to keep patients alive were beginning to pose moral questions as to whether or not such action *should* be taken. That doctors were unaccustomed to discussing such matters in public probably did not help, nor did the widespread view that the doctor was becoming an ever more remote figure. Economic pressures, too, played a part: in America especially, critics of ‘for-profit, free-market, fee-for-service medicine’ argued (correctly, as a 1974 Senate investigation would reveal) that ‘there were too many unnecessary procedures’⁹⁷. By the 1960s medicine was increasingly seen as ‘out of control... driven not by the patient’s health needs but by collective professional ambition, corporate financial pressures, and deluded imperatives – not least an itch to intervene’ (where such intervention was either unnecessary or counterproductive)⁹⁸. The result, in the mid- to late-20th Century, was the growth of a ‘powerful patients’ rights movement’⁹⁹.

The Limitations of Historical Traditions of Medical Ethics

It is possible to read the above examples as supporting the contention that the content of medical ethics has simply changed over time. On such a reading we would conclude that, where for the ancient doctor ‘medical ethics’ meant practising medicine in a certain way and upholding certain standards of behaviour for therapeutic reasons, and for the 18th and 19th Century doctor meant advancing medicine through the establishment of professional relationships and regulation, so for the 20th Century doctor ‘medical ethics’ became a matter of those ‘neglected’ areas identified by Beauchamp and Childress (to recap: ‘truthfulness, privacy, the distribution of health care resources, communal responsibility, the use of research subjects and the like’). Adopting such a reading does not necessarily mean agreeing that the ethical problems facing the 20th Century doctor *replaced* those facing his or her predecessors. It is perfectly possible to argue, as Jonsen does, that these new issues *supplemented* those that came before (so that, for example, for the 18th and 19th Century doctor ‘medical ethics’ meant practising medicine in a certain way, upholding certain standards of behaviour *and* establishing and maintaining professional relationships and regulation, and so on).

Our own account suggests a more complex picture. First of all, it is clear that these 'neglected' areas *had* been of concern to doctors prior to the 20th Century *insofar as they had encountered them*. In addition to examples mentioned above, in the case of research Percival had proscribed non-therapeutic investigation and instructed that such research as did take place should only be pursued after consultation with fellow professionals¹⁰⁰, whilst the AMA condemned early research into yellow fever that involved deliberately injecting patients with the disease¹⁰¹. Similarly, in terms of medical costs, both Percival¹⁰² and the AMA *Code*¹⁰³ devoted space to mentioning doctors' moral obligation to offer their services charitably to the poor. But it was not only the case that changing social and historical circumstances placed new moral problems before the doctor, for the doctor and his professional ethics were themselves *part* of those social and historical circumstances. In some respects the very success of Percival and those who followed him in reshaping medicine into a unified, scientific profession with a state-sanctioned monopoly over healing can be seen to have played a part in shaping the moral challenges facing their successors. For example, human experimentation had itself become a necessary part of medicine, giving rise to concerns such as Guttentag's regarding its effect on doctor/patient relationships; striving to keep patients alive could now (as in the case of the patients described to Jonsen by his colleague) itself raise new moral concerns.

Historical traditions of medical ethics can hardly be blamed for failing to anticipate these changes, but there is some evidence that a focus on the moral concerns already embodied in historical traditions and professional ethics left doctors unprepared for them. The involvement of doctors in debates regarding abortion is a case in point. By the 19th Century, English common law and state legislatures in the United States regarded most abortions carried out past the point of 'quickening' as criminal, sometimes with clauses excepting such cases where they were deemed necessary to save a woman's life¹⁰⁴. At this point the profession took society's lead: Percival also allowed that terminations were 'not always unlawful' but noted that 'when no moral or salutary end is in view [that is, the preservation of the mother's life] the simple act itself... falls under the denomination of murder'. For the doctor, the chief ethical concern was to ensure that any danger to the mother was properly diagnosed and that care was taken not to harm her given the 'drastic' quality of the procedure¹⁰⁵. The records of the Central Ethical Committee suggest that the medical profession in

Britain followed this early lead until well into the 20th Century. The BMA's members do not seem to have regarded it as a *medical* ethical issue at all: between 1902 and 1939 the Committee received only one enquiry regarding it¹⁰⁶.

Across the Atlantic the AMA did become involved, from 1859 onwards, in efforts to reform the abortion laws to criminalise non-therapeutic terminations from the moment of conception onwards. Again, however, they do not appear to have seen this as an ethical issue *per se*; as Percival had noted with his reference to 'the Father of Physic' (Hippocrates), any ethical question was regarded as long-settled by 'tradition'¹⁰⁷. The AMA saw themselves as simply bringing this injunction into line with current medical thinking, which had come to regard 'quickenings' as a mistaken throwback to outmoded medical concepts¹⁰⁸. Despite this, their stance clearly involved tacit moral claims. First of all, as Luker has argued, they were claiming 'that physicians [were] sufficiently trustworthy to be charged with the transcendent task of weighing the competing life-and-death rights of two parties'¹⁰⁹. Secondly, it discounts the possibility of any form of moral argument in favour of abortion that does not depend on the foetus not being alive from the moment of conception; contrary to the AMA's claims otherwise, prior to 1859 'women (and the general public) [already] knew that pregnancy was a continuous *biological* process... where they disagreed was upon the *moral* implications of such biological facts'¹¹⁰.

The position of American physicians served to obscure any debate as to these moral implications: Luker describes the period from the end of the 19th Century until the 1960s as 'the century of silence'¹¹¹ when 'abortion as a major social, political and ethical issue [disappeared] beneath the cloak of an emerging profession's claims'¹¹². For the most part, this appears to have gone unnoticed by doctors themselves: debates within the profession were framed, not in moral terms but, following Percival, as matters of 'technical competence'¹¹³ and, as we have already noted above, professional ethics discouraged such debates from being held in public. In practice, very few (if any) of the medical profession actually held to the strong moral claim with which the profession found itself allied, namely that the foetus be regarded from the moment of conception as a full human being, the logical consequence of which would be to render almost all therapeutic abortions morally impermissible. The definition of what constituted medical grounds for abortion enabled the medical

profession to incorporate two distinct views, perhaps deliberately so: the 'strict constructionist' view (that the foetus was a human being and its destruction was not permissible under any but the direst circumstances) and the 'broad' or 'liberal constructionist' view that the foetus had a limited right to life which nevertheless counted for less than the mother's¹¹⁴.

Luker finds it ironic that American doctors were in the forefront of both the movement to restrict abortion in the 19th Century and the movement towards greater liberalisation in the 20th¹¹⁵. In fact, their repositioning of the debate in this way stored up tensions which made this almost inevitable. In the 19th and early 20th Centuries, professional discretion and the limited nature of medicine (which meant that tuberculosis, cardiovascular or renal disease, and pernicious vomiting could be taken as physical indications for terminating pregnancy¹¹⁶) all allowed for a great deal of latitude in interpretation. As medical science progressed, however, these physical indicators ceased to be relevant due to advances in obstetrical and gynaecological medicine, with the result that by the mid-20th century proportionally more abortions were being performed for social or psychiatric reasons. In a situation in which very few abortions were medically necessary in the strict constructionist sense, divisions within the medical profession (which had been deeper than either side had supposed) began to emerge¹¹⁷.

Another argument in favour of regarding the decision to abort as solely a medical one had been that the procedure was, in general, medically dangerous¹¹⁸ and should not be performed by laypersons. This may not, in fact, have been true when it was first advanced: there is some evidence that medical abortions were in fact more likely to be lethal than those offered by other practitioners¹¹⁹. By the early 20th century, however, the 'back alley' abortionist was likely to be both 'disreputable and dangerous'¹²⁰ when compared to their medical counterpart. Historical studies of 1950s Yorkshire mining towns suggest that 'many female illnesses resulted from self-induced miscarriages'¹²¹. At the same time, financial pressures and the more secure social standing of the medical profession (which had made doctors more confident in turning down requests for terminations) led to an increase in the rate of 'criminal' abortion¹²². Many who favoured legal reform were able to argue that criminalising abortion 'killed women'¹²³. The broad constructionist, in asserting the primacy of the mother's own

health, could accept such an argument; the strict constructionist, committed to the view that abortion was murder, could not.

Unable to present a united front, the medical profession found it impossible to keep the debate 'in house'. Moreover, it was becoming difficult and in some cases burdensome to maintain the position that the only 'live' questions regarding abortion were clinical ones. There is evidence that some medical professionals no longer felt comfortable with the responsibility placed on them: Jonsen recounts a conversation with an exasperated psychiatrist charged with assessing the rights or wrongs of potential terminations, who felt he was being presented not with questions regarding patients' mental health but rather concerns about the emotional, social and economic problems faced by the women in question¹²⁴. As it became clear that 'tradition' had not settled the ethical questions so finally as had been thought, it was clear that some form of help from outside the profession was necessary. This help was not forthcoming from further scientific advances: at least one scientist of the period noted that, whilst advances in embryology made it possible to show the existence of gill slits and a tail on the early embryo, the question as to whether this constituted evidence that the foetus should or should not at this stage be considered 'human' did not seem to be a scientific one but rather a matter for the law or, perhaps, philosophy¹²⁵.

Conclusions

The advances made by medicine in the late 20th Century brought with them fresh moral challenges that may be summarised as follows. Firstly, advances in life-sustaining treatments prompted questions of whether it is always right for the doctor to strive to prolong life (from which may follow, depending on the answers, questions as to whether it is *ever* right for the doctor to intentionally hasten death). Secondly, the need for large-scale trials to validate experimental methods and treatments raised questions both as to how such research can be conducted ethically (especially given that it would in most cases involve some risk to the patient) and as to how the relationship between doctor and research subject(s) may alter or conflict with the more traditional relationship between doctor and patient(s). Thirdly are concerns as to whether the increasingly technological nature of medicine, and the limitations of this technology in dealing with chronic conditions, might in some way dehumanise both

doctor and patient. Fourthly, given the increasing cost of medicine, are questions of how limited resources are to be justly allocated and, perhaps, of who is to pay for a treatment where a patient cannot. Finally, there are questions as to how far a doctor's authority over his or her patient did, might or should extend.

It would be a mistake, however, to infer from the relative inability of historical traditions of medical ethics to deal with these problems that they had in some way 'failed' the 20th Century doctor or to conclude (with Leake) that they dealt merely with problems of 'etiquette'. As we have argued over the previous five chapters both the Hippocratic *Corpus* and the professional ethics of Percival and his successors dealt with issues relating to the doctor's conduct, practical competency, epistemology, professional organisation and social standing that were pressing moral concerns in the social and historical context in which they were produced: they were not and *were not intended to be* exhaustive moral theories. These traditions were, however, unhelpful in two important respects. Firstly, the success of professional, scientific medicine in tackling the moral problems faced by medicine in the past had encouraged doctors to think that they were primarily technical or organisational even as new, specifically moral, concerns were emerging. Secondly, they had encouraged doctors to keep discussions of such problems to themselves, something which put strain on doctors, patients and their relationship with each other. As we shall see over the course of the next two chapters, progress in addressing the problems identified in this chapter over the subsequent decades was to depend firstly, on doctors accepting that these problems existed and secondly, on accepting that those outside the profession could help.

¹ Porter, R. *The Greatest Benefit to Mankind* pp.275-6

² *Ibid.* p.307-9

³ *Ibid.* pp.320-1

⁴ *Ibid.* pp.342-3

⁵ *Ibid.* pp.333-4

⁶ *Ibid.* pp.367-8

⁷ *Ibid.* pp.369-70

⁸ *Ibid.* p.372

⁹ *Ibid.* pp.369-70

¹⁰ *Ibid.* p.372

¹¹ Weindling, P. 'From Infectious to Chronic Diseases: Changing Patterns of Sickness in the Nineteenth and Twentieth Centuries' in Wear, A. (ed.) *Medicine in Society* (Cambridge: Cambridge University Press, 1998) p.308

¹² Jonsen, A.R. *The Birth of Bioethics* p.12

¹³ Porter, R. *The Greatest Benefit to Mankind* p.307

¹⁴ Peck, M.S. *Denial of the Soul* (London: Pocket Books, 1999) pp.10-13

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- ¹⁵ Jonsen, A.R. *The Birth of Bioethics* pp.ix-x
- ¹⁶ Ibid. p.13
- ¹⁷ Ibid. pp.125-6
- ¹⁸ Jacquart, D. 'Medical Scholasticism' p.221
- ¹⁹ Porter, R. *The Greatest Benefit to Mankind* p.275
- ²⁰ Jonsen, A.R. *The Birth of Bioethics* p.126
- ²¹ Porter, R. *The Greatest Benefit to Mankind* p.367
- ²² Jonsen, A.R. *The Birth of Bioethics* p.127
- ²³ Ibid. pp.129-131
- ²⁴ Wall, L.L. 'The Medical Ethics of Dr. J. Marion Sims: A Fresh Look at the Historical Record' in *Journal of Medical Ethics* 2006; 32 (6) 346-350 p.348
- ²⁵ Jonsen, A.R. *The Birth of Bioethics* p.133
- ²⁶ Ibid. p.133
- ²⁷ Porter, R. *The Greatest Benefit to Mankind* p.649
- ²⁸ Jonsen, A.R. *The Birth of Bioethics* p.135
- ²⁹ Ibid. p.134
- ³⁰ *Nuremberg Code in Trials of War Criminals before the Nuremberg Military Tribunals under Control Council Law No. 10, Vol. 2* pp.181-2 Available at <http://ohsr.od.nih.gov/guidelines/nuremberg.html> [retrieved 17 February 2009]
- ³¹ Jonsen, A.R. *The Birth of Bioethics* pp.137-8
- ³² Ibid. pp.135-6
- ³³ Porter, R. *The Greatest Benefit to Mankind* p.650
- ³⁴ Ibid. p.650
- ³⁵ Jonsen, A.R. *The Birth of Bioethics* p.138
- ³⁶ Porter, R. *The Greatest Benefit to Mankind* p.650
- ³⁷ Jonsen, A.R. *The Birth of Bioethics* p.139
- ³⁸ Ibid. p.137
- ³⁹ Ibid. p.147
- ⁴⁰ Ibid. pp.153-4
- ⁴¹ Ibid. p.145
- ⁴² Ibid. p.138
- ⁴³ Porter, R. *The Greatest Benefit to Mankind* p.413
- ⁴⁴ Blume, S. 'Medicine, Technology and Industry' in Cooter, R. and Pickstone, J. (eds.) *Companion to Medicine in the Twentieth Century* (London: Routledge, 2003) p.171
- ⁴⁵ Ibid. pp.172-3
- ⁴⁶ Ibid. p.176
- ⁴⁷ Ibid. p.175
- ⁴⁸ Ibid. p.174
- ⁴⁹ Ibid. p.175
- ⁵⁰ Ibid. p.176
- ⁵¹ Ibid. p.172
- ⁵² Ibid. pp.176-7
- ⁵³ Jonsen, A.R. *The Birth of Bioethics* p.12
- ⁵⁴ Porter, R. *The Greatest Benefit to Mankind* p.686
- ⁵⁵ Jonsen, A.R. *The Birth of Bioethics* p.12
- ⁵⁶ Porter, R. *The Greatest Benefit to Mankind* p.685
- ⁵⁷ *The Boys From Brazil* dir. Franklin J. Schaffner (ITC, 1978)
- ⁵⁸ *A View to a Kill* dir. John Glen (Danjaq, 1985)
- ⁵⁹ *Marathon Man* dir. John Schlesinger (Paramount Pictures, 1976)
- ⁶⁰ *The Six Million Dollar Man* dir. Various (Harve Bennet Productions, 1974-8)
- ⁶¹ *Iron Man* dir. Jon Favreau (Paramount Pictures, 2008)
- ⁶² *Robocop* dir. Paul Verhoeven (Orion Pictures Corporation, 1987)
- ⁶³ *Return of the Jedi* dir. Richard Marquand (Lucasfilm, 1983)
- ⁶⁴ Trumbo, D. *Johnny Got His Gun* (Secaucus: Lyle Stuart, 1970) p.286
- ⁶⁵ 'One' James Hetfield and Lars Ulrich (Elektra, 1989)
- ⁶⁶ Webster, C. *The National Health Service: A Political History* (Oxford: Oxford University Press, 1998) p.5
- ⁶⁷ Porter, R. *The Greatest Benefit to Mankind* p.637
- ⁶⁸ Webster, C. *The National Health Service: A Political History* pp.3-4

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- ⁶⁹ Ibid. p.5
⁷⁰ Ibid. p.16
⁷¹ Webster, C. *The National Health Service: A Political History* pp.5-6
⁷² Porter, R. *The Greatest Benefit to Mankind* p.652
⁷³ Ibid. p.652
⁷⁴ Ibid. p.639
⁷⁵ Webster, C. *The National Health Service: A Political History* p.10
⁷⁶ Ibid. p.25
⁷⁷ Ibid. p.26
⁷⁸ Ibid. p.28
⁷⁹ Porter, R. *The Greatest Benefit to Mankind* p.654
⁸⁰ Ibid. p.654-5
⁸¹ Jonsen, A.R. *The Birth of Bioethics* p.11
⁸² Porter, R. *The Greatest Benefit to Mankind* p.658
⁸³ Blume, S. 'Medicine, Technology and Industry' p.171
⁸⁴ Jonsen, A.R. *The Birth of Bioethics* p.x
⁸⁵ Porter, R. *The Greatest Benefit to Mankind* p.656
⁸⁶ Jonsen, A.R. *The Birth of Bioethics* p.12
⁸⁷ Porter, R. *The Greatest Benefit to Mankind* p.657
⁸⁸ Ibid. p.658
⁸⁹ Morrice, A.A.G. 'Honour and Interests' pps.29-30
⁹⁰ Percival, T. *Medical Ethics* pp.27-8
⁹¹ Porter, R. *The Greatest Benefit to Mankind* p.680
⁹² Jonsen, A.R. *The Birth of Bioethics* p.4
⁹³ Kevles, D.J. *In the Name of Eugenics* p.170
⁹⁴ Ibid. p.169
⁹⁵ Searle, G.R. 'Eugenics and Class' in Webster, C. (ed.) *Biology, Medicine and Society 1840-1940* (Cambridge: Cambridge University Press, 1981) pp.225-7
⁹⁶ Ibid. p.226
⁹⁷ Porter, R. *The Greatest Benefit to Mankind* p.687
⁹⁸ Ibid. p.687
⁹⁹ Grodin, M.A. 'Introduction: The Historical and Philosophical Roots of Bioethics' p.5
¹⁰⁰ Percival, T. *Medical Ethics* p.32
¹⁰¹ Jonsen, A.R. *The Birth of Bioethics* pps.128-9
¹⁰² Percival, T. *Medical Ethics* p.57
¹⁰³ American Medical Association *Original Code of Medical Ethics* pps.105-6
¹⁰⁴ Jonsen, A.R. *The Birth of Bioethics* p.288
¹⁰⁵ Percival, T. *Medical Ethics* p.94
¹⁰⁶ Morrice, A.A.G. 'Honour and Interests' p.20
¹⁰⁷ Percival, T. *Medical Ethics* p.95
¹⁰⁸ Jonsen, A.R. *The Birth of Bioethics* p.289
¹⁰⁹ Luker, K. *Abortion and the Politics of Motherhood* p.43
¹¹⁰ Ibid. p.25
¹¹¹ Ibid. p.40
¹¹² Ibid. p.39
¹¹³ Ibid. p.45
¹¹⁴ Ibid. p.39
¹¹⁵ Ibid. p.16
¹¹⁶ Ibid. p.55
¹¹⁷ Ibid. p.55
¹¹⁸ Ibid. p.20
¹¹⁹ Ibid. p.38
¹²⁰ Jonsen, A.R. *The Birth of Bioethics* p.288
¹²¹ Harrison, B. 'Women's Health and the Women's Movement' in Webster, C. (ed.) *Biology, Medicine and Society 1840-1940* (Cambridge: Cambridge University Press, 1981) p.44
¹²² Luker, K. *Abortion and the Politics of Motherhood* p.31
¹²³ Jonsen, A.R. *The Birth of Bioethics* p.292
¹²⁴ Ibid. p.289
¹²⁵ Kevles, D.J. *In The Name of Eugenics* (Harmondsworth: Pelican, 1986) p.286

Chapter 7: From Conferences to Committees: Responses to Moral Concerns in Medicine in the mid- to late 20th Century

From 1960 onwards, during what Jonsen has termed ‘The Decade of Conferences’¹, prominent members of the scientific community began to meet together in efforts to address some of the growing moral concerns regarding the direction taken by medicine and medical science. Initially, these conferences were primarily scientific affairs: at the first, ‘Great Issues of Conscience in Modern Medicine’ at Dartmouth College in New Hampshire, the ‘humanities’ were represented *en masse* not by academics but by two *novelists* (the first of whom was also a doctor): C.P. Snow and Aldous Huxley². As the decade wore on, however, they would gradually come to incorporate other figures, from politicians and lawyers to (initially) theologians and (eventually) philosophers. In 1968, such discussion began to be incorporated into public decision-making when Senator Walter Mondale convened governmental hearings in the United States for the purpose of addressing concerns raised by ‘genetic engineering and heart transplantation’³ and from the early 1970s onwards, there was a shift away from conferences and towards ‘a general framework of research fostered by several new permanent centres’⁴ in which interdisciplinary work on medical ethics could take place.

Philosophers’ initial absence from these discussions is commonly attributed to the discipline’s preoccupation at the time (in Britain and America at least) with metaethical concerns. Jonsen⁵, for example, cites Warnock’s argument that an emphasis on ‘treating ethics as the analysis of ethical language’ not only made academic moral philosophy ‘boring’ but led ‘to the increasing triviality of the subject’⁶. As we shall see below, this judgement is not entirely fair; nevertheless, we should note that by the time philosophers *did* become involved a broad structure for the academic discussion of moral concerns in medicine had already been established. In order to examine the role philosophy eventually came to play in interdisciplinary medical ethics, then, it would seem sensible to examine both what this structure was and how and why it had come about. For this reason, this chapter will examine the aims, intentions and achievements of four particular conferences: the aforementioned ‘Great Issues of Conscience in Modern Medicine’; the CIBA Conference ‘Man and

his Future' held in London in 1962; the Nobel Conference 'Genetics and the Future of Man' held at Gustavus Adolphus College, Minnesota in 1965 and finally, 'The Sanctity of Life' at Reed College in Portland, Oregon, in 1966, together with the work of two key theological figures in mid-20th Century theological medical ethics: Joseph Fletcher and Paul Ramsey⁷.

Great Issues for *Whose* Conscience? Dartmouth, 1960 and London, 1962

In his opening address at Dartmouth, Dr. S. Marsh Tenney explicitly recognised that the problems faced by modern medicine and medical science were largely due to its increasingly technological nature. In doing so, he appeared to be making a case for medicine to pay renewed attention to the human needs of the patient. Describing the practice of medicine as 'the welding of science and humanism' he described the present climate as one in which 'medicine has been forced to remind itself that it is often the human factors that are determinant'⁸. Yet the make-up of the conference attendees at both Dartmouth and the CIBA conference in London two years later may cause us to question whether the organisers were fully in agreement. Lectures at Dartmouth were given by an impressive array of distinguished scientists including a Nobel Prize winner and the head of the World Health Organisation; in London, of the twenty-seven participants, 'five... were Nobel prize winners'⁹. By contrast, those with a serious background in ethical thought were noticeable by their absence: at Dartmouth, neither Snow nor Huxley was a specialised academic of the standing of the scientists involved; in London there was a single 'ethical' representative in the form of an Anglican priest, also a doctor, and not a distinguished theologian¹⁰.

In their deliberations, too, the conference attendees paid scant attention to 'human' matters in the manner we may expect, given Tenney's opening address and the concerns we encountered in Chapter 6. Lecture subjects at Dartmouth included 'the effects of ionizing radiation, the pollution of water and air, and chemical adulteration of food'¹¹. At London, the opening address made no mention of the possibly dehumanising effects of technological progress, focussing instead on the problems of overpopulation and the supposedly dysgenic impact of medicine. 'Man and his Future' 'replicated the style and themes of its Dartmouth predecessor' with a program including discussion of issues such as 'agricultural productivity, world resources, and

environmental degradation'¹². Both conferences were a curious mixture of the optimistic and the dystopian: the prospect of a cure for cancer or of any other disease, including mutations, was often discussed not as a possible result but rather as the *inevitable* outcome of scientific medicine. On the other hand, it was expected that these advances might '[bring] in their beneficial wake unintended problems'¹³.

The likely nature of these problems as described by attendees at both Dartmouth and London was however very different from those discussed in the previous chapter. Instead, the chief focus of discussions was the widespread assumption that medicine was contributing to both a 'population explosion and the pollution of the gene pool'. The greatest 'issue of conscience' faced by medical science, to the minds of the attendees, had little to do with individual patients but instead concerned the supposed threat posed to the health of populations (or perhaps even the human species as a whole) by 'antibiotics... insulin for diabetes and diet for phenelkytonuria'. At London, the microbiologist René Dubos did consider the plight of those individuals kept alive 'who cannot derive either profit or pleasure from existence'¹⁴, yet did not mention unfortunates of the kind encountered by Peck or Jonsen as described in Chapter 6. Although mentioning the aged, and challenging the consensus that medicine (and in particular 'the conquest of infectious disease') was responsible for overpopulation in the world's poorest countries, his lecture focused on children born with genetic defects.

Perhaps mindful of Nazi atrocities, no-one present at either conference advocated a return to the idea of (voluntarily or otherwise) breeding out 'unhealthy' or 'undesirable' traits; some, however, came perilously close. In Dartmouth, Aldous Huxley provided a dissenting voice to calls for measures similar to those he had satirised in his novel *Brave New World*, such as Hermann Muller's proposal for the creation of a bank of 'healthy' sperm, by noting their 'susceptibility to totalitarian manipulation'¹⁵. In London, some subjects engendered rancorous debate: '[sessions] devoted to genetics and brain sciences' in particular 'incited a turmoil... loud protests against totalitarianism were heard'¹⁶. Laudable though such protests may have been, however, they too failed to recognise that preventing 'the otherwise inevitable degradation of the [human] race'¹⁷ was not, in fact, a particularly pressing concern and in some cases distracted from more immediate realities. Dubos, for example, in

considering the social and financial ‘burden’ of caring for the aged and chronically ill began to raise questions as to the relationship between society and individual that may have helped illuminate such concerns in new and interesting ways. For the time being, however, these were matters with which the medical and scientific communities chose not to confront themselves.

It is against this backdrop that the absence of philosophers from these debates should be considered. On the one hand it is true that, in Anglophone philosophy, normative ‘[first-order] moral discourse... comprising discussions and arguments about what kinds of actions or policies were morally right or wrong, or what characteristics of persons were good or evil’ was, put simply, out of fashion¹⁸. Instead, the real meat of postgraduate courses in moral philosophy was concerned with ‘second-order discourse... reflections about what people mean when they use words like ‘right’ or ‘wrong’, ‘good’ or evil’¹⁹. As Jonsen puts it, English and American philosophy graduates of the mid-20th Century could ‘pass an ethics course without wrestling with any dark angel of moral perplexity’²⁰. Graduate seminars at Oxford during the period were given over to the discussion of propositions such as whether or not the colour of a tie could be considered morally offensive²¹, ‘grading fruit, or choosing fictitious games equipment’²². For some, this was how it should be: Ayer and Stevenson, for example, drew a distinction ‘between moral philosophers, who analyse the language of moral discourse, and moralists, who practice it’²³. Philosophers were ‘first to show the propositions of morals are not scientific, that is, that they do not state empirical facts, and... then to analyse the terms which they do contain. When this [had] been done, [their] task [was] over’²⁴. Others disagreed but, as we shall examine further in the following chapter, still believed that second-order concerns needed to be addressed before moving on to first-order work.

Nevertheless, even if philosophers had been interested in first-order work, their help had not been requested by a scientific and medical community that in some cases still failed to acknowledge that certain problems even existed. Jonsen has described the subject matter of the Dartmouth and London Conferences as ‘large questions’²⁵ which they undoubtedly were and are. Unfortunately, given the changes affecting medicine at the time, we may conclude that they were not the ‘large questions’ that were actually being *asked* by anyone except the attendees themselves who, as Jonsen has

noted, discussed ‘what *their* consciences told *them* were the great issues [my emphasis]’²⁶. At neither conference was any mention made of moral concerns regarding abortion, nor of research with human subjects, nor of changes in the relationship between physician and patient. Delegates were not concerned to any great extent with practical moral advice for individual doctors, nor did they believe they should be: in Dartmouth, C.P. Snow explicitly stated that such ‘private’ matters of ethics could be safely left to the medical profession at large²⁷. The attendees did not seem to consider that these ‘private’ concerns could be linked to the issues they were discussing, that the population and species with which they were so concerned was made up of individual lives, and/or that any measures they proposed (for example, the proper collection and distribution of ‘healthy’ sperm) would most likely have to be administered by individual doctors.

Delegates and Dartmouth and London generally aired concerns without providing much by way of conclusions; many were not even sure how agreeing on the latter would be possible. In London, Jacob Bronowski offered the hopeful opinion that the ‘search for truth’ embodied in science itself would help to inspire moral progress; Sir Peter Medawar, by contrast, expressed perplexity at how any progress would be possible in the face of such a wide diversity of opinion²⁸. For others, that the conference had been convened *at all* was the most important thing; that the issues had been aired was enough. Dubos, for example, felt that the proper role of the scientists extended only to explaining the issues to the fullest possible extent, in order to allow ‘society’ to pass moral judgement²⁹. The problem with such a position, however, is that it itself involves at least two forms of moral judgement, firstly in terms of deciding upon which issues are moral and thus require further explanation, and secondly in terms of which *parts* of those issues can and/or should be further explained (not to mention whether those parts can and/or should only be explained in scientific terms). We have encountered an example of how this kind of approach can be problematic in our discussion of changing attitudes to abortion in Chapter 6, in which focussing only on questions of ‘quickening’ obscured other concerns and arguments relating to the interests of the mother and the status of the foetus.

'Doing Better': St. Peter, 1965 and Portland, 1966

An address by the Nobel Prize-winning physicist William Shockley at the inaugural Nobel Conference 'Genetics and the Future of Man' at Gustavus Adolphus College in St. Peter, Minnesota was to prove influential in pointing the way towards how conferences might, to borrow Jonsen's paraphrase of Medawar's expression 'do better' than Dartmouth and London. This had little to do with the content of the address itself, which explicitly advocated a return to the ideals of the 19th Century eugenics movement (and in doing so may be seen as an interesting counterpoint to Bronowski's hope that the practice of 'science' in its broadest sense may itself make men more moral). Starting from the (discredited) premise that 'intelligence was largely genetically determined', Shockley suggested that society should go beyond measures such as Muller's suggestion of creating a reserve of 'healthy' sperm (which he praised) and move on to 'serious efforts to improve human intelligence... by various methods, including sterilisation, cloning, and artificial insemination'³⁰.

Shockley's proposals were not uncontroversial: they were significantly more radical than Muller's, which had not only been sharply criticised at Dartmouth by Huxley but also 'stirred up a storm' when read *in absentia* in London. Some, like Bronowski, had pointed out that deciding on how best to 'improve' humanity was beyond them and 'were willing to admit that not even they were competent to select the qualities for the future human'. Muller himself agreed that the 19th Century eugenics movement had been hopelessly perverted by race and class prejudice, which he found repellent³¹. Despite this, even those critical of such proposals held in common an attitude of 'genetic pessimism': the view that the human species was coming under increasing 'genetic load' through the preservation of harmful mutations. For Muller and others, the moral issues at hand were the 'feasibility and consequences' of the available methods for reducing the number of harmful mutations³². Indeed, one of Muller's critics, Joshua Lederberg, found his proposals problematic because they would not counter this trend quickly *enough* and sought instead to pursue the possibility of direct intervention at the genotypic level: 'using our increasing mastery of DNA to improve brain power, control immune response, and diminish senescence'³³. In St. Peter, however, Shockley was to encounter an entirely different kind of criticism, and one for which he was entirely unprepared.

The Protestant theologian Paul Ramsey, who had requested from Muller a list of suitable readings in genetics in order to prepare his case³⁴, countered Shockley's address with an 'analytic refutation from a scholar trained in ethics' the like of which had until this point been absent from the world of scientific conferences³⁵. Ramsey chose to leave the geneticists to debate whether or not the 'genetic load' was in fact increasing³⁶, and enumerated only briefly the 'scientific and socio-psychological' doubts as to whether a program such as Shockley's was either practical³⁷ or conceptually possible³⁸ (although in doing so he was still arguably drawing attention to the paucity of settled evidence for embarking on such a project). Instead he chose to contrast the value judgements present in both Shockley and Muller's work (which he saw as prioritising, respectively, capacity for thought and individual freedom) with his own view of human dignity in which '[there were] more elements in the nature of man which are deserving of respect and should be withheld from human handling and trespass'³⁹. In particular he drew attention to the morally loaded nature of 'regarding procreation as an aspect of biological nature to be subjected merely to the requirements of *technical control*'⁴⁰.

Ramsey would go on to become, in Jonsen's terms, a '[star] in the bioethical firmament'⁴¹. Had he done no further work in the field, however, his inaugural conference appearance would still merit discussion not for the specific content of his arguments against Shockley's proposals, but rather for his managing to shift the ethical debate onto grounds where the scientists were no longer expert. In doing so, Ramsey was able to demonstrate just what scholarly ethicists could bring to the conference table. As he pointed out, whilst his own Christian ethic was not to be found 'among the contents of natural science', neither was Muller's insistence on human freedom and voluntary choice: '[there] is no conflict here between religion and science, but... between two philosophies'⁴². The impact was profound: in Dartmouth and London, a previously reticent scientific and medical community had '[broken] their silence... [and] aired their qualms of conscience... before their colleagues and even lay audiences'⁴³. Following the conference at St. Peter, 'The Sanctity of Life', held at Reed College in Portland, Oregon in March 1966, now saw scientific veterans of the earlier conferences such as Medawar joined by individuals from a wide range of backgrounds. Alongside Ramsey and the anaesthesiologist Henry Beecher were a

sociologist (Edward Shils), a (British) barrister and Member of Parliament (Norman St. John-Stevas) and a philosopher (Abraham Kaplan).

Jonsen has argued that two principal factors account for what he sees as the success of the Portland conference: '[it] 'did better' because the issues were more closely defined and a *proper* philosopher and a *proper* theologian were invited to do some scholarly ethics [my emphasis]'⁴⁴. Neither of these claims should be accepted without qualification. First of all, although the conference did concentrate on more 'closely defined' issues in the sense that most speakers offered a detailed discussion of a single topic (for example, 'Ramsey spoke on the morality of abortion, Medawar on eugenics, and Beecher on research involving human subjects') it was more open than Dartmouth, London and St. Peter in that the organisers had moved on from the earlier attitude that it was part of their role to determine what issues posed moral questions and to set the parameters within which they were discussed. In his opening address, conference chairman Daniel Labby argued that 'The Sanctity of Life' was an appropriate locus for discussion *not* because of any controversy within the scientific community, but because it seemed to reflect concerns amongst the wider public: 'an unpopular war [in Vietnam] was threatening to escalate insanely... the wounds of the thalidomide tragedy were still unhealed, and contraception and abortion were troubling moral dilemmas'⁴⁵.

Indeed, rather than offering a 'closely defined' set of questions, 'The Sanctity of Life' may be seen instead to have taken steps to further broaden the discussion of moral concerns facing mid-20th Century medicine. Even in the absence of a 'proper' philosopher and a 'proper' theologian, the contributions of the other speakers drawn from outside medicine and the natural sciences would have been valuable and noteworthy innovations. Just as Ramsey's paper at 'Genetics and the Future of Man' had introduced his religiously derived perspective of the value of human life in contrast with what he saw as Shockley's 'science-based ethic', so Shils considered whether (and if so, how) a secular basis could be found for similar values (something he believed possible through 'the rediscovery of what it was that for so long gave such persuasive power to Christian thought')⁴⁶. Similarly, as Huxley had pointed out in Dartmouth, proposals requiring social or political intervention (such as Muller's bank of 'healthy' sperm) had often failed to take into account the full impact of their

implementation into public policy; the Portland conference avoided this by having the lawyer and politician St. John-Stevas lecture on the subject of 'Law and Moral Consensus' in which he argued that '[law] rests on the sentiment and the will of the governed... if correspondence ceases, the law can no longer be enforced'⁴⁷. Furthermore, he concluded that it was not left to the 'scientist or geneticist' alone to 'moderate the tyranny of scientific techniques; such resistance could come from religious traditions or the values expressed in the common law'⁴⁸.

Moving on to the second part of Jonsen's claim, then, there is the question of just what the 'scholarly ethics' done by the 'proper' philosopher present brought to these discussions. Jonsen has identified two main elements of Kaplan's contribution at Portland. First of all, as part of his conference duties, he was responsible for the summarising of proceedings; more importantly for our purposes here, he delivered a paper in which he envisaged a role for the philosopher in future discussions as performing what Jonsen terms 'the exposé of ethical oversimplification'⁴⁹, paraphrasing Russell to the effect that his purpose was 'first, to make complicated things simple and, second, to make simple things complicated'⁵⁰. Furthermore, Kaplan also introduced the explication and introduction of the thought of canonical moral philosophers (in this case, Kant) into the realm of moral debate in medicine. It is important to note, however, that despite taking this latter step Kaplan (whose specialty as a philosopher was not ethics but logic⁵¹) still appears to have conceived of the philosopher's role as primarily one of linguistic and logical analysis. He mentions Kant only briefly⁵² and emphasised that '[our] task... is not so much to offer solutions... but rather to raise these problems in an effective way'⁵³. We will return to these themes in due course when further considering the role of philosophy in mid- to late-20th Century medical ethics in Chapter 8.

Moral Theology and the Methodology of Interdisciplinary Medical Ethics in the mid- to late-20th Century

Despite the presence of a religious figure at the 'Man and his Future' conference in London, the biologist Francis Crick had expressed the opinion that moral debate in medicine would in the future be increasingly secular⁵⁴. In the short term at least, he was to be proved wrong: a 1968 conference in Houston following the first successful

human heart transplant, for example, was organised by a theologian and dominated by theological ethicists⁵⁵, whilst book-length works of scholarly medical ethics in the mid-20th Century were, when not written by doctors themselves, almost exclusively the province of the theologian. Moreover, the works produced by doctors (such as Beecher's 1966 exposé of 'twenty-two examples of medical researchers who had conducted unethical human experimentation endangering the health or life of their subjects'⁵⁶) were devoted mainly to drawing attention to particular moral concerns or problems; it was theologians who offered detailed analysis of such problems, coupled with conclusions or suggestions as to what would constitute 'moral' behaviour. The two 'milestone' works of medical ethics in this sense produced during the period were Ramsey's *The Patient as Person*⁵⁷ and *Morals and Medicine* by another Protestant theologian, Joseph Fletcher⁵⁸.

Unlike philosophers of the time, theologians *were* expected to offer their professional opinion on moral questions. The sacrament of confession made it imperative for Catholic theologians to respond to the needs of their congregations⁵⁹; indeed, in the 1960s, they came under vocal pressure to do so from 'a perplexed and informed laity'⁶⁰. Moreover, 'Catholic moral theology concerned not only the personal morality of individuals but also the social morality of institutions'⁶¹ such as hospitals, governments or even medicine itself. The Church hierarchy had also given Catholic moral theologians the task of investigating the moral implications of scientific developments such as organ transplantation, life support and brain death (in the first case, well in advance of such treatment being possible)⁶². In the late 1950s, Pope Pius XII had pronounced on all three matters, and declared that 'extraordinary' measures could be brought to an end in certain circumstances⁶³; he also called for further scientific work to be done in order to better define 'death' (something which the medical establishment had shied away from doing)⁶⁴. Similarly, their Protestant counterparts, especially in the United States, were concerned with providing for their flocks a practical expression of Christian doctrine⁶⁵. As a result, '[both] traditions called for serious engagement in political, social and economic life'⁶⁶. The result of this engagement would shape the initial direction of interdisciplinary medical ethics in three main ways.

First of all, and perhaps unsurprisingly given the pressure placed on moral theologians by their congregations, much of their early work reflected public concerns similar to those explored in the previous chapter, especially with regards to patients' rights. Although organised religion, much like medicine, was an institution whose authority was increasingly called into question throughout the 1960s, the emphasis that both Fletcher and Ramsey placed on the patient's role as decision-maker was in tune with the mood of the times. Fletcher's *Morals and Medicine*, written in 1956, was notable for exploring medical ethics from the point of view of the patient, and for its emphasis on 'the importance of freely-exercised patient choice based in knowledge'. Similar to Ramsey at St. Peter, Fletcher argued that clinical practice could not be 'considered solely within the domain of the medical profession' as it was 'not exclusively technical in nature, but normative as well and thus within the realm of *patient choice*' [my emphasis]⁶⁷. Ramsey's *The Patient as Person*, as may be surmised from the title, further developed these concerns, concentrating on establishing the position of the patient with regards to 'definitions of life and death, personhood, abortion, and the foregoing of life-sustaining treatment'⁶⁸.

Secondly, moral theologians 'in contrast to philosophers [did not] speak about morality in the abstract' and instead discussed moral issues through the detailed analysis of specific cases⁶⁹. Catholics in particular outlined their views through a complex system of *casuistry*, that is, by exploring the application of 'fundamental moral principles derived from natural law and divine revelation' to 'specific topics [such as] abortion, contraception, sterilisation, euthanasia and various types of surgery'⁷⁰. Protestant theologians, though in Jonsen's eyes lacking 'the detailed moral analysis found in Roman Catholic moral theology', proceeded in a similar way, grounding their consideration of 'the moral life' in terms of principles drawn from 'large Biblical themes [such as] Justification and Covenant, Law and Grace, Providence and Freedom'⁷¹. Writing in 1978, Ramsey was able to describe 'medical ethics to date' in *Ethics at the Edge of Life* as 'a concrete case of Christian 'casuistry' – that is...the outlooks of the predominant Western religions *brought down to cases* and used to determine their resolution'⁷².

Prior to the mid-20th Century Catholic casuistry with regards to medicine had proceeded from two main suppositions. The first was *physicalism*, the variant of

natural law that held that knowledge of the proper purposes of the human body and its organs could settle moral questions regarding its and/or their use (for example with regards to abortion, contraception and homosexuality). The second was *ecclesiastical positivism* under which the final justification for any moral position is found in the approval of the Magisterium ('the teaching authority of the Church, constituted by the bishops under the supreme authority of the Pope')⁷³. Following the Second World War, however, Catholic moral thought was in turmoil. Physicalism had become a hotly debated topic: with regards to sexuality, for example, several thinkers encouraged instead the adoption of *personalism* '[which entailed] a fuller view of married sexuality'⁷⁴. The Second Vatican Council (1962-5) set up by John XXIII seemed to move away from physicalism, only for Paul VI to reverse any such change and instead attempt close down discussion of the matter with an encyclical 'prohibiting artificial birth control' in 1968⁷⁵.

The result, in some cases, was to cause Catholic theologians to reject the Magisterium's claim to having the final say on all matters and place the demands of their consciences before the demands of their Church. Jonsen, who had been a Jesuit priest⁷⁶, was one of many involved in medical ethics to depart the following the hardening of the traditional line⁷⁷. He was not alone: two 'non-tenured professors... at the Catholic University of America, Warren Reich and George Kanoti' also left their positions. The former joined the Kennedy Institute of Bioethics at Georgetown University; the latter eventually became the first 'bioethicist in residence' at the Cleveland Clinic⁷⁸. Yet whilst these thinkers were now ethicists by profession, and working within interdisciplinary centres where they were no longer answerable to the Church hierarchy, they remained Catholic moral theologians by training. In self-imposed exile from settled traditions the question arises of just how these newly-minted ethicists intended to justify the concepts, rules, and principles they were to apply to the cases brought before them. Both Ramsey and Fletcher offered an example of how this might be done.

For both Ramsey and Fletcher the *grounding* of their principles was not a matter of primary importance. Indeed, for the former, acceptance of conventionally religious elements of Christian thought such as the divinity of Christ or indeed the existence of God were not, strictly speaking, necessary for Christian moral ideas to have relevance

(although there are no grounds for suggesting he did not himself believe in either of these things). Rather, Ramsey felt that the apocalypticism of Christ and the Old Testament prophets had allowed them to *get at* two basic moral insights that would remain important whether one shared in this apocalypticism or not and *however* one came to discover them. The first is that moral conduct is rooted in an unqualified, disinterested love for one's neighbour motivated neither by preferential interest nor an expectation of punishment or reward (*agapé*). The second is that morality is not concerned with ends or goals in the teleological sense but rather with shared duties arising from the covenants with our neighbour such love demands (*hesed*)⁷⁹. Importantly, he felt these insights were 'independent of [their] origin... and stood on [their] own'⁸⁰. Thus, although the basis for his thought was an 'ultimate appeal to scripture or theology'⁸¹, he also allowed that the same principles could be derived from an alternative, humanist ethics (although it was a subject he himself had 'no interest' in pursuing further)⁸².

Fletcher also based his moral thought on a religious conception of *agapé* (translated as 'love'⁸³); but like Ramsey was willing to admit the possibility of a secular 'higher good or *summum bonum*' such as 'self-realisation in the ethics of Aristotle'⁸⁴. Also like Ramsey, he was less concerned with the origin and nature of concepts, rules, and principles than with the way in which such things were put to use when considering moral questions. In his 1966 work *Situation Ethics*, he characterised most (Judeo-Christian) theological approaches⁸⁵, together with 'classical ethics', 'jurisprudence'⁸⁶ and (implicitly) Kantian moral philosophy⁸⁷ as *legalistic*: that is, concerned primarily with establishing universal rules and principles which are to serve as a guide to action. These are 'not merely guidelines or maxims to illuminate the situation; they are *directives* to be followed... [solutions] are preset, and you can 'look them up' in a book – a Bible or a confessor's manual'⁸⁸. He contrasted this view with two others. The first was the *antinomianism* he found in 'some Anabaptists, some sects of English Puritanism... some of Wesley's followers... the Hellenistic Jew-Christians St. Paul addresses in his First Letter to the Corinthians'⁸⁹ and the existentialism of Sartre and de Beauvoir⁹⁰ that has 'no principles or maxims whatsoever, to say nothing of *rules*'⁹¹. The second, and that which he advocated, was *situationism*: the view that concepts, rules, and principles are important, but may be set aside 'if love seems better served by doing so'⁹².

As a result, when, in 1975, James Gustafson summed up a growing consensus amongst those working in the field of medical ethics by publicly arguing that the ongoing contribution of theology was ‘likely to be of minimal importance, for the moral principles and values needed... can be grounded in other ways’⁹³ he was some way behind the theologians themselves. This brings us to the third contribution of theologians to interdisciplinary discussions of medical ethics: the application and/or development of ethical theories. It is possible to argue, as Jonsen does, that Fletcher and Ramsey were, unencumbered by any need or desire to engage in meta-ethics, simply getting on with the business of first-order moral philosophy⁹⁴. Certainly, Ramsey’s conception of ‘disinterested neighbourly love’ is, as Hauerwas puts it, if ‘not exactly Kant [then] at least in Kant’s ballpark’⁹⁵. Similarly, Fletcher’s contention that the morality of an action is rooted solely in terms of its outcome or projected outcome (‘[for] example, ‘Almsgiving is a good thing *if...*’... never [just]... ‘Almsgiving is a good thing’⁹⁶) seems to fit Frankena’s description of him as an act-utilitarian⁹⁷, and he clearly had deontological theories in mind when borrowing Constant’s criticism of Kant⁹⁸ (without, as we have noted above, mentioning the Prussian philosopher) to describe a legalist as someone who would not lie even to a crazed killer ‘escaped from an asylum [and asking] where his intended victim is’⁹⁹.

Such a reading, however, risks overemphasising the differences between the two thinkers when what is of most interest in terms of their wider contribution to medical ethics are the similarities between them. For one thing, it is clear that despite his willingness to be described as such, Fletcher is far from a perfect fit as a consequentialist. If one chooses only relatively unsophisticated examples and sticks to the shallow reading offered by Fletcher it is equally possible to portray consequentialist thought as leading to arguments that appear to commit his cardinal sin of thinking of morality only as ‘being able to justify [oneself] in terms of [a] rule’¹⁰⁰. For example, we may consider the following, as put forward by ‘Y’ and ‘Z’ in Harris’ ‘The Survival Lottery’: ‘Y needs a new heart and Z new lungs [where no donor organs are currently available]... if just one healthy person were to be killed his organs could be removed and both of them saved’¹⁰¹; it seems unlikely that Fletcher would consider this the ‘most loving’ course of action available! His ethics are in fact, as Jonsen points out, ‘theoretically thin’ and do not contain any attempt to outline a comprehensive system of moral thought¹⁰². Quite the reverse, in fact: he mentions

Kierkegaard approvingly as having been ‘correct... in his hatred for systems’¹⁰³ in terms strongly reminiscent of Nietzsche (‘I mistrust all systematists and avoid them. The will to system is a lack of integrity’¹⁰⁴). Despite this, Fletcher was clearly not opposed to systematic thought as a *part* of moral reflection, provided such systems were used in the way he thought proper: although he sometimes described the detailed casuistry of his Catholic colleagues with wry amusement (‘an elaborate system of exceptions and compromise... rules for breaking the rules!’¹⁰⁵) he also admired it as a bulwark against the ‘punishing and sadistic use of law to hurt people instead of helping them’¹⁰⁶.

Fletcher agreed with Dewey, for whom he held a professed admiration, that whilst the proper aim of ethical thought was to devise a method for approaching moral problems rather than a fixed set of systematic rules and concepts¹⁰⁷, such systems could be a useful part of such a method. In fact, they may even be *necessary*, with the proviso that ‘principles or maxims or general rules’ (he prefers the first term over the others) are regarded as ‘*illuminators* [rather than] *directors*’¹⁰⁸. Principles, so understood, are like the ‘rules of thumb’ taught to novices at (American) football, baseball and bridge that it is necessary to follow in order to learn the game properly, that is, to learn when it is *appropriate* to break them¹⁰⁹. As such, Fletcher seems to have held that detailed moral reflection of the type in which Ramsey engaged is itself a valuable practice: an attempt to enumerate yet more sophisticated ‘rules of thumb’ to apply in all but the most problematic moral cases¹¹⁰. Ramsey also held that *currently existing* rules and principles were not to be obeyed without question (arguing as he did that *his* use of *hesed* and *agapé* represented a ‘radical revision’ of the norm¹¹¹). As such, where he sought to follow Catholic theology in building an ever more rigorous and intricate set of concepts, rules and principles to apply to individual cases¹¹², he was performing what Fletcher would regard as necessary work.

Both Fletcher and Ramsey have been criticised for the perceived limitations of their ethical thought. Jonsen has described *Morals and Medicine* as ‘a book which ends the past [rather] than one that opens the future’ arguing that Fletcher is too reluctant to criticise doctors, regard ‘physician paternalism as an offence to patient autonomy’ or oppose ‘the imperialism of medical technology’¹¹³. Similarly, Hauerwas had argued that Ramsey’s approach is unable to deal with moral concerns regarding ‘the aims of

medicine, what health or illness means or how they are determined... the meaning and place of pain and suffering [and] issues such as the economic and political presumptions that do or should sustain medicine'¹¹⁴ since 'like a doctor who is more likely to find the diseases she has been trained to find, Ramsey made the primary moral issue in medicine the issue for which his ethics was designed'¹¹⁵. We may argue, however, that such criticisms are fundamentally misplaced.

First of all, in Ramsey's case especially, one may say that several of the most pressing moral concerns were *already* issues for which his ethics were designed: questions concerning the subordination of the individual to teleological demands (for example Shockley's plans to 'improve' the human race), immediate moral relationships (such as that between doctor and patient he described as a shared duty explicable through obligations derived from *hesed* and *agapé*) and whether a doctor's 'vocation to cure [can end] without relaxing [his or her] duty to care for the dying'¹¹⁶. Moreover, both Fletcher and Ramsey's specific conclusions and choice of subject matter, together with their differences over theory, were to prove of less significance in the long term than their shared beliefs concerning how moral thought should be conducted and (more importantly) applied. Both held a firm belief in the importance of dialogue in terms of resolving moral issues one way or the other. Both sought to build or use a system of principles to aid in moral practice. Both also held an equally firm belief that ethics was primarily a practical rather than a theoretical activity and should involve detailed discussion and analysis of real-world situations as well as that of concepts, rules and principles.

Conclusions

Despite their doubtless good intentions, the first efforts of the wider scientific community to engage with the moral questions brought about by social and scientific changes in medicine during the 20th Century must be regarded as a failure. Although overpopulation, pollution and contamination or exhaustion of food supplies were and remain important issues, they have little to do with 'the welding of science and humanism' to which the first conferences aspired. Moreover, the solutions proposed were often either morally problematic and/or fanciful (at London, J.B.S. Haldane had delivered a speech outlining a possible future in which, for example, children destined

to be astronauts could be bred without legs to cut down on food requirements and muscle wastage in zero gravity; it is quite possible the speech was intended to be a parody, although, if so, not all of the audience appear to have realised¹¹⁷). They were, however, a step in the right direction.

Attempts to overcome these failings during the 'Decade of Conferences' reshaped the discussion of medical ethics in the following ways. First of all, such discussion was to become interdisciplinary. Neither the moral questions raised by medicine nor the likely answers to them were exclusively clinical. In some cases they contained value judgements dependant on everyday terms (such as 'the sanctity of life') which in reality covered a wide variety of possible opinions and arguments that themselves required further investigation and explication by social scientists such as Shils. In others, proposed solutions (such as Muller's bank of 'healthy' sperm or Shockley's program of sterilisation) would require sweeping changes not only in terms of public policy but in the relationship between individual and state that raised political and legal questions such as those tackled by St. John-Stevas in Portland.

Furthermore, all of these clinical, sociological, legal and political elements were bound together in moral and ethical arguments that could be further examined, critiqued and challenged by those with a background in ethical theory and argumentation. With the exception of Kaplan's lecture at 'The Sanctity of Life', the relative absence of philosophers from interdisciplinary discussions at this time meant that this work was done, in the main, by theologians, with three main consequences. First of all, in line with other social changes, the agenda for discussion was moved further in the direction of those moral questions and dilemmas that patients and the wider public found most immediate or perplexing. Secondly and thirdly, that the format of these discussions generally followed established theological norms led to an emphasis on the discussion of specific cases and attempts to articulate a system of rules and principles that could be used in analysis of them. As the 1960s came to a close, however, widespread philosophical interest in first-order work was to be rekindled, and it is to the initial encounter between philosophers and 20th Century medical ethics that our attention will now turn.

¹ Jonsen, A.R. *The Birth of Bioethics* p.13

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- ² Ibid. p.13
- ³ Ibid. p.90
- ⁴ Ibid. p.20
- ⁵ Ibid. p.73
- ⁶ Warnock, M. *Ethics Since 1900 (Third Edition)* p.136
- ⁷ Grodin, M.A. 'Introduction: The Historical and Philosophical Roots of Bioethics' pp.4-6
- ⁸ Marsh Tenney, S. 'Opening Assembly' in *Dartmouth Alumni Magazine* (Volume 53) pp.7-8 in Jonsen, A.R. *The Birth of Bioethics* p.13
- ⁹ Ibid. p.15
- ¹⁰ Ibid. p.16
- ¹¹ Ibid. p.13
- ¹² Ibid. p.15
- ¹³ Ibid. p.15
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Chapter 8: Initial Contributions of Philosophy to Interdisciplinary Medical Ethics in the mid- to late 20th Century

As the 1960s drew to a close there were signs that ‘a new vitality was stirring in moral philosophy’ led by a new generation of ‘moral philosophers [who] were determined to show the relevance of their discipline’¹. Both Jonsen and Singer credit this change to the growing civil rights movement in the United States and especially to the ‘public disaster [of escalating] American military involvement in Southeast Asia’². Certainly, philosophers found themselves subject to public rebuke for a perceived refusal to engage with wider social issues, of which the Vietnam War was one. Such rebukes ranged from the protests organised by students ‘demanding that their courses be relevant to the larger social issues of the day’ recalled by Singer³ to the ‘stinging attack’ launched on the Vietnam War by the linguist Noam Chomsky at a 1968 meeting of the Western Division of the American Philosophical Association that, for Jonsen, ‘[let] the genie out of the bottle’. Chomsky did not save all his ire for generals or politicians: he concluded by suggesting that the problems posed by the war were (or should be) typical of moral philosophy and that, through not engaging with them, moral philosophers were evading their responsibilities⁴.

Jonsen and Singer may be overstating the case in claiming that social pressures alone drove philosophers back towards first-order work in normative moral philosophy. The Vietnam War, though perhaps a unique *American* crisis at the time, was not a unique *human* crisis. Insofar as any war may be described as ethical, it would still be a considerable stretch to say that it was the *first* to be fought with dubious methods and for dubious reasons (although we may concede that the dubiousness of the motives and methods were, through the mass media, visible to the general public in a way that would not have been possible earlier in the century). If ‘public disasters’ are required to stimulate philosophical interest in moral matters then the first half of the 20th Century had surely provided more than enough: tens of millions of human beings enslaved, gassed, butchered in the name of perverted ‘science’, maimed or slain in battles and bombing raids, deliberately infected, needlessly left untreated or marched through clouds of radiation. It is perhaps more fitting to say that wider events (of which the Vietnam War was just one) may simply (or also) have served to shift public

and academic opinion towards those who were *already* engaged or interested in such work.

Although the general preoccupation with second-order work had begun largely in response to Moore's 1903 *Principia Ethica*⁵, it is reasonably clear (and should not be forgotten) that Moore himself had had no desire to close off the possibility of philosophical work in normative ethics. For all that he branded casuistry as 'less respectable' than his own work, he conceded that first-order work remained the proper final goal of the moral philosopher⁶. As noted in the previous chapter, there were those who had remained interested in attempting to tackle the perceived problems of ethical language with a view to *informing* normative moral philosophy and, in Jonsen's terms, '[refurbish] the objective grounds for ethical judgments'⁷; one, whose particular contribution to medical ethics we will discuss in more detail below, was R.M. Hare. Others had attempted to sidestep meta-ethical concerns altogether. Although 1971 saw the launch of the journal *Philosophy and Public Affairs* with a focus on contemporary concerns such as Vietnam (which would appear to support Jonsen's contention)⁸; it also saw the publication of a major book-length work of normative ethics from a philosopher with a professed lack of interest in analysis of language or meaning⁹ that had been gestating for at least twenty years: Rawls' *A Theory of Justice*¹⁰.

Both Hare's and Rawls' work demonstrate how concerns less concrete and immediate than the war in Southeast Asia could push philosophy back in the direction of first-order work. In Hare's case, the nature of moral language as he understood it suggested that we adopt a form of preference utilitarianism. For him, a hallmark of moral statements was that they were *prescriptive*; in other words, intended to compel us to perform actions¹¹. Moreover, 'specifically moral prescriptions must be capable of being universalised [as] a moral *principle*'¹² which, Hare argued, is one that all other relevantly similar actors would assent to under relevantly similar conditions. In order to be moral, for Hare, statements must therefore accord with what are (to the best of our knowledge) the rational preferences of all those involved¹³: as Warnock puts it (somewhat crudely) the 'test question' for moral debate becomes 'how would you like it if someone did this to you?'¹⁴. In Rawls' case, since he saw 'all morality as social morality'¹⁵ *A Theory of Justice* and the works that emerged to criticise it (such as

Nozick's *Anarchy, State and Utopia*) could not help but become involved in matters of law, politics, sociology and education. As Warnock has pointed out they were all 'pretty clearly [either] right-wing or left-wing theories... not only political philosophy... come to mingle with moral philosophy [but] politics itself'¹⁶. Insofar as some of the moral problems that were emerging in medicine in the 20th Century were related to these issues (for example in terms of social justice) it seems philosophers engaged in such work could not help but become concerned with them also.

Regardless of philosophers' readiness to involve themselves with ethical problems in medicine, the growth of medical ethics as an interdisciplinary activity continued to be resisted by a significant proportion of the medical profession. When, in 1968, Senator Walter Mondale convened governmental hearings in the United States for the purpose of discussing concerns raised by 'genetic engineering and heart transplantation', medical reaction ranged from the 'lukewarm' to the outright hostile. Some doctors, such as Christiaan Barnard (who had performed the first human heart transplant a year earlier), felt that any kind of extra-medical regulation was largely unnecessary in terms of clinical decision making and/or might slow the pace of medical research. Owen Wangenstein, Professor Emeritus of Surgery at the University of Minnesota, went further and rejected the view that that theologians, philosophers and others had anything to offer in moral debates concerning medicine¹⁷. Others disagreed: the Nobel prize-winning biologist Joshua Lederberg not only welcomed the Mondale hearings but suggested that they be expanded from a one-year fixed term inquiry into a permanent standing body, whilst Beecher advocated the involvement of other academics and professionals in multidisciplinary ethical committees¹⁸.

Antagonistic medical attitudes persisted well into the mid-1970s. In 1975, the psychiatrist Dr. Jay Katz was so sure of his colleagues' ire that he asked Jonsen (as noted in the previous chapter, a former Jesuit priest) to administer the last rites before delivering a conference paper outlining the conflict of interest he perceived when doctors acted as both researcher and caregiver in clinical trials¹⁹. Wider public, governmental and academic opinion, however, continued to move towards favouring interdisciplinary work: although Katz's 1966 Yale seminars on the ethics of research had been received poorly by medical students, they were enthusiastically welcomed by those studying law²⁰. Interdisciplinary research centres such as the Hastings

Centre²¹ and the Kennedy Institute of Ethics at Georgetown University²² were established, and 1975 saw the launch of the *Journal of Medical Ethics*, with its stated aim ‘to provide a forum for the reasoned discussion of moral issues arising from the provision of medical care’ by ‘[calling] on the resources of the disciplines of law, philosophy, and theology as well as on the whole range of medical and paramedical specialties’²³. Over the course of the decade philosophers were able to demonstrate their worth in both deepening and, in some cases, attempting to resolve moral debates in medicine.

Not all philosophers, however, saw this return to first-order work as the hallmark of a ‘new vitality’: John Silber, for example, had offered an immediate response to Chomsky’s criticisms in which he emphatically rejected that philosophers had any wider responsibility to influence first-order decisions at all and instead reaffirmed that their role in public policy began and ended with distinguishing competing kinds of ethical theories from each other²⁴. Indeed, some viewed the efforts of those who *did* choose to become involved in first-order work as a ‘cheap purveying of proper philosophy’²⁵. Although many philosophers initially had a hard time taking them seriously, theologians working in medical ethics could at least draw on a tradition which had few if any qualms over asserting its authority in moral affairs and an established way of working. By contrast, the majority of philosophers were, in a sense, pioneers who had set off into territory that many in their academic background had left uncharted for some time. They lacked an ‘overarching philosophical theory’, had little in the way of ‘orthodoxy or a common methodology’ beyond ‘a method of analysis to be applied to other disciplines and activities’ and were unaccustomed to regarding themselves as moral authorities²⁶. Perhaps unsurprisingly, many felt ‘at pains to represent themselves [as] professionals with their own particular brand of expertise’²⁷; the nature of this ‘expertise’, however, and its role in wider discussions, was yet to be defined.

Establishing a Role for Philosophy in Interdisciplinary Medical Ethics: Hare's 'Medical Ethics: Can the Moral Philosopher Help?' and Rawls' 'Outline of a Decision Procedure for Ethics'

Building on a 1975 conference address, Hare's 'Medical Ethics: Can the Moral Philosopher Help?' offered an outline for the role of philosophy in medical ethics which both acknowledged Chomsky's criticisms and built on that envisioned by Kaplan at Portland in 1966. According to Hare, '[if] the moral philosopher cannot help with the problems of medical ethics, he ought to shut up shop'; for him '[the] problems of medical ethics [were] so typical of the moral problems that moral philosophy is supposed to help with, that a failure [to do so] would be a sign either of... uselessness [or] incompetence'²⁸. But what was the nature of the help that the philosopher was to offer? Hare identified three separate, yet related, strands. The first of these dealt with conceptual analysis and the assessment of both the language and structure of arguments involved in a given moral debate²⁹: the philosopher was to evaluate arguments and the language used to make them using certain 'general standards of rigour' including but not limited to 'knowing, and being able to explain, exactly what one means when one says something... being able to say what follows logically from it and what does not [and] what it is logically consistent with'³⁰. In other words, the philosopher was to examine different moral positions with a critical eye in order to weed out inconsistency by clarifying 'tricky words' and establishing 'canons of valid argument'³¹.

Both Jonsen and Winkler appear to have mistaken this part of Hare's proposal (what the former terms 'only a philosophical instrument'³²) for the whole. Indeed, Winkler goes so far as to describe Hare's position as 'optimistic' in terms that suggest he believed moral debate would be a thing of the past once philosophers had helped to 'order our understanding of practical issues and... overcome various confusions and fallacies'³³. In doing so he misrepresents both Hare's view of the practical difficulties involved (which he felt '[were] likely to remain serious'³⁴, something Jonsen at least acknowledges³⁵) and his stated position on the ability of philosophy to resolve moral debate. Although Hare thought that 'once the issues are thoroughly clarified... problems will not seem so perplexing as they did at first'³⁶ he also argued that '[philosophers] cannot give their patients pills which the patients can just swallow'³⁷.

Hare seems to have envisaged conceptual analysis as serving to reduce to their most basic elements the theoretical and practical issues that are the object of debate. The closest to any resolution such analysis might achieve by itself lies in the identification of arguments that are unlikely to ever succeed by showing that their premises stand little chance of being established one way or the other (Hare gives arguments against abortion that describe it as the ‘intentional killing of an innocent human being’ as an example, arguing that too many of the words involved are resistant to precise definition³⁸).

This aspect of Hare’s proposal is, in fact, concerned less with the immediate resolution of moral problems than it is with achieving clarity about just what is at stake, something that can be drawn out by considering another example he gives of how to apply this kind of philosophical analysis to one sort of argument regarding a problem in medical ethics, namely those against euthanasia that appeal either to a general moral principle against killing or to a more specific principle that doctors should strive always to preserve the life of their patient³⁹. Hare offers utilitarian arguments both for and against such principles: ‘it will be argued on the one side that the cases calling for euthanasia... are very numerous and that [we should] *change* our attitudes... on the other side that these cases are relatively few, and can be looked after in other ways’⁴⁰. What is important, for him, is that such questions can be investigated ‘with some hope of discovering the answer’: for example, we might undertake to discover how many such cases there are, or to ‘ask what it would be like, in hospitals and in the homes of dying patients, if one attitude or the other were adopted’. The process would end, not with a decision having been made, but with the philosopher ‘*returning* the problem to the non-philosopher for further investigation’ [my emphasis]⁴¹.

This example also introduces the second element of the ‘help’ Hare envisages the philosopher offering when tackling problems of medical ethics. Along with their analytical and evaluative skills, philosophers also brought with them knowledge of ‘classical theories of ethics’⁴² which could be applied to real or projected scenarios of moral controversy (we have already encountered one example of this in the previous chapter with Kaplan’s invocation of Kant). Yet although Hare’s own work in meta-ethics had convinced him of the rightness of his own conception of preference

utilitarianism, he acknowledged elsewhere that no such theory is universally accepted⁴³. This was, however, not an especially serious problem for him since he argued that *in practice* different theoretical approaches such as the Christian ‘golden rule’, Kantian deontology and Rawlsian contractarianism were likely to lead to similar conclusions to his own in the form of general universal moral principles (for example, against killing)⁴⁴: he was perfectly at ease employing contractarian⁴⁵ or Kantian⁴⁶ arguments elsewhere in his work. Hare sometimes seems to suggest that this practical agreement might itself help to resolve theoretical disputes⁴⁷; at others (‘[the philosopher] will have to *start* from some general theory [my emphasis]’⁴⁸) he comes close to arguing it is *necessary* for the proper development of ethical theory. Significantly, he contends that it is the *practical* elements of deontological arguments that need to be accommodated through the sophistications he sought to introduce to utilitarian theory⁴⁹.

The third part of the role Hare envisaged for philosophy in medical ethics builds on elements of the first two and is concerned with working out how the fruits of these activities can be put to use in concrete settings. What Hare contends he has described so far is the second ‘kind of thinking’ we do about moral matters: the sort ‘we ought to do when we are not faced immediately with a particular problem’. At such times ‘we can take [problems] at our leisure, including what happened *after* [any] crucial decision was made’. We can also ‘*invent* details to illustrate particular points’ and ‘consider hypothetical, even fantastic, cases’⁵⁰. Although this thinking will, for Hare, necessitate establishing certain principles he accepts that these are likely to be too specific to be of immediate practical use in the majority of situations⁵¹. We should not forget, argues Hare, the *first* kind of moral thinking: the sort we engage in when confronting a particular case⁵². Most of the time ‘doctors and others... are not going to be able to give the cases in which they find themselves involved nearly so much thought, because they will not have the time or the information’. What Hare argues are needed are ‘general [principles] which give the best guidance in the ordinary run of cases’; principles that ‘doctors [should] adopt almost as second nature’⁵³. These everyday principles are quite different to those established during the first kind of thinking, since although they are binding in the majority of circumstances ‘in very particular cases [doctors] may find themselves constrained to depart from them’⁵⁴.

These three aspects of the role that Hare envisaged for philosophy in medical ethics carry with them two further implications. First of all, they seem to presuppose or at least strongly recommend further interdisciplinary work beyond the encounter between doctor and philosopher. Social scientists, for example, would presumably be able to furnish the arguments and attitudes already present in debates, or to examine whether (if at all) a change in doctors' attitudes towards keeping their patients alive when *terminally* ill fundamentally altered (as it was argued it might⁵⁵) their attitude towards attempting to save those only *gravely* ill. Similarly, the input of lawyers would seem to be required to help work out if, when and how best to adapt or apply rules into legislation. Secondly, Hare describes moral thought regarding medicine as a *necessarily* ongoing process; what we might term a continuous moral engagement with medicine. Much as we have argued was the case with the rules and guidelines of Hippocratic and professional ethics, the general principles Hare envisages would be dependent to an extent on information and/or circumstances (from the general, such as just what constitutes 'the ordinary run of cases' to the specific, such as 'the number of people who die in agony of terminal cancer'⁵⁶) that are subject to change.

Given the nature of the problems facing medicine in the 20th Century as described in Chapter 6, Hare's proposal has several attractions. It offers, or appears to offer, a method for philosophy to contribute to reducing and/or negotiating a wide range of complex ethical problems even in the absence of any universally agreed ethical theory, and even allows for the use of existing ethical theories to illuminate problems without any requirement they be proved universally correct. Furthermore, Hare appears to account for both how and why moral change of the type we have described with regards to Hippocratic and professional medical ethics takes place due to ongoing practical and theoretical developments. In the former case, for example, Hare notes elsewhere that the development of an over-the-counter abortifacient pill would alter at least one aspect of the abortion debate in that doctors' consciences would no longer be involved (although he forgets that pharmacists' consciences might)⁵⁷; in the latter it seems that it might always be possible to think up new hypothetical cases which illuminate our understanding of moral problems in new ways and lead us to revise our principles. Moreover, his account seems to suggest that doctors, philosophers and others should be alive to the likelihood of such change taking place (after all, we *ought* to be thinking about hypothetical moral problems even when not

faced with them, and/or reflecting on how we dealt with real-world problems after the fact) and considering how any new insights developed might be applied in practice.

Other than in his description of conceptual analysis, Hare's proposal in fact comes close to approximating a method suggested by Rawls over two decades earlier in his 1951 paper 'Outline of a Decision Procedure for Ethics'. The aim of this paper was, given the existence of ethical propositions, to discover if 'there [exists] a reasonable method for validating and invalidating given or proposed moral rules and those decisions made on the basis of them'⁵⁸. Rawls divided his paper into six parts, with the bulk of his proposed method occupying the second, third and fourth. These can be broadly categorised as follows. Initially, there is the question of defining 'first, a class of competent moral judges and second, a class of considered judgements'⁵⁹. Once these have been established, there is a second task: 'to discover and formulate a satisfactory explication of the total range of these judgements'⁶⁰. Finally, there remains 'the principal aim of ethics... the formulation [from such judgements] of justifiable principles which may be used in cases wherein there are conflicting interests to determine which one should be given preference'⁶¹.

The first element required for such a process, Rawls' proposed class of 'competent moral judges', are defined as needing to be no more than averagely intelligent, with a knowledge of the world, the likely consequences of frequently performed actions and the specific features of individual cases that might reasonably be expected of such an individual. They should be willing to use 'inductive logic to establish what is proper... to believe', to try to find reasons for and against different courses of action when confronted with a moral situation, and to be aware of and attempt to take into account questions of prejudice and bias, without being fatalistic as to their influence in determining decisions. They should be able to display imagination when confronted with situations they have not themselves directly experienced⁶². In making their considered moral judgements, they should be free from all foreseeable consequences of the judgement (for example, they should not be punished for judging one way or the other, nor should they stand to gain anything from doing so), have as much information as possible about the case before them, and sufficient time to reflect upon it. Judgements should be made with a degree of certitude, and be stable (that is, likely to be made by other competent judges at other times with regards to similar cases)⁶³.

Once a set of moral judgements has been arrived at, the next step is to use these to create (or perhaps, discover) 'reasonable principles' by which we could determine whether a given course of action was 'just and right'⁶⁴ through a process Rawls terms 'explication'. The goal of this process is to produce 'a set of principles, such that, if any competent man were to apply them intelligently and consistently to the same cases under review, his judgements, made systematically nonintuitive by the explicit and consistent use of principles, would be, nevertheless, identical, case by case, with the considered judgements of the group of competent judges'⁶⁵. Broadly speaking, principles represent 'the invariant in what we call 'moral insight'', with their formulation from a collection of individual judgements filtering out '[individual] predilections'⁶⁶. The only judge of a principle lies in its ability to resolve existing and likely cases of moral complexity, and its ability to 'hold its own' against considered judgements (that is, produce an intuitive response in cases of conflict that the judgement is *at least* as likely to be in error as the principle); the judgement or principle may then be revised as necessary⁶⁷.

Rawls' method is of course open to objection. Notably, there is a great deal of assumption going on in his initial selection of 'competent moral judges' for which he is initially able to offer only the contentious argument that 'it is men of their character whom we would want to decide any case in which our interests are at stake'⁶⁸. Yet Rawls accepted that the method he proposed was in a sense, experimental and needed to be *tried* to see what results, if any, it was capable of yielding⁶⁹. He did not know (and did not believe it possible to know) 'ahead of time' whether his method was the correct one or, indeed, whether any principles of the type he described even existed at all; as such, there will be 'in all probability, instances in which we could not decide whether a person is a competent moral judge or not'⁷⁰. He thus meets with more success when moving away from a positive definition of such individuals and instead considering criteria which should *not* be used for selecting them: claims for 'a monopoly of the knowledge of truth and justice for some particular race, or social class, or institutional group [in which] competence is defined in terms of racial and/or sociological characteristics'⁷¹. Since it is not possible to pre-judge what will constitute the content of moral principles (should any exist) prior to the application of this method it seems reasonable to *start* by removing such prejudices as it is possible or practical to remove from consideration.

These objections aside, the work of Rawls' 'competent moral judges' seems very much like the second kind of moral reflection identified by Hare, and the process of 'explication' very much like the creation of general principles for use in the first. On such a view, we would identify Rawls' 'considered moral judgements' of particular cases with principles in the first sense Hare uses the word, and Rawls' principles with the second. Such an approach has the advantages of drawing a clear line between the two senses of the word principle (which, on Hare's account, seem very distinct from one another) and of firming up the status of principles in the second sense. A set of rules, guidelines and/or attitudes that have the effect of causing us to question our intuitive judgements seems to correspond very well with Hare's requirements for general principles: 'even if [a case] is peculiar – even if in this case we ought to break the good general principle – we shall do so with the greatest misgiving [and that] does not... mean that the good general principles are no good'⁷². Before adopting such a reading, however, there appear to be three significant points of difference between the two accounts that need to be dealt with. Firstly, Rawls' judges should not undertake conceptual analysis, either of 'of the meaning of the ethical terms used in the judgements' or 'what people intend to assert when they use ethical expressions'⁷³. Secondly, judges should consider only cases in which there are actual conflicts of interests (so not, for example, hypothetical cases)⁷⁴. Finally, although judges may make use of intuition (including reflection and common-sense rules) they should not use in the first instance detailed ethical theories or principles derived from them⁷⁵.

None of these three differences are insurmountable; indeed, it is possible to argue that Rawls' account is in fact improved in this respect by adopting elements of Hare's. First of all, whilst it makes sense that, if we cannot know for certain what any invariant in moral judgement (should there be one) is we should not rule out any sincerely held judgements straight off the bat, it does not seem possible that explication would be possible without further analysing whether our competent moral judges have always said quite what they mean, or if they (perhaps subconsciously) mean more than they say. Secondly, whilst it seems right that the object of moral deliberation be real-world cases of moral debate (and not, for example, choosing ties or grading fruit) that need not rule out the use of hypothetical examples or thought experiments to demonstrate and/or explore the practical or logical consequences of a particular principle or course of action. Finally, it is hard to see what objection Rawls

could have to the use of ethical theories or principles provided one accepted the possibility that these theories or principles could be revised by considered moral judgements (as Hare seems to) given his example of a typical ‘common-sense rule’ that would be acceptable (‘promises ought to be kept’⁷⁶). After all, key elements of many philosophical theories of ethics (‘secure the greatest good for the greatest number’, ‘treat people as ends not means’) are also (or have become internalised as) common-sense rules, albeit less specific ones.

Much like Ramsey and Fletcher, the influence of Hare and Rawls lay in assuming the basic correctness of some kind of moral insight underpinning the major traditions of moral philosophy that meant they could, even in the absence of a universally-accepted theory, be employed to carefully consider particular examples (be they real-world cases or thought-experiments) in an attempt to move forwards. The early involvement of philosophers in interdisciplinary medical ethics generally reflected their approach. In 1976, for example, The Project on Moral Problems in Medicine at Case-Western Reserve University, established in 1970 in order to ‘educate philosophers about the questions raised in science and medicine’ published an anthology entitled *Moral Problems in Medicine*⁷⁷. The purpose of the anthology was to provide a collection of material ‘of value both to students training for the health-care professions and to those studying the humanities’⁷⁸; it contained ‘a mixture of philosophical and medical materials’ organised around various categories such as paternalism, truth and social justice⁷⁹. Rather than providing a ‘pill that could just be taken’ the philosophical content juxtaposed appropriate selections from ‘the reflections of classical philosophers’ with descriptions of concrete ethical dilemmas in clinical decision making, with the dual purpose of attempting to inform philosophers about medical matters and deepen doctors’ moral reflection⁸⁰. The ultimate goal of the project was to ‘develop a set of principles or perhaps a single principle that will enable us to make morally correct decisions and perform morally correct actions’⁸¹. In the United States, the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research suggested what three of these principles might be in the 1978 *Belmont Report* concerning biomedical and behavioural research: ‘respect for persons, beneficence and justice’⁸².

Early Examples of Philosophical Reflection in Late 20th Century Medical Ethics: the President's Commission's *Defining Death*, Thomson's 'A Defense of Abortion' and Hare's 'Abortion and the Golden Rule'

In the previous chapter we noted that early efforts to address the moral questions posed by changes in 20th Century medicine had been frustrated by three main factors. Firstly, as the content of the earliest conferences made clear, the scientific and medical establishment had proven unable or unwilling to recognise the moral issues *actually* before them. Secondly, doctors still tended either to mistake ethical problems for clinical problems or to neglect the ethical elements *of* clinical problems (hence, for example, the frosty reception to Katz's 1975 presentation on research ethics). Finally, as Ramsey's response to Shockley had demonstrated, these failings had been compounded by an inability to fully envisage the consequences of any conclusions reached if applied in practice. Societal pressure and the work of pioneering interdisciplinary conferences had gradually forced the medical profession to begin to face up to the problems identified in Chapter 6; it remained to be seen whether the philosophical tools identified above (the critical analysis of language and argument, the use of thought experiments, and the application of traditional ethical theories) could move things forward.

For one example of how the first of these tools could be applied to concrete situations, with results that showed Wangenstein had been flatly wrong in asserting that philosophers had 'nothing to offer', we may consider the outcome of the first enquiry undertaken between 1980 and 1981 by a new United States government body: The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research's attempt to create 'a uniform legal definition of death'⁸³. Demand for a revision of the standard legal definition (which had focused on the cessation of respiration, circulation and heartbeat) had been steadily growing since the invention of the modern ventilator in 1952. It had become apparent that some patients placed on the apparatus 'failed ever to breath again on their own and... slipped into deep unconsciousness, kept alive only by the [machine]'. Debates arose as to whether such patients should be allowed to die or were, in fact, already dead⁸⁴; By the 1960s, French neurologists began to develop the concept of *coma dépassé* (or 'ultra-coma') that allowed for death to be recognised as a neurological state separate

from respiratory and/or cardiopulmonary function. Although this criterion had been warmly accepted by some of those attending the 1966 CIBA Conference, others had voiced concerns as to the likelihood of its acceptance amongst both the medical profession and the general public. The result was a medical literature suffused with confusing terms such as ‘immanently’ or ‘virtually dead’⁸⁵.

An early American attempt to clarify the situation, the so-called ‘Harvard Definition’, introduced the concept of ‘brain death’ and allowed for legal statutes to be passed to recognise it⁸⁶. Despite swift acceptance, however, the report which outlined the Harvard Definition was (as Jonsen puts it) ‘odd in many ways’. It had been drafted by an *ad hoc* committee assembled by Beecher at Harvard Medical School whose final report ‘[stitched] together some medical information, a legal opinion and a theological statement’ (the theologian involved, Ralph Potter, could not remember in later years making any contribution of his own: he had deferred uncritically to Pope Pius XII, who had commented on the matter of artificial respiration in 1957). Crucially, with regard to several important elements, the ‘definition’ it provided was anything but. The concept of ‘irreversible coma’, for example, was not properly distinguished from either cessation of function in the brain stem or indeed ‘brain death’ itself, nor was it made clear whether turning off a ventilator constituted allowing a terminally ill patient to die through ceasing life support or withdrawing respiratory support from the body of the deceased. Despite a plethora of similar statements in subsequent years, two basic questions remained: to borrow Jonsen’s formulation: ‘what are the human functions that define human life and how are their presence and absence recognised?’⁸⁷

It is perhaps unsurprising that Jonsen describes these questions as philosophical⁸⁸; indeed, the debate surrounding them was filled with the kind of imprecise language and argumentation that was ideally suited to resolution through the ‘clarification of tricky words and establishment of canons of valid argument’. The President’s Commission appear to have agreed, asking the two staff philosophers to clarify the various positions involved as a preliminary step before debating the issues. The first, Daniel Wikler, ‘sorted out three distinct arguments: loss of an essential characteristic of personhood, such as rationality, loss of personal identity, and loss of the value of being alive’⁸⁹ whilst the second, Robert Veatch, examined ‘the policy issues

associated with social decisions to treat a person as dead'⁹⁰ and argued against use of the term 'brain death', having identified the term as ambiguous (it could refer 'either to cessation of brain functions or to the death of a person based upon that cessation')⁹¹. Following this, the Commission held a round-table discussion of these issues involving 'religious scholars, lawyers and neuroscientists' with a view to examining whether an appropriate legal definition could or should be reached⁹².

The result was a report (*Defining Death: A Report on the Medical, Legal and Ethical Issues in the Definition of Death*) which contained a recommendation for the enactment of a Uniform Determination of Death Act, described in the following terms:

Recommended Uniform Determination of Death Act

An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards⁹³.

Defining Death marked a notable success not only for the Commission itself, but for the two philosophers involved and the methodology they had employed. Despite 'a spirited Talmudic debate' between two Rabbis (which Jonsen recalls involving a great deal of quotation in Hebrew 'much to the dismay of the recording stenographer') agreement on the proposed definition of death was reached with a speed that surprised the commissioners. Hare's hope that, following conceptual analysis, problems might not seem so 'perplexing' now appeared to have been a prophetic insight: this success was possible largely as a result of the analysis performed by Wikler and Veatch, which identified the key stumbling-block that had 'plagued' efforts to resolve the debate since the Harvard Definition had been arrived at, namely the failure to sort out 'the confusion between permanent coma and total organic death'⁹⁴. Moreover, the same care with language was employed with regards to the recommended Uniform

Determination of Death Act itself: having identified as a ‘major problem’ amongst various “‘model laws” and state variations [the] overly complex or inexact wording that characterises many of them’⁹⁵ every part of the definition had been worded specifically to address practical concerns over how it might be interpreted and/or implemented.

Cessation of cardiopulmonary function, for example, was identified as the primary indicator since ‘in the vast majority of cases [it] will be the obvious and sufficient basis for diagnosing death... when a patient is not supported on a respirator, the need to evaluate brain functions does not arise [and] the basic statute in this area should set forth the basis on which death is determined in such cases’; to use this cessation as an indicator of loss of function in the brain, whilst ‘conceptually acceptable’, seemed an unnecessary break with tradition⁹⁶. The phrase ‘irreversible cessation of *functions*’ was preferred to ‘loss of activity’ since ‘[bodily] parts, and the subparts that make them up, are important for the functions they perform’; undirected metabolic activity ‘cannot contribute to the operation of the organism as a whole’ and is thus ‘irrelevant in judging whether the organism, as opposed to its components, is “dead”’⁹⁷. It was also chosen ahead of ‘destruction of the organ’, which ran the risk on the one hand of confusing death with decomposition and on the other of not taking into account that one day ‘new clinical capabilities’ might mean that ‘even *destruction* of an organ [would] not prevent its functions from being restored’⁹⁸. ‘Is dead’ was preferred to the ‘will [or shall] be considered dead’ found in several model statutes since the latter ‘might be read to indicate that the law will consider someone dead who by some other, perhaps wiser, standard is not dead’⁹⁹, whilst ‘in accordance with reasonable medical standards’ was preferred to ‘in accordance with accepted medical standards’ since ‘lay jurors [might] conclude that a medical practice, although generally adopted, was “unreasonable”... [even] the prospect of [which] would unnecessarily disrupt orderly decision-making in this field’¹⁰⁰.

For an example of how such critical analysis of language and argument might be further supplemented through the discussion of thought-experiments, we may turn our attention to an earlier philosophical work: Judith Jarvis Thomson’s 1971 article ‘A Defense of Abortion’. The article begins by considering the most common argument

against abortion (discounting, for example, those that view the foetus as the property of a woman's male relatives), one she summarises as follows:

Every person has a right to life. So the foetus has a right to life. No doubt the mother has a right to decide what shall happen in and to her body; everyone would grant that. But surely a person's right to life is stronger and more stringent than the mother's right to decide what happens in and to her body, and so outweighs it. So the foetus may not be killed; an abortion may not be performed¹⁰¹.

Certainly, this reflects almost exactly the stated views of both the Catholic Church and, in the United States at least, part of the medical profession for much of the 19th and early 20th Centuries. As Thomson notes, discussions of this argument have generally involved attempting to demonstrate that the foetus is or is not a person (a question that, as we noted in Chapter 6, medical science had found frustratingly difficult to answer). Although Thomson was of the view 'that the foetus is not a person from the moment of conception' she nevertheless agreed with Hare that this question was unlikely to be answered: 'the prospects for 'drawing a line' in the development of the foetus look dim'¹⁰².

For this reason Thomson instead allows, for the sake of argument, the first premise (that the foetus is a person). Since the position she has described is, broadly speaking, syllogistic, she is therefore committed in trying to argue against it to addressing the second (that every person has a right to life that outweighs all others). She proceeds to consider whether this is, in fact, the case by offering several examples, restated in different iterations over the course of the article, of which we may consider the following three. Firstly:

You wake up in the morning and find yourself back to back in bed with an unconscious violinist... He has been found to have a fatal kidney ailment, and the Society of Music Lovers [have] kidnapped you, and last night the violinist's circulatory system was plugged into yours, so that your kidneys can be used to extract poisons from his blood as well as your own. The director of the hospital now tells you... 'To unplug you would be to kill him. But never mind, it's only for nine months. By then he will have recovered from his ailment, and can safely be unplugged from you.' Is it morally incumbent on you to accede to this situation?¹⁰³

Secondly:

There you are, in bed with the violinist, and the director of the hospital says to you 'It's all most distressing, and I deeply sympathise, but you see this is putting an additional strain on your kidneys, and you'll be dead within the month. But you *have* to stay where you are all the same. Because unplugging you would be directly killing the violinist, and that's murder, and that's impermissible.'¹⁰⁴

And finally:

[Suppose] it were like this: people-seeds drift about in the air like pollen, and if you open your windows, one may drift in and take root in your carpets or upholstery. You don't want children, so you fix up your windows with fine mesh screens... [however] one of the screens is defective; and a seed drifts in and takes root. Does the person-plant who now develops have a right to the use of your house?¹⁰⁵

From these three thought-experiments, Thomson argues that abortion is permissible in cases of pregnancy resulting from rape¹⁰⁶, in cases where the health of the mother is threatened¹⁰⁷, and that the foetus does not have a 'right' to reside in a woman's womb simply because she has consented to intercourse¹⁰⁸.

Whether one agrees either with these positions or with Thomson's arguments for them is perhaps less important for our current purposes than acknowledging the value of her methods. Through examining the structure of an argument against abortion, Thomson was able not only to identify that agreement was unlikely to be reached on the first premise but that the second premise was based on a moral judgement. Secondly, through her use of thought experiments like those above, she was able to show this judgement (though compelling when taken at face-value) is problematic. In doing so, she demonstrated how tools common to philosophy could resist the presentation of complex moral issues simply as matters of clinical judgement (and, we should not forget, in doing so gave voice to the arguments of many women – and some doctors¹⁰⁹ – that the traditional argument had left 'shouting into the wind'¹¹⁰). Moreover, her examples are not simply rhetorical flights of fancy; they are used to demonstrate how taking even a relatively unproblematic moral judgement at face value can misrepresent the complexity of real-world cases. For example, Thomson argues that the traditional argument sees no compelling moral difference between 'a sick and desperately frightened fourteen-year-old schoolgirl, pregnant due to rape'

and a woman who '[requests] an abortion... in her seventh month... just to avoid the nuisance of postponing a trip abroad'¹¹¹.

As Hare noted in his own exploration of similar issues in 'Abortion and the Golden Rule', Thomson's argument is noticeably theory-light, something that could prove to be a drawback: '[the article] has been justly praised for the ingenuity and liveliness of her examples [but she] simply parades [them] before us and asks what we would say about them... how do we know whether what we feel inclined to say has any secure ground?'. As Hare points out, Thomson's subsequent dialogue with an opponent of abortion, Finnis, whose 'intuitions... differ from hers... in the wildest fashion', was every bit as unproductive as the wrangling over whether or not the foetus was a person since we 'do not know how to tell whether [either] is on safe ground' in making their respective claims¹¹². Hare agrees with Thomson that it is unlikely that the issue can be resolved through attempts to establish whether or not the foetus is a 'person', although for different reasons: for him, asking 'physicians [or] metaphysicians' to determine whether or not the foetus is a person is an attempt to evade responsibility for doing moral thinking of our own. He argues instead that we *already* have the information required for moral deliberation of the relevant question (namely 'How ought a creature, about whose properties, circumstances, and probable future we are quite adequately informed, be treated?') and that 'the word "person" is doing no work here (other than that of bemusing us)¹¹³. However, he also argues that the issue is unlikely to be settled by 'claims that women have a right to do what they like with their own bodies' since the term 'right' is too ambiguous to provide clear guidance: '[does] it... mean that it is not wrong for them to terminate their own pregnancies, or that it is wrong to stop them doing it, or that it is wrong not to assist them [?]'¹¹⁴.

For Hare, rather, the only way for philosophers to help 'contribute to the solution of this and similar practical problems' is to attempt to establish 'a theory of moral reasoning that will determine which arguments we ought to accept'¹¹⁵. As in 'Medical Ethics: Can the Moral Philosopher Help?', he notes that he believes his 'own universal prescriptivism' to be the most promising candidate, but he also reaffirms that this approach is underpinned by 'a type of argument which... has been the basis of almost all theories of moral reasoning that have contributed much that is

worthwhile to our understanding'. Of these approaches (including 'the Christian (and indeed pre-Christian) "Golden Rule", the Kantian Categorical Imperative, the ideal observer theory, the rational contractor theory [and] various kinds of utilitarianism') Hare elects to consider the problem in light of the first, noting firstly that 'the problem is discussed as often as not from a Christian standpoint' and secondly that 'do to others as we wish them to do unto us' (rephrased as 'do to others what *we are glad was done to us*') should be acceptable not only in terms of his own moral theory but to all disputants in debates regarding abortion¹¹⁶. The application of this rule to the debate is deceptively straightforward: since, 'if not terminated... pregnancy is highly likely to result in the birth and growth to maturity of a person just like the rest of us'¹¹⁷ it seems to follow that '[if] we are glad that nobody terminated the pregnancy that resulted in *our* birth, then we are enjoined... not to terminate any pregnancy which will result in... a person having a life like ours'¹¹⁸.

Despite this, Hare does not think that the application of this approach to the problem does in fact '[render] impregnable the extreme conservative position' that no abortions are morally permissible whatsoever. Rather, it 'creates a rebuttable or defeasible presumption against abortion, which is fairly easily rebutted if there are good indications'. First of all, as Hare points out, if we are obliged to take into account the potential for the foetus to eventually have a life for which it is glad, we are also obliged to take into account other potential beings, for example 'the next child that the mother will have if this pregnancy is terminated but will not have if the pregnancy is allowed to continue [for example if she] would die or be rendered sterile [as a result]'¹¹⁹. Although we may assign potential foetuses less moral weight than actual foetuses (due to their – at present – correspondingly lower chances of at some point being glad of their lives) this may vary in accordance with what is known about the life-chances of the actual foetus: for example, if the actual foetus is likely to grow into a 'miserably handicapped' child but a potential foetus is not (as may happen should the mother contract Rubella) 'there would be reason to abort this foetus and... bring to birth the next child, in that the next child will be much gladder to be alive'¹²⁰. Moreover, '[the] interests of the mother may well, in many cases, provide such good indications [as may justify an abortion], although, because hers is not the only interest, we have also to consider the others'¹²¹. So whilst Hare concludes that 'abortion is *prima facie* and in general wrong in default of sufficient countervailing

reasons' he *also* argues that 'countervailing reasons are not too hard to find in many cases'¹²²; indeed, he contends that his arguments grants liberals 'all that they could reasonably demand'¹²³.

It is important to note that Hare's argument does not, despite his acerbic closing comment that 'it is such a pity that so many people – even philosophers – think that they can discuss abortion without making up their minds on the fundamental problems of moral philosophy'¹²⁴, relegate Thomson's examples and others like them to uselessness. As we have already noted, Hare himself saw the value of employing thought experiments and 'fantastic cases' when undertaking second-level moral thinking (which is the kind that he thinks the problem of abortion necessitates¹²⁵) and he concedes that '[her] examples are entertaining, and help to show up our prejudices'. Instead, his argument demonstrates firstly that such examples are best understood as one *part* of philosophical reflection to be supplemented by others and that secondly, once our prejudices and intuitions have been revealed, moral theory may (even in the absence of universal agreement on just what that theory should be) be able to play a role in attempting to decide 'which prejudices ought to be abandoned'¹²⁶.

Conclusions

If the examples above offer some illustration of just what philosophers could contribute to interdisciplinary discussions of the moral problems posed or encountered in mid- to late-20th Century medicine, we should not forget that these problems themselves contributed to giving philosophers a context (similar to that described by Rawls) in which to exercise their skills (of a type similar to that outlined by Hare). The 'expertise' that philosophers offered in such discussions may therefore be seen, not simply as something they brought with them from their own discipline, but as something that arose from the interaction between several separate technical skills or areas of knowledge that they possessed (for example, analysis of language and/or argument, familiarity with traditional theories of ethics) on the one hand and the needs of others in tackling a range of different problems (for example, the recognition of arguments and/or the clarification of concepts used in them) on the other. The initial impact of philosophers' involvement may be seen to have been a qualified success;

however, there remained those who would dispute whether this was in fact the case, or if so, whether it could be sustained.

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 - ⁴ Jonsen, A. *The Birth of Bioethics*. p.76
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 - ⁶ Ibid. p.75
 - ⁷ Ibid. p.73
 - ⁸ Jonsen., A.R. *The Birth of Bioethics* p.76
 - ⁹ Rawls, J. 'Outline of a Decision Procedure for Ethics' in Rawls, J. ed. Freeman, S. *John Rawls: Collected Papers* (London: Harvard University Press, 1999) p.8
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 - ²⁹ Winkler, E.R. 'From Kantianism to Contextualism' p.346
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 - ³⁷ Ibid. p.3
 - ³⁸ Hare, R.M. 'Medical Ethics: Can the Moral Philosopher Help?' pp.3-4
 - ³⁹ Ibid. pp.7-8
 - ⁴⁰ Ibid. p.9
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 - ⁴³ Hare, R.M. 'Survival of the Weakest' in Gorovitz, S., Macklin, R., Jameton, A.L., O'Connor, J.M. and Sherwin, S. (eds.) *Moral Problems in Medicine* (Prentice-Hill: Englewood Cliffs, 1976) p.364
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 - ⁴⁶ Hare, R.M. 'A Kantian Approach to Abortion' in Hare, R.M. *Essays on Bioethics* p.172
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 - ⁴⁸ Hare, R.M. 'Survival of the Weakest' p.364
 - ⁴⁹ Hare, R.M. 'Medical Ethics: Can the Moral Philosopher Help?' p.6

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- ¹²⁶ Ibid. p.58

Chapter 9: Criticisms of Moral Philosophy in Interdisciplinary Medical Ethics in the late 20th Century

As we saw in the previous chapter, the initial encounter between philosophy and interdisciplinary medical ethics in the late 20th Century appeared to lead to some progress in tackling the issues at hand: cases were examined, arguments clarified and, in the United States at least, the ideas expressed over the course of various debates passed into both public consciousness and, occasionally, the statute books.

Philosophers had, as Winkler puts it:

contributed to the reduction of traditional forms of paternalism in medicine, to a general strengthening of the rights of patients and research subjects, and to improved conceptions of the appropriate use of medical technology and of the proper goals of medicine

and their involvement in bodies such as the President's Commission had proved a 'powerful counterpoint to the precious conceit of the *ancien régime* that "philosophy boils no cabbages"'¹. Nevertheless, some within the medical profession believed that a focus on theoretical and intellectual matters was distracting attention away from the realities of clinical practice, something that (it was felt) philosophers and other moral theorists did not acknowledge or understand.

On the basis that 'only the physician is in a position to really understand and address moral problems in medicine', these critics advocated the adoption of what they termed clinical ethics: 'dominated by people from the medical scientific community [and] centred in the clinic... informed by the realities of actual professional practice'². Certainly it is hard to argue against the view that a knowledge of and appreciation for the realities of medical practice is of value to anyone who intends to reflect on moral issues in medicine. Similarly, it is doubtless important for moral theorists to remember that it is doctors and not theorists themselves who will most often bear responsibility for such moral decisions as are taken in the course of medical practice. On the other hand, we may remember from earlier chapters that 'the medical scientific community' had, when entrusted with sole responsibility for deciding on moral matters in medicine, not proved particularly adept at dealing with them. Moreover, the

literature produced by the clinical ethics movement tended to differ in language only from work already being done: ‘an increase in clinical data [and] a decrease in philosophical jargon’ nevertheless ended up leading to ‘recommendations... otherwise indistinguishable from what one would expect’ from their intended targets³. It was not only the medical profession, however, who criticised philosophers’ involvement in medical ethics; by the mid-1980s, dissenting voices could be found amongst lawyers, social scientists, politicians and within the discipline of philosophy itself.

Surveying criticism of his and his colleagues’ work during this period, Gorovitz was able to identify ten main criticisms from a variety of sources that he grouped into four main strands: those that ‘[reflected] misgivings about... methods and foundations’ (for example, claims that ‘unlike work in the sciences [ethics] consists of assertions without prospect of verification’)⁴; those ‘[centred] on pedagogical matters’ (for example, claims that ‘ethics in general can’t be taught but is a matter of character that depends on nonacademic influences for its development’)⁵; those ‘[focused] more generally on utility’ (for example claims that philosophers’ involvement ‘makes practical matters worse... confuses health care providers, heightens the anxiety of patients, complicates the work of planners and policymakers, and promotes regulations that impede clinical practice’)⁶; and those concerned with ‘moral integrity’ (for example claims that philosophers either ‘[promote] unwholesome relativism... or systematically [overemphasise] certain social values, such as liberal individualism’)⁷. Gorovitz allows that ‘each of these criticisms has some merit, yet each is somewhat misguided’ and, as we shall see over the course of the following chapter, his assessment is probably about right. Yet, as he also points out, ‘even criticisms that are untenable as stated may point to prospects for improvement in what they criticize’⁸; as Lesser has argued with respect to one of the specific works we will consider below, they are unfair mainly in what they leave out⁹. For this reason, the following examination of several of these criticisms can be seen to contribute to our understanding of several important aspects of philosophical moral thought in medicine.

‘Moral Experts’ or ‘Moral Options Brokers’?

The philosophically-trained lawyer Cheryl Noble’s ‘Ethics and Experts’ was penned in 1980, just as proceedings at the President’s Commission were getting underway, and later reprinted in the *Hastings Center Report* together with responses from a doctor and three philosophers. The article was strongly critical of what Noble saw as philosophers’ ‘pretensions’ in the field of applied ethics (including medical ethics and the use of philosophy in ethical discussions regarding other areas of public life such as business¹⁰) and in particular of what she saw as their claim to ‘a special competence to resolve matters of right and wrong’¹¹. Furthermore, she argued that the pre-eminence of philosophy in interdisciplinary medical ethics was not the result of its usefulness in addressing the issues at hand but rather of a mixture of opportunism and historical accident. Whilst allowing that ‘not even philosophy’ could remain indifferent to the social upheavals of the late 20th Century, Noble characterises applied ethics chiefly as an attempt by academics to secure students and funding, helped by a social climate ‘fed up with its own scepticism and relativism’ and eager to see ‘moral problems [as] the cause rather than an integral part of other social conditions’, and the fact that ‘something *called* ethics has been taught in philosophy departments for as long as philosophy has had a department [my emphasis]’¹².

In effect, Noble claims, the practice of philosophical applied ethics amounts to little more than a confidence trick. Philosophers (on this view) simply dress up ‘conclusions... drawn from a preexisting range of alternatives’ in technical language that privileges the philosopher over the layperson and gives rise to the idea of a ‘philosophical expert’ who can be consulted in moral matters ‘just as there are experts to deal with environmental and engineering problems’. Noble argues that, far from contemporary philosophy having been ‘broadened to encompass moral reflection [it had rather] narrowed the field of moral reflection [in line with the] technician’s skills’¹³. Philosophers remain ‘indifferent to history, sociology, and psychology and... inevitably [produce] a kind of moral criticism that is conventional, comfortable and tame’¹⁴; they do not explore, for example, the social context in which something is considered to be moral or otherwise: ‘the ‘facts’ apparently do not extend to an understanding of historical or economic context’¹⁵. As examples, she points to two essays by Nagel, one on the morality of war and one on the justice of income

differentials between 'professionals' and 'blue collar workers', in which she saw little more than 'highly abstract descriptions of norms already embodied in those practices'¹⁶.

When Noble's article was reprinted in the *Hastings Center Report* all four respondents flatly rejected her claim that philosophers' needlessly complicate everyday moral issues, instead stressing the opposite view that philosophy '[clarifies] our thinking about moral issues through the analysis of important concepts and by organizing and rectifying arguments and points of view'¹⁷. The doctor, Jerry Avorn, argued that – far from having taken issues out of his hands – he was more than happy to be able to turn to philosophers in order to 'utilise their expertise to sharpen the focus of [moral] issues'¹⁸ (which is of course quite different to *resolving* them for him). Beauchamp helped to outline just how philosophy could do this, noting that the critical analysis of language Noble called for with regards to Nagel's supposedly uncritical use of the word 'fight' in his article on war is in fact typical of rather than antithetical to philosophy¹⁹ (somewhat confusedly, Noble had also criticised Dworkin for offering too *many* accounts of what 'equality' and 'justice' can mean in an article on positive discrimination she dismissed as 'tedious and complex'²⁰); we may also recall from the previous chapter that philosophers did in fact perform this role with great success in the compilation of *Defining Death*. Beauchamp also noted that this analysis could be extended to arguments as a whole, revealing contradictions or unexpected consequences of commonly-held positions that would call for them to be revised²¹.

With regards to just what these revisions might be, Singer believed that, given his own views, he should 'be allowed a chuckle' at Noble's claim that philosophers only arrived at conventional conclusions²² (Noble's own response to this – that they were typical of any 'garden variety liberal'²³ – scarcely accommodated the examples he gave: '[a] defective human being has no more right to life than a dog, or a pig at a similar mental level' and '[infanticide] is often justifiable'²⁴). Moreover, philosophers working in interdisciplinary bodies did in fact come to conclusions that proved unacceptable to their colleagues: the President's Commission's 'essentially conservative' definition of death as cessation of *all* (rather than higher) brain functions was adopted *against* the advice of the philosophers involved²⁵. Noble's

argument also overlooked two further points. Firstly, as we have argued was the case with Thomson's 'A Defense of Abortion', a philosophical argument that concludes by lending support to a pre-existing viewpoint can be still be valuable *should that viewpoint have been unfairly marginalised or neglected*. Secondly, novelty in moral theory is not always a recommendation: whilst we should expect that moral philosophy should in some cases be 'subversive' (that is, retain the ability to 'undermine [the] assumptions of ordinary morality'²⁶) it is more-or-less self-evidently absurd that we should expect it to do so *in all cases*. Indeed, were a moral theory to suggest that even the majority of our previous conceptions of moral conduct were wrong, that would be reason enough to approach said theory with a degree of scepticism.

Beauchamp and Singer also repudiated Noble's claim that they saw 'the resolution of moral problems' as the 'special province of philosophy', and denied that they wanted 'to have moral problems of all kinds handed over to them as the appropriate experts'²⁷. Instead, two of Beauchamp's four examples of the use of philosophy in medical ethics involve dialogue with members of other disciplines with regards to policy and case decision (which is not the same as *instructing* them in what to do)²⁸. Noble responded by contending that philosophers still presented themselves in such discussions as 'the sole professionally competent ethicists', possessors of special knowledge beyond that of the layperson²⁹. Yet this criticism could only be sustained were philosophers to claim this 'special knowledge' was specifically related to morality (after all, *all* professionals have special knowledge beyond that of the layperson). It is quite clear that the philosophers who responded did not believe this to be the case: with regards to Singer, for example, the 'advantages that [he believes] philosophers *may* have over others when it comes to *discussing* moral problems [my emphases]³⁰ are concerned with 'powers of analysis and clarification [and] skill in... reasoning and argument' rather than any claim to a specifically *moral* skill or knowledge.

As Winkler has pointed out, however, this kind of rejection of the notion that philosophers possess moral expertise is 'consistent with the possibility that on many, or most, or difficult and complex moral issues, factual understanding together with philosophical analysis and moral argument... can at best only partially reduce the

range of what survives as defensible or justifiable moral options'³¹. Indeed, by the early 1980s it was becoming apparent that, despite its undoubted usefulness, philosophical work in medical ethics seemed in some cases to be coming close to its practical limits. For example, although *Deciding to Forego Life-Sustaining Treatment* had (by concluding that 'phrases like "right to die," "right to life," "death with dignity," "quality of life," and "euthanasia" [had] been used in such conflicting ways that their meanings [had] become hopelessly blurred'³²) been able to arrive at several definite conclusions regarding 'resuscitation policy... care of the permanently unconscious patient, and the ill newborn' it was unable to prevent the emergence (contrary to the Commission's expectations) of a 'vigorous, even rancorous, debate over assisted suicide'³³. The philosopher was becoming what Winkler has termed the 'moral options broker', doing little more than '[clarifying] alternative positions and [relating] them to central aspects of moral theory'³⁴: 'after problematic cases were trotted out, initial positions taken, facts and values clarified, and positions rectified and systematised, everyone tended to wind up with more elaborate versions of the views they had started with'³⁵.

Must Philosophers Claim to be 'Moral Experts'?

For some, this state of affairs was in keeping with the proper role of the philosopher in moral debate. Like Noble, Maclean's *The Elimination of Morality: Reflections on Utilitarianism and Bioethics* argues that philosophers involved in interdisciplinary medical ethics have pretended to a moral expertise that they have no right to claim. Similarly, just as Noble saw the involvement of philosophers in medical ethics as the result of a mixture of opportunism and historical accident, so Maclean attributes the late-20th Century growth of interest in first-order ethical work amongst philosophers, not to the new and perplexing moral challenges offered by (for example) the rapid growth and unprecedented success of technological and scientific medicine, but to philosophers' personal weaknesses and socio-economic changes in what was expected from academics and academic institutions. First of all, she argues, '[it] flatters [the philosopher's] self-esteem to see himself as a moral expert, an authority on moral matters called in to advise and assist important people like the doctor'; secondly, the materialist political climate of the 1980s had led to a need to show philosophy to be relevant and of 'use' that was at worst greedy and at best somewhat craven'³⁶. *Unlike*

Noble, however, Maclean has a clear conception of what philosophers might instead contribute to the field.

Perhaps surprisingly, Maclean describes what she thinks philosophers *should* be doing in terms that recall both the respondents to Noble's article and (at least part of) our own arguments in the previous chapter. For Maclean, the proper task of the philosopher in medical ethics is to help health professionals and others undertake critical analysis of their own values and moral judgements. First of all, philosophers should pose questions regarding moral judgements of particular situations: '[why] is it a moral issue at all for us? How does it connect up with other issues? What values does it put at stake?'. Following this, they can further analyse answers to these questions, since the answers, questions, and the situations that prompt the questions tend to be 'exceedingly complex [and] it is easy to confuse considerations relevant to one of these issues with considerations relevant to another, or to misunderstand the character of a particular claim or a particular objection'. In doing so, philosophers can help to identify logical fallacies and confusions between different sorts of issues (for example, empirical and conceptual issues), and analyse concepts (such as 'quality of life') that are 'vague, ambiguous, or even incoherent'³⁷. In summary (Maclean argues), the philosopher's task in medical ethics is 'primarily one of *clarification*: the clarification of issues, types of issue, assumptions, arguments and concepts'³⁸.

For Maclean, however, many philosophers (no matter how much they may protest otherwise) have given into the temptation to go beyond this role and are in fact committed by their methodology to doing so. Despite her title and her focus on utilitarian philosophers Maclean's book is not, in fact, an attack on consequentialist thinking *per se* but 'on a particular form of rationalism in ethics, to which she claims these writers subscribe'³⁹. And not only these writers: Maclean defines 'bioethics' as 'medical ethics as conceived and practised by philosophers working in the utilitarian tradition'⁴⁰, so for her 'all bioethicists are utilitarians', albeit 'invariably of an impure sort'⁴¹ (and presumably whether they agree with this judgement or not!). Maclean illustrates the commitment of philosophers working in medical ethics to this view via the following quotation from Harris:

[Our] interest in all these problems and dilemmas will be an interest in their resolution... just as the proper business of medicine is not merely to understand the nature and cause of illness but to try to prevent or cure it, so the proper business of medical ethics is not merely to understand the nature of the moral problems raised by medical practice but to try to resolve them⁴²

According to Maclean, this analogy ('*if* carried far enough [my emphasis]'⁴³) entails the view that it is the task of the philosopher to discover '*the right answers* to... moral questions' and that these will be like 'the right answers to certain other sorts of questions – mathematical questions... or technical questions'⁴⁴. In other words, it is to find 'the answers it is *rational* to give'⁴⁵: those justified by a 'reason (or principle) [that] it is demonstrably rational to select'⁴⁶. This description is, in fact, very close to what Winkler describes as the deductivist "'applied ethics" model of moral reasoning'⁴⁷. Under this model, '[one] justifies a particular judgement by showing that it falls under a rule', the rule under a principle, and the principle under 'the most abstract level of theory', with the final aim or 'Holy Grail' of moral thinking a 'single, comprehensive and coherent theory... based in universal, basic principles'⁴⁸.

We may of course simply object that this analogy should not be carried as far as Maclean chooses to: it may be that it is not only, as she thinks, a bad analogy for what philosophers *can* or *should* do in medical ethics, but a bad analogy for what they *actually* do and/or have done. Certainly, as noted in the previous chapter, Hare (who Maclean criticises at length later in the book⁴⁹) employed very similar language while still flatly denying that the philosopher could produce answers in this sense ('pills which the patient can just swallow'). Moreover, far from asserting the philosopher's special competence to *resolve* moral problems, we may also recall that Hare's proposals appeared to presuppose the philosopher working with others as part of an interdisciplinary effort and that (for example in the case of the President's Commission) this was in fact exactly what many philosophers ended up doing. Certainly, as Lesser has noted, with the possible exception of Singer, 'even utilitarian bioethicists... do not in fact believe [that they are moral experts in this sense]'⁵⁰ something attested to by the responses to Noble's criticisms considered above. On the other hand, Maclean advances 'a plausible argument that logically they should: if you believe that it is possible to discover the basis of ethics by the correct use of reason,

and also that you are using reason correctly in order to discover this basis, surely you must draw the conclusion that you are now a moral expert!’⁵¹.

Lesser has offered three reasons why this argument ‘though plausible, is unsound’. First of all, even were philosophers to believe that they ‘have reached the truly rational conclusion’ regarding moral matters they are also likely, given the difficulty of the task and the historical ‘lack of success [encountered] over many centuries [by] many great minds’ in attempting it, to accept that it is ‘close to certain... that they are partly wrong, and more likely than not they are seriously wrong’. Philosophers are therefore likely to accept that: ‘there are no moral experts... because there is no point at which we can claim immunity from further philosophical scrutiny’⁵². Secondly, although ‘[attempting] to work toward what is best supported rationally and may at the moment be taken as what is most likely to be true’ is a philosophical exercise, it does not follow that an academic training in philosophy is either necessary or sufficient to undertake it: ‘Socrates and Plato had no [such] training [whilst] Frege, though a brilliant logician, remained a rabid anti-semiter’⁵³. Finally, whilst working out fundamental principles of ethics may be ‘useful’ it is, again, neither necessary nor sufficient for moral conduct: it is not ‘necessary, because in practice... subsidiary principles [such as ‘it is wrong to cheat’] may serve as better guides to action’; it is ‘not sufficient, because we can still make mistakes in applying the principles [and] may be deflected... by all kinds of temptations and self-deceptions’⁵⁴. As such, ‘the rational search for basic moral principles... can be carried out without... the arrogant assumption that we are moral experts’⁵⁵.

Further Criticisms of the ‘Applied Ethics’ Model: ‘The Unbearable Lightness of Principle’

Maclean, however, does not simply wish to make the case that there are no (philosophical) moral experts *in practice*; she wishes to advance the stronger claim that in principle there *can* be no such thing or, to put it another way, that rational investigation into the fundamental principles of ethics is ultimately a fruitless enterprise that cannot get philosophers beyond the position of ‘moral options broker’ even if they would like it to: ‘disagreements [will] remain, and health carers and their patients will have no option but to live with them’⁵⁶. If philosophers remain

committed to the rationalist position she describes, then (she argues) such investigation must consist of an attempt to '[strip] away from our moral lives all the irrational elements, leaving behind only what can be defended on rational grounds'⁵⁷. This would result, she argues, in arguments such as the following, that she attributes to Harris:

Foetuses and infants... lack self-consciousness, and it follows from that that their lives are valueless; they are not lives that, other things being equal, it would be seriously wrong to end. On this account there are no rational grounds for moral qualms about either abortion or infanticide; for we may kill foetuses and infants if it suits us to do so... That... is *the rational conclusion*; if it proves repugnant to our *feelings* it is these we must disregard, and not what reason dictates⁵⁸

Maclean accepts that '[these] are not Harris's words' but asserts that 'they are a fair summary of what his argument implies'⁵⁹; furthermore, she contends that this is a typical example of bioethical arguments and has all the features that are generally admired by philosophers working in the field of applied ethics⁶⁰. Such arguments are, Maclean contends, open to objection on three main grounds. First of all, they are (indeed, *needs must* be) circular. Secondly, they result in 'reasons or principles' (for example regarding the value of life) that she regards as fundamentally unintelligible in the context of actual moral practice. Finally (as her remark regarding 'our *feelings*' emphasises) they take insufficient account of our emotional response to moral situations.

Maclean concludes that such arguments are inevitably circular since philosophers '*argue backwards*; and... have no alternative but to do so'⁶¹. They must work by starting out with those beliefs on which there is general agreement, and from there attempt to 'extract from them a theory which can be used to bring about agreement (among *rational* people at any rate) where there is presently contention and conflict'⁶². Maclean accepts that it may be possible, by so discovering that (for example) some of the things that we value about *adult* human life are linked to self-consciousness, to establish a *sufficient* condition ('value must be attached to the life of any creature that is rational and self-conscious'). But it is not possible to establish a *necessary* condition ('it is *only* the lives of rational, self-conscious creatures that have value') without first assuming that creatures that do not have these capacities do not

have value *in some other sense*. Nor would it be enough to argue that any ‘other sense’ chosen was simply an assumption and therefore irrational, since the process itself begins with such an assumption (namely, that adult human life is in some sense valuable)⁶³. In other words, such an argument starts, not from the standpoint of ‘reason’, but from the standpoint of *other values*.

Secondly, for Maclean ‘statements justifying what is to be done... take place in a certain context... and require no reference to anything outside that context’⁶⁴; indeed, for her, reference to anything outside that context is likely to be highly misleading. For Maclean, our moral practices do not proceed from decisions or judgements made for a reason or in accordance with a fundamental principle or principles, but rather from *attitudes* that are expressed in, and justified through, the practices themselves⁶⁵:

We are not of the *opinion* that it is generally wrong to kill babies. Our thinking this is a matter of what we *do*, as a *matter of course and without question*... We treat babies in some ways and not in others; not, for example, as if their lives were at our disposal... there is no reason [for our doing so] – or, to put the same point differently, their being babies *is* the reason, all the reason in the world.⁶⁶

On this view, any attempt to extract reasons and/or principles from these practices that can be applied in other situations inevitably involves presupposing the existence of questions and answers that are not, in fact, present in the situations themselves. For example, in the kind of argument Maclean attributes to Harris, ‘day-to-day decisions’ concerning the end of life in a medical context ‘tacitly presuppose an answer to the question of what makes life (or *a* life) valuable’⁶⁷. For Maclean, however, this is not the case; indeed, for her, the question ‘what makes life valuable?’ refers to the ‘value of life’ in a ‘metaphysical sense (non-sense)’⁶⁸ that she argues does not have any clear meaning at all⁶⁹.

To illustrate this, Maclean considers some specific examples of situations in which this sense of the ‘value of life’ should play a deciding role; for her, it is simply not present. Instead, questions of the ‘value of life’ are posed with specific reference to concrete qualities linked to individual lives in the situations themselves rather than ‘life’ in general. So, for example, when a doctor concludes that it is not in the best interests of a ninety-year old patient whose heart has stopped to attempt resuscitation

by administering drugs or making use of a defibrillator it is not because he has referred to an external standard and found her life to be 'less valuable, less worthy of preservation'⁷⁰ than another's when weighed against an absolute reason or principle that determines when life is and is not valuable; rather it is from a 'concern with [the] value [of her life] to her'⁷¹. Similarly, if a doctor agrees to carry out the abortion of 'a foetus on the grounds that it is handicapped, physically or mentally or both' because he believes the family will be unable to cope, then it is that inability to cope that is the important factor: 'the child's entitlement to life, or lack of it, does not enter into the matter'⁷². Again, were the doctor to agree on the grounds that the child would lead a miserable life, then it is *that* quality of life that is at issue and not 'its failure to pass some test which would have secured it the prize of an entitlement to life'⁷³.

Maclean is not alone in arguing that the principles employed by 'applied moral philosophy [are] too general and vague to apply to concrete situations'⁷⁴. Just as her view of rationalism in ethics was similar to Winkler's description of a 'top-down' deductivist model of applied ethics, so her discussion of what she claims to be Harris' account of the 'value of life' recalls Winkler's discussion of another principle, one on which a 'heavy emphasis'⁷⁵ was placed in early philosophical discussions of medical ethics: autonomy. Winkler offers for consideration the example of a man suffering from Multiple Sclerosis who is admitted to hospital having contracted 'spinal meningitis with a bacterial origin'. Although the patient has historically responded well to having MS ('he has various interests, hobbies and so forth') and this 'has not worsened', he asks not to be treated⁷⁶. The patient seems to be acting autonomously, but is this in fact the case? On this occasion, further investigation reveals that 'the patient has been very withdrawn and depressed recently' and 'has been deprived of the usual... support of other family members'. It thus seems probable that the patient's decision is the result of a temporary situation. Antibiotics are administered, family counselling arranged 'and everything turns out fine'. Cases of this type did, in fact, lead the principle of autonomy to be revised: '[particularly] when the stakes are high, it is not enough merely to be competent and rational... [it] can also be critical whether the choice is authentic'⁷⁷.

We may draw from the above example the conclusion that an overly-simplistic principle of autonomy ('do whatever the patient wants at the time') has been replaced

with a more nuanced version ('consider the patient's wishes, but also the circumstances under which their decisions are made'). But is this the right conclusion to draw? Winkler thinks not, and offers a second case, that of a motorcyclist left paraplegic after a crash who, depressed and 'embittered' by his injuries, makes the decision to refuse food, thus 'endangering his life'. Such a decision is clearly inauthentic: there is no reason to suppose that the patient will not be able to eventually come to terms with his condition in the same way as the patient with MS has, and so it would seem the patient should be kept alive. But force-feeding a patient (even intravenously) is not the same as administering antibiotics or arranging for family counselling. We may wish (we may even be morally required) to entreat with the patient to eat, and to inform him of the quality of life others in his condition have been able to attain, but coercive treatment, in Winkler's terms, 'would be perfectly brutal and without foreseeable end'. For Winkler, it is not at all clear whether the conclusions about autonomy drawn from the previous case still hold in this context⁷⁸; indeed, it is not certain that 'autonomy' means anything at all outside of a specific context.

Hoffmaster has argued that attempts to extract principles from concrete situations encounter these problems because philosophers employ an 'approach that creates and sustains the impression that moral theory and moral practice are discrete'⁷⁹. This approach, he argues, attempts to fit actual situations into a conceptual framework of abstract principles rather than considering the complexities of the situations themselves and does 'not take adequate account of the complexities of interplay between our understanding of practical issues [and] principles'⁸⁰. For Hoffmaster, terms such as 'value of life' or 'autonomy' are 'essentially contested': though conceptual analysis may distinguish 'a number of different senses these concepts can have, and [expose] ambiguity and equivocation'⁸¹ it can never fully determine what a concept really 'means'. As an example, he identifies four senses of autonomy (as free action, as authenticity, as effective deliberation and as moral reflection) and contends that no one of them provides a reliable guide for action. The senses are not ranked hierarchically, so how are we to know how to proceed should a patient's decision satisfy one (or two, or three) of the criteria but not the others? Hoffmaster does not believe we can; instead 'the answer... must turn on an assessment of the underlying substantive considerations, not further refinement of the concept'⁸².

Did Philosophers Ever *Really* Subscribe to the ‘Applied Ethics’ Model?

In attempting to illustrate the pernicious influence of the kind of philosophical thought she sees as suffusing the teaching of late-20th Century medical ethics, Maclean asks us to consider the following scenario:

Seven sailors are cast away on a barren island, with a plentiful supply of water... but no food at all... The ship’s captain... says that all they can do in these circumstances is resign themselves to their fate; but the ship’s doctor is far from agreeing with him. Fortified by his newly acquired knowledge of the value of life, he proposes to the captain that one of the sailors – the fattest – should be killed and eaten... The captain is shocked by this proposal [but the] doctor... proceeds to argue he is in a muddle. The captain, he says... values the lives of individual people... Why allow seven deaths when only one is necessary? ...Consequently, the suspicion enters the captain’s mind that courses in bioethics are not all they are cracked up to be⁸³.

Given that the ship’s captain is ‘entirely innocent of moral philosophy’ and encounters someone claiming to be expert in it only in the person of the ship’s doctor, it is hardly surprising that he is suspicious (he is, on the available evidence, probably quite right to be); whether this is true for Maclean herself is another matter. The comparison of a (fictional) student of philosophical medical ethics advancing a shallow and poorly-thought-through argument with a (fictional) layman who is a deeper, if less eloquent, moral thinker hardly qualifies as evidence that rational enquiry into the fundamental principles of ethics is either fruitless or (as the example seems to imply) morally questionable; if anything, it is evidence for Lesser’s point that a philosophical education might not necessarily offer protection from making bad arguments or having a morally questionable character.

That the scenario, in order to emphasise philosophers’ supposed oversimplification of complex moral issues, presents as typical an argument so crude that its relevance to any actually held position is highly questionable is in fact rather typical of *The Elimination of Morality* as a whole. Elsewhere, for example, Maclean states that Harris implicitly argues (with regards to foetuses and neonates in the example above) that anything that is not a rational, self-aware ‘person’ does not have ‘moral status’⁸⁴ despite acknowledging (perhaps revealingly) in a footnote that Harris’ argument is

both more complex and *explicitly* argues for something quite different⁸⁵. Similarly, in the example mentioned above, a quotation from Harris describing the decision not to resuscitate a patient as an implicit judgement that their life is ‘less valuable, less worth saving’ is followed by discussion of an actual case in which Maclean asks whether the doctor involved considers his patient’s life as ‘*not* worth saving... *without* value [my emphases]’⁸⁶. This tendency is especially damaging for Maclean’s third criticism (that it presupposes we entirely disregard our emotions in making moral judgements) for, as Lesser has pointed out, far from applying to all forms of consequentialist rationalism it ‘fails against any subtle form of consequentialism’ since it is likely the cultivation of emotional attachments, familiar relationships and friendships will contribute to ‘human happiness and the reduction of suffering’ in general ‘even if on particular occasions this fails to produce the best short-term results’⁸⁷. Maclean at times appears to be criticising a parody of her targets rather than the targets themselves (a tendency carried to quite unfortunate lengths in her discussion of Harris’ ‘The Survival Lottery’, which we will consider in more detail below).

Such oversimplification is not unique to Maclean. Although Winkler concedes that there were, by the last decade of the 20th Century ‘very few [philosophers] left in bioethics’ who would subscribe to what he terms the ‘applied ethics’ model of moral reasoning ‘and probably none at all who have had any experience with moral problems in clinical settings’⁸⁸, we may in fact question whether this model was – in practice – ever applied at all in the way that Maclean, Winkler and Hoffmaster appear to suggest. To illustrate this we may, initially, consider the above example in light of the kind of approach we identified with Hare and Rawls in the previous chapter, especially with reference to their concepts of ‘principles’. We may remember that principles in Rawls’ sense, and in the second sense used by Hare, are not principles in the sense Maclean or Winkler describe (that is, supposedly universally binding rules grounded in the higher reaches of abstract moral theory). For the former, they represent the ‘invariant’ elements established (as far as is possible) from careful examination of such considered moral judgements as we have made so far, and need do no more than cause us to carefully question our judgements of new situations. For the latter, they represent those attitudes and habits that serve to guide us in the

majority of less-problematic moral situations, but may be broken (and this is important to note) *with regret* in certain very unusual circumstances.

Returning to the barren island and the unfortunate seven stranded thereon, Maclean argues that the ship's doctor is following his training and applying what she regards as a key 'bioethical' principle, that of maximising lives, which she defines via another quotation from Harris: 'in cases where we have to choose between lives when we cannot save all at risk, we should choose to save as many lives as we can'⁸⁹.

Moreover, the doctor is, in doing so, arguing that this is the *only* morally acceptable decision: he is *not* arguing that although killing and eating the fattest sailor 'will be a terrible thing to do' it may be justified 'by the extremity of the circumstances' (Maclean explicitly rules this out)⁹⁰. Given this, it is quite clear that the doctor is not applying a principle in either of the senses described above: he is not making a 'considered moral judgement' and if he were, he might consider whether this self-evidently very unusual situation is one in which said principle applies. It is, in fact, the captain who appears to come closest to approaching the situation in the sense that Rawls and Hare suggest. He is not denying that the principle involved is a good one *in general*; he is denying – with some regret, since to do so is a death sentence for his sailors – that it is applicable in this very unusual case. Moreover he is, in fact, making a *more principled* decision than the doctor: for example in taking into account other general principles regarding his duty as captain to care for and protect individual crewmembers, the general moral impermissibility of killing, and the almost total moral impermissibility of cannibalism.

When we consider the *actual* work of philosophers in medical ethics in the latter decades of the 20th Century in both teaching and research, and moreover when we consider such work in terms of historical context, it in fact bears little resemblance to Maclean's examples or to Winkler and Hoffmaster's more synoptic accounts. For example, it is difficult to see how the ship's doctor would have come away from his 'course in bioethics' thinking as he did were it to have been run by the philosopher Ruth Macklin, whose work in hospital setting in the early 1980s was described in the *New York Times* as follows:

Doctors come to her with questions, and she gives them questions back. They come with gut reactions and she hacks away at the reactions with analytic cleavers. It is not her role, she said, to decide matters but rather to place them in a moral context.... "They're not expecting answers from me," said Dr. Macklin... , "They're looking for guidance. Legal precedents. How to think about a problem. I give arguments on both sides."⁹¹

Similarly, as Gorovitz points out, philosophers were not insensitive to the demands placed on individuals by pre-existing social obligations, quoting Caplan's contention that '[different principles] may be relevant in thinking through a case depending upon the presence or absence of such relationships as friendship, kinship, [and] leadership'. This is hardly a view that privileges 'abstract' principles over 'underlying substantive concerns'; indeed, in the same article Caplan also emphasises how this sensitivity requires scrupulous attention be paid to the specific context in which a given moral problem occurs: 'the more knowledge one has about the various kinds of relationships and roles that exist among individuals in everyday life the better skilled one will be in the exercise of practical judgment with regard to normative matters'⁹².

The importance of considering historical context when approaching the work of philosophers in late 20th Century medical ethics is important for two further reasons. First of all, we may recall Maclean's criticism that philosophers attempt to consider in terms of 'reasons' and 'values' things that are better expressed as 'attitudes embodied in practices'. As Lesser has pointed out, there are two main drawbacks to this argument. First of all, since practices are apparently self-justifying it appears to commit us to a form of relativism, for (as we saw in Chapter 2) there have, in fact, been cultures in which the lives of babies were 'as a matter of course and without question' at the disposal of their parents, and sometimes of the state as well, and '[there] appears to be no way of saying that "this is what we do" settles the matter when what we do is nice and not when it is nasty'⁹³. Moreover, it is simply not the case that reasons cannot be given for practices, '[indeed], the reverse is true: practices imply certain assumptions, both factual and evaluative [and that] it is often – though not always – unnecessary to refer to them does not mean that they are not there'. For instance, in the abortion example above 'the child's entitlement to life, whether mentioned or not, does very much enter into the matter [since to] consider abortion at all is to presuppose... that the entitlement is not absolute'⁹⁴. Similarly, as Hare

pointed out, a general principle (for which we may fairly read practice) will have to take into account judgements of fact; for example, our principle(s) regarding the care of patients with terminal cancer will depend on how many such patients ‘die in agony’, something that may be subject to change as a result of, for example, advances in techniques and technologies for pain management.

This last point is of particular importance as the majority of philosophical work in medical ethics in the mid- to late 20th Century took place precisely because, as we have argued earlier in this thesis, such changes were taking place. As Gorovitz noted in answering the criticism that philosophers placed too great an emphasis on patient autonomy, changes in society and in medicine itself had meant that ‘historically grounded conventions of practice... no longer [fitted] the changing contexts of modern medical care... the development of new medical capacities... invited divergence between the values of the physician and those of the patient [and it] became crucial to emphasise the role of independent judgment by patients in the making of medical decisions’⁹⁵. Maclean also appears to have failed to consider just what it is that we are supposed to *do, as a matter of course and without question* when ‘new kinds of questions – for example, what the limits should be on the use of high-technology reproductive techniques, such as frozen-embryo transfer, or how decisions should be made about foetal surgery – find no ready answer in appeals to traditional values’⁹⁶. Indeed, our traditional values may themselves sometimes lead us into difficult areas; we may recall from Chapter 6, for example, Jonsen’s colleagues haemodialysis patients. One sensible answer would seem to be that, as Gorovitz suggests, when faced with ‘unprecedented, morally troubling situations, when the appeal to traditional values provides no unequivocal answer’ we should critically explore what we ordinarily do and/or value without question⁹⁷.

An appreciation for historical context is also important if we are to fairly evaluate individual examples of this critical reflection (perhaps more so if we are to take these as paradigmatic examples). To illustrate the problems that can occur when such examples are considered in isolation, we may examine Maclean’s criticism of Harris’ ‘The Survival Lottery’, which we first encountered in our discussion of Fletcher’s situationism in Chapter 7. We may recall that Harris’ article begins with a proposal to their doctors from two individuals identified as Y and Z that another, healthy,

individual ('A') be killed so as to provide them with the heart and lungs they respectively need to survive. This is, in fact only the first step in their argument, which in its fullest form reads as follows:

Y and Z... propose that everyone be given a lottery number. Whenever doctors have two or more dying patients who could be saved by transplants, and no suitable organs have come to hand through 'natural' deaths, they can ask a central computer to pick the number of a suitable donor at random and he will be killed so the lives of two or more others will be saved⁹⁸

Further possible modifications to the plan include referring to the killing of donors as their being 'called to 'give life' to others', adjusting the computer programme to ensure 'whatever is considered to be an optimum age distribution throughout the population' and refusing to give donor organs obtained in this way to 'people who have brought their misfortune on themselves' so that 'the abstemious B' will not have to give up his lungs to the smoker W and/or his liver to the drunkard X. The end result is that 'everyone's chances of living to a ripe old age might be increased... lives might well be more secure under such a scheme'⁹⁹.

Note that we have attributed this argument to Y and Z, not to Harris himself, and for good reason: for, as we shall see in a moment, it is by no means certain that their position is his. Maclean, however, does not agree. For her, Y and Z are Harris' mouthpieces and 'The Survival Lottery' is his 'proposal intended to remedy the chronic shortfall in the number of vital organs that presently become available to physicians for use in transplant surgery'¹⁰⁰. This reading – in effect, treating a philosophical article as the equivalent of a Government White Paper – is, quite frankly, bizarre and only becomes more so when one considers both the contents of the article itself and the context in which it was produced. First of all, Y and Z are clearly not making their proposal in the 1975 of 'chronic shortfalls' during which the article was published; indeed, 'The Survival Lottery' begins '*[let] us suppose* that organ transplant procedures have been perfected... [my emphasis]'¹⁰¹. Moreover, Harris accepts that even if someone were to make such a proposal in earnest it would be 'unlikely' that their doctors would feel obliged to consider it¹⁰². A more likely purpose is to critically examine some common arguments regarding death and dying, in particular the traditional distinction between 'killing' and 'letting die'.

Such a reading is supported when we consider that the validity and usefulness of this distinction was at the time increasingly being called into question by advances in life-sustaining technology. In the same year that 'The Survival Lottery' was published, for example, Rachels had challenged it in his article 'Active and Passive Euthanasia' in the *New England Journal of Medicine*¹⁰³ and the President's Commission would go on to identify it as needing to be 'rehabilitated' in 'Deciding to Forego Life-Sustaining Treatment', with the recommendation that a distinction between action and omission be used to *identify* rather than *decide* morally complex situations¹⁰⁴. That Maclean describes Y and Z's use of the doctrine of double-effect to absolve themselves of any malevolent intentions towards A ('they merely wish to use a couple of his organs, and if he cannot live without them... *tant pis!*'¹⁰⁵) as 'nothing more than an attempt to satirise' this position¹⁰⁶ seems manifestly unfair; Harris is, quite properly, exploring possible consequences of this position in a new and unfamiliar context. Nor does it seem that Harris is making a straightforward claim that we are obliged to engineer 'a society in which saintliness would be mandatory'¹⁰⁷ because it is the rational thing to do, no matter what our feelings tell us. Although he appears to concede that the proposal should be accepted – if possible to implement – by both utilitarians and deontologists¹⁰⁸ and that it may only be possible to answer Y and Z 'by relying on moral intuition, on the insistence that we do feel there is something wrong... and our confidence that this feeling is prompted by some morally relevant difference between bringing about the death of A and... of Y and Z'¹⁰⁹, he does not necessarily suggest that this answer would be invalid.

More Sophisticated Approaches to Applied Ethics: Wide Reflective Equilibrium and The Web of Ideas

That the 'applied ethics' model was not a good 'fit' for the actual work being done by philosophers in the field did not go unnoticed; as Winkler points out, by the final decade of the 20th Century 'most current work in bioethics [was] sensitive to the need for a Rawlsian kind of "reflective equilibrium" between principles and concrete judgements'¹¹⁰. This kind of method was developed from that proposed in 'Outline of a Decision Procedure for Ethics', as discussed in the previous chapter, and had been further revised in Rawls' later works such as 'The Independence of Moral Theory' in which he had drawn out a distinction between 'narrow' and 'wide reflective

equilibrium'¹¹¹. The latter method, as further developed by Daniels, seeks to address problems of theory acceptance in ethics by rejecting the 'widely-held... two-tiered view of moral theories' as consisting 'of a set of moral judgements plus a set of principles that account for or generate them'¹¹². For Daniels, this view has led to theoretical disputes in ethics becoming 'intractable, unless... one is willing to grant privileged epistemological status to the moral judgments (calling them "intuitions") or to the moral principles (calling them "self-evident" or otherwise *a priori*)' neither of which he finds an attractive option. Similarly, while appeals to 'elementary coherence... constraints between principles and judgments sometimes allows us to clarify our moral views or to make progress in moral argument', they do not seem to do enough to justify either judgements or principles 'especially in the face of the many plausible bases for rejecting moral judgments; e.g., the judgments may only reflect class or cultural background, self-interest, or historical accident'¹¹³. Instead, Daniels advances a method that seeks to 'produce coherence in an *ordered triple* of sets of beliefs held by a particular person, namely, (a) a set of considered moral judgments, (b) a set of moral principles, and (c) a set of relevant background theories [my emphasis]'¹¹⁴.

As with 'Outline of a Decision Procedure', Daniels' proposed method begins by collecting an individual's initial moral judgements, and then proceeding to 'filter them to include only those of which he is relatively confident and which have been made under conditions conducive to avoiding errors of judgment'¹¹⁵. As with Rawls' conditions for selecting competent moral judges, Daniels appears to accept that these conditions cannot be precisely established straight away. Certainly, it seems likely that we should generally be more confident about judgements made when 'the person is calm and has adequate information about cases being judged'¹¹⁶. On the other hand, Daniels allows for the possibility that '[sometimes] anger or (moral) indignation may lead to morally better actions and judgments than "calm"' and acknowledges that, moving forwards, the method will need to 'correct for divergence between stated beliefs and beliefs revealed in action'¹¹⁷. Once the process of filtering is complete, the following step is to 'propose alternative sets of moral principles that have varying degrees of "fit" with the moral judgments'. It is at this point that that the third part of Daniels' 'ordered triple' becomes important, for the aim is not to 'simply settle for the best fit of principles with judgments... which would give us only a *narrow*

equilibrium'¹¹⁸; '[instead], we advance philosophical arguments intended to bring out the relative strengths and weaknesses of the alternative sets of principles (or competing moral conceptions)'¹¹⁹. The end result is a complex collection of judgements, theories and principles, with the latter providing a structure of 'provisional fixed points': as Winkler puts it, 'principles [and theories] may be modified or rejected under the pressure of considered moral judgements [whilst] judgements remain open to revision under the pressure of theory-based principles'¹²⁰.

This last element helps to distinguish wide reflective equilibrium from 'a [sophisticated] form of... subjective intuitionism' (that is, from an attempt to grant privileged epistemological status to our moral judgements)¹²¹, a charge Hare had levelled at Rawls' *A Theory Of Justice*¹²². Although, as Daniels points out, this may well be the case with *narrow* reflective equilibrium (in which our moral judgements are 'fitted to' a set of principles without scope for further revision), that *wide* reflective equilibrium starts with a set of individual moral judgements should not be taken to 'mean that this represents an order of epistemic priority or a natural sequence in the genesis of theories'¹²³. The 'Level III' considered judgements contained in the 'ordered triple' should not, in fact, be the same as the 'Level I' judgements we started out with¹²⁴ and both types of judgement can continue to be revised in one of several ways:

Feasibility testing of the background theory may lead us to reject it and therefore to revise the considered judgment. The judgment may be part of one background theory that is rendered implausible because of its failure to cohere with other, more plausible background theories, and so the considered judgment may have to be changed. The considered judgment may be part of a system of background theories that would lead us to accept principles, and consequently some other level I considered judgments, which we cannot accept. If [however] we can trace the source of our difficulty back to a level III considered judgment that we can give up more easily than we can accept the new level I judgment, then we would probably revise the level III judgment¹²⁵

The purpose of wide reflective equilibrium is not to 'merely systematize some determinate set of judgments'¹²⁶; rather we are, as Daniels puts it, to 'imagine the [moral] agent working back and forth, making adjustments to his considered judgments, his moral principles, and his background theories'¹²⁷.

It appears to be the case that wide reflective equilibrium not only allows for what Winkler describes as a more ‘adequate account of the complexities of interplay between our understanding of practical issues and our understanding of principles’¹²⁸, but also enables us to address some of the criticisms of philosophical enquiry that depend on the assumption that philosophers adhere to the ‘applied ethics’ model; in this respect, it appears to be a better ‘fit’ for what work was already being done. First of all, we may consider Maclean’s criticism that philosophers depend on circular reasoning in order to establish supposedly ‘objective’ values and principles. If we consider the example she offered as ‘typical’ of bioethical thinking in the context of wide reflective equilibrium, this criticism clearly does not apply. The proposed Level III judgement that the lives of foetuses and neonates are utterly without value would have to contend with the strong Level I judgement that they are valuable in some sense; in this case it seems reasonably clear that it is easier to revise the Level III judgement by adopting a more sophisticated theoretical position (for example that value may be attached to sentience, interests and/or potential) than to give up the Level I judgement entirely (indeed, that this is probably a better account of how arguments regarding moral status historically ended up proceeding is something Maclean appears to accept¹²⁹). Moreover, this process places us in the position of having to think carefully about what it is we *do* value about the lives of foetuses and neonates, which again seems to be a necessary element of the kind of analysis that Maclean thinks philosophers *should* undertake.

This example also addresses Hoffmaster’s criticisms that philosophical applied ethics finds it difficult to cope with ‘crucial moral issues [that] challenge assumptions upon which the theoretical edifice of applied ethics is based’, in particular questions regarding the moral status of non-rational beings¹³⁰, and that it cannot account for moral change (for example, why issues of animal rights and welfare are now considered important, when in the past it was ‘self-evident’ that they were not¹³¹). Reflection of the sort that Rawls and Daniels propose (and that, we have argued, philosophers were collectively already engaged in) can (in some cases) reveal both that we do not value things in the way we thought we did, and that we *should* value things we thought we did not. For example, as Beauchamp noted in his response to Noble, philosophical analysis of one definition of ‘persons’ adopted by the United States Supreme Court showed it to be so broad as to apply to ‘infants and animals as

well as human foetuses'¹³², an analysis that does not only raise questions about what we value in human life. For example, it is a short step from this realisation to the argument that we should not perform vivisection on certain of the great apes because we would not do so on humans with a similar level of mental capacity. Hoffmaster's criticism that such conclusions are 'inadvertent [and] not [the result] of attending to the particular moral controversy in question'¹³³ is somewhat puzzling; after all, if moral enquiry produces moral insights, what is so 'inadvertent' about that?

Furthermore, just as Hare's approach depended to an extent on factual information concerning the context in which particular decisions are to be made, so Daniels' approach here appears to suggest that Hoffmaster is correct in suggesting ethnographic study can 'give content to the vague notion of "putting moral problems into context"'¹³⁴. One possible advantage of considering the theoretical approaches used to justify competing principles is that it may reveal that disagreements over moral judgements may 'rest on other, nonmoral disagreements'¹³⁵ found in the 'relevant background theories'. As an example, Daniels offers Parfit's proposed explanation of differences between utilitarians and contractarians over matters of distributive justice, in which:

the utilitarian, perhaps supported by evidence from the philosophy of mind, uses a weaker criterion of personal identity than that presupposed by, say, Rawls's account of life plans. Accordingly, he treats interpersonal boundaries as metaphysically less deep and morally less important. The problem between the utilitarian and the contractarian thus becomes the (possibly) more manageable problem of determining the acceptability of competing theories of the person¹³⁶

So, Daniels would most likely agree with Hoffmaster that Anspach's study into how the differences between doctors' and nurses' interpretation of cases in a neonatal intensive care unit were related to each profession's conception of the proper function of medicine made a valuable contribution to the understanding and, possibly, resolution of such differences (for example, by revealing how it may be possible to negotiate a mutually acceptable definition); he might even agree that it is a contribution that could not be made by a philosopher lacking the expertise to conduct such studies¹³⁷. However, given that Daniels' article predates Hoffmaster's by *thirteen years*, he would in doing so most likely disagree with the latter's conclusion that

philosophers are interested only in ‘whatever moral problems are brought before [them], assuming... that moral problems can be dealt with independently of the contexts in which they arise’¹³⁸.

Daniels himself accepted that his work needed further development; in particular, he felt that ‘some story about moral *practice* and what we can learn from it, and not just about moral thought experiments, seems to be needed’¹³⁹. In order to consider one way in which this might be possible, it may be instructive to compare Daniels’ ideas with Rachel’s adaptation into moral philosophy of Quine’s account of ‘the web of belief’ (which, in its original form, had been intended to express the relationship between observation, theory, and logic in the material sciences). Whereas in the ‘applied ethics’ model justification moves downwards from theory to principles to judgements, and in Daniels’ model up *and* down from judgements through principles to theory and back again, Rachels instead suggests we imagine ‘a network of beliefs which are connected to each other in various ways’¹⁴⁰. At the centre of this ‘web of ideas’ are those elements of our moral thought and practice we hold most strongly, or in which we have most confidence. These can include particular moral judgements (Rachels gives as an example that the deeds of the Manson family were wrong) and more wide-ranging principles (for example, that causing pain is wrong)¹⁴¹; there seems to be no reason why they need not include certain theoretical intuitions as well (for example, that the consequences of our actions are of moral importance). Moving outwards, we encounter those elements about which we are less certain (Rachels’ examples are the judgement that the behaviour of the Reagan administration in the arms-for-hostages affair was wrong, and the idea that there is a difference between causing harm and allowing it to happen¹⁴²).

As with Daniels’ account, ‘no belief, theoretical or practical, is absolutely insulated from revision, whatever its position in the web may be at any given time’¹⁴³; however, these revisions, like the positions of the elements themselves, may be derived from more than one kind of source: practical and/or theoretical, moral and/or nonmoral. So, for example, Rachels suggests that the idea that animals had moral status was pushed closer to the centre of the ‘web’ by Darwin’s demonstration that humans share a common origin with other species in the 19th Century, and again by the philosophical arguments of Singer in the 20th¹⁴⁴. Indeed, just as in Daniels’ account, where “‘It is

wrong to inflict pain gratuitously on another person” is [revisable, but] so hard to imagine not accepting... that some treat it as a necessary moral truth’ since ‘to imagine revising such a provisional fixed point we must imagine a vastly altered wide reflective equilibrium that nevertheless is much more acceptable than our own’, so on Rachels’ those items closest to the centre of the ‘web’ are likely to be, to an extent, self-reinforcing. It is also worth noting that, rather than moving other elements outwards, new elements may instead reflect a deepening or broadening of elements already close to the centre; so, for example, we may interpret Rachels’ example regarding animals as a broadening of the already strongly-held belief that *some* kinds of thing have moral status (a belief that in the past was in all likelihood not extended to cover all human beings).

We should note that adopting Rachels’ model does not preclude the importance of the kind of philosophical work we introduced in the previous chapter. Not only will analysis of language and argument play a part in moving different elements around the web of ideas, ‘it might’ as he points out ‘still be possible, when surveying the web at any given time, to systematise what one finds there in the traditional way’¹⁴⁵. As Winkler accepts in his criticism of the ‘applied ethics’ model, in non-problematic cases (which of course make up the vast majority), we can and often do employ a simple ‘top-down’ deductive method, not from the level of a perfect ‘holy-grail’ theory, but from a ‘mid-level’ theory and/or our own web of ideas (which may of course be ‘implicit and inchoate’). When encountering those cases in which moral choices are ‘clear and straightforward... certain values or principles can be seen to apply normatively without difficulty or hesitation [and] we can always construct a deductive, or quasi-deductive, syllogism that derives our moral conclusion from the principle we then see it as upholding’¹⁴⁶. Moreover, even in difficult cases, they will form part of the ‘framework of central cultural values and guiding norms’ which enable us to make a ‘reasonable, well-justified, considered judgement’; indeed, it will be ‘the tensional structure of values and principles that shape and contour the basic nature of the problem itself’¹⁴⁷. Although Winkler believes that this precludes any approach that accepts that moral theories or principles may ‘override considered moral judgement’¹⁴⁸, it appears to be the case that any truly ‘considered moral judgement’ needs must take into account theoretical and principled concerns.

To illustrate this point further, we may consider the examples offered by Winkler in his discussion of autonomy, in particular that of the paraplegic patient's refusal of food. Where the 'applied ethics' model would describe this situation as a 'conflict' between principles in which we need to determine to which principle our theory assigns the most moral weight, we may instead see various values and principles 'shaping' the problem: the debate is taking place over the issues in their broadest sense. So, the authenticity of the patient's decision may rightly be considered an important issue were the procedure he would be forced to undergo short and relatively painless (say, an injection of antibiotics). But, where the procedure will be 'brutal and without foreseeable end', the authenticity of his decision seems less important than a consideration of the suffering that might result. Differences between principles concerned with obligations to help and to refrain from causing harm give form to, and are given form by, differences within a principle or principles regarding how far we may, or are obliged to, override another's decisions regarding their own life and/or body. We are not left with an easy decision (and, where someone is likely to either starve to death or to live on feeling that, at the very least, their wishes and/or bodily integrity have been violated, it is *entirely proper* that we should not be) but we are likely to have a broader and deeper understanding of what this decision involves. Far from 'eliminating' morality, philosophical enquiry will have helped to *enrich* our moral understanding.

Conclusions

We may instructively compare Rachels' account of the 'web of ideas' with our exploration thus far of the history of moral thought in medicine. To recap, from its very earliest beginnings, the practice of healing understood as a specialist skill has laid a moral obligation on its practitioners to be competent (we may think of this as one of the central points on our web, without which, as we argued in Chapter 1, it is difficult to see how we can meaningfully discuss medical ethics at all). As this obligation led to the development of practical skills, so these skills began to pose moral questions regarding the uses to which they could be put. Over time, the naturalistic turn in Greek thought and medicine further deepened and broadened moral concerns regarding the doctor's methodology, concerns that continued to develop throughout the Middle Ages. At the same time, these concerns were

paralleled by, and sometimes entwined with, questions regarding the organisation of medical men and the social and legal status of medicine itself. Furthermore the growth, in response to these questions, of a scientific medical establishment in the 19th and 20th Centuries brought about medical advances that posed fresh variations on them as described in Chapter 6.

Beyond this, adopting a model similar to Rachels' seems likely to bring with it certain practical advantages. First of all, in addition to accounting for the way in which our moral ideas can change and grow over time, it also allows us to marshal our collective moral thinking regarding earlier controversies when faced with new and difficult situations. Moreover, it allows for the tools of moral philosophy, such as critical analysis of language, concepts and arguments, the use of thought-experiments and the application of ethical theories to be brought to bear upon them, together with the resources of the medical and social sciences. Furthermore, although neither our own enquiry or the adoption of the 'web of ideas' is sufficient to disprove entirely the existence of a 'holy grail' theory of applied ethics, they nevertheless serve to remind us of the likelihood that, even were we to establish such a theory, we would most likely be faced with new problems in deciding just how to apply it, especially following new and perhaps unexpected medical or social developments. As such, it reminds us to guard against moral complacency (and in any case, as Daniels has argued, if there are objective moral facts, this may be the best way to discover what they are and what *kind* of fact they are¹⁴⁹). In order to demonstrate these advantages further, we will now move on to consider one possible example of a way that one set of 'provisional fixed points' may help to both deepen our understanding of moral problems in medicine and offer practical guidance in negotiating them: Beauchamp and Childress' 'four principles' of autonomy, beneficence, nonmaleficence and justice.

¹ Winkler, E.R. 'From Kantianism to Contextualism' p.351

² Ibid. p.351

³ Ibid. p.352

⁴ Gorovitz, S. 'Baiting Bioethics' in *Ethics* 1986; 96 (2) 356-374 p.356-7

⁵ Ibid. p.357

⁶ Ibid. p.357

⁷ Ibid. p.358

⁸ Ibid. p.359

⁹ Lesser, H. 'Anne Maclean's Criticism of Bioethics' in Häyry, M. and Takala, T. (eds.) *Scratching the Surface of Bioethics* (Amsterdam: Rodolphi, 2003) p.57

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- ¹⁰ Noble, C.N. 'Ethics and Experts' in *Hastings Centre Report* 1982; 12 (3) 7-9 p.8
- ¹¹ Ibid. p.7
- ¹² Ibid. p.7
- ¹³ Ibid. p.9
- ¹⁴ Winkler, E.R. 'From Kantianism to Contextualism' p.346
- ¹⁵ Noble, C.N. 'Ethics and Experts' p.8
- ¹⁶ Ibid. p.9
- ¹⁷ Winkler, E.R. 'From Kantianism to Contextualism' p.346
- ¹⁸ Avorn, J. 'A Physician's Perspective' in *Hastings Center Report* 1982; 12 (3) 11-12 p.11
- ¹⁹ Beauchamp, T. 'What Philosophers Can Offer' in *Hastings Center Report* 1982; 12 (3) 13-14 p.14
- ²⁰ Noble, C.N. 'Ethics and Experts' p.8
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Part Three:
Beauchamp and Childress' Four Principles
Approach to Medical Ethics

Chapter 10: Criticism and Development of Beauchamp and Childress' *Principles of Biomedical Ethics* from 1st to 6th Editions

As we saw in Chapter 8, the work of developing a principle or set of principles for moral guidance in specifically medical situations had begun in 1970 with Gorovitz' Project on Moral Problems in Medicine at Case-Western Reserve University and continued through the publication of the first two editions of *Moral Problems in Medicine* and the specification of three principles (respect for persons, beneficence and justice) in the *Belmont Report*. In 1979 this project came to fruition with the publication of a 'a thorough and systematic development' of these principles¹ by two members of the Kennedy Institute of Ethics², the 1st edition of Beauchamp and Childress' *Principles of Biomedical Ethics* (henceforth *Principles*). By combining 'a commitment to the centrality of principles in moral reasoning, with a respect for the exigencies of circumstance and a liberating pluralism'³, *Principles* appeared to hold the 'promise of overcoming the impasse of undecidability which was bedeviling the encounter between philosopher and physician and the clinic'⁴: as Winkler puts it 'the mid-level... principles [appeared] to provide enough substance to guide practice' yet also '[keep] faith with the ideal of comprehensive justification because each [principle] is linked with... our central traditions on normative theory'⁵. In the United States especially, the book 'received a hearty welcome... when first it appeared'⁶; it would, over the course of the next decade, go on to become the 'most widely used textbook on medical ethics'⁷ and, in Winkler's terms, 'achieve the status of a standard or genuine paradigm of the field'⁸. Despite their widespread early acceptance (they are, as Erin puts it, 'almost impossible for anyone with even a passing interest in the subject to avoid'⁹) however, the 'Georgetown Mantra', as the four principles are sometimes (and sometimes 'contemptuously'¹⁰) referred to have been the focus of much criticism

Principles' genesis was in many ways a microcosm of bioethics as a whole, with the authors coming from different academic and theoretical backgrounds: Beauchamp, a philosopher and consequentialist; Childress, a theologian and deontologist¹¹. The purpose of the 1st edition of *Principles* seems, at first glance, to have been clear and unambiguous: an attempt to offer 'a systematic analysis of the moral principles that

should apply to biomedicine'¹². Broadly speaking, the authors' goal was to 'sort out' work already done and 'bring some order and coherence to the discussion of [such] problems'. Through 'examining moral principles and determining how they apply to cases and how they conflict' Beauchamp and Childress hoped to rectify a situation in which 'moral judgements involved in one dilemma [appeared] to be unconnected to the moral judgements in others'¹³. Despite this apparent simplicity of purpose, however, there has been little subsequent consensus from its critics on just what approach the 1st edition of *Principles* and its five subsequent revisions have advocated:

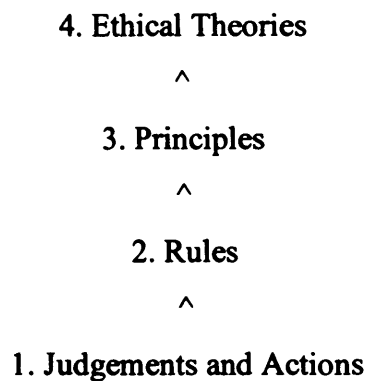
Some... concerns have included that the four concepts have *too little content* (that they can mean anything, depending on the person using them); that they have *too much content* (that people using them are forced to buy into an exclusively American system of values); that there are *too many* principles (that, for instance, nonmaleficence and beneficence should be fused together as a principle of utility); and that there are *too few* of them (that, for instance, the virtues of care, friendliness and charity, crucially important in good health care provision, are not addressed of all, or at least they are not included in the list)¹⁴

For this reason, the following chapter will attempt to address these criticisms through an exploration, firstly of how Beauchamp and Childress' approach to philosophical reflection developed from the 1st through to the (current) 6th edition of *Principles* and secondly, of the intended meaning and use of the principles themselves.

Moral Theory in *Principles* from 1st to 6th Editions

Despite our argument in the previous chapter that few, if any, philosophers working in the field of medical ethics *actually* subscribed to the simplistic 'top-down' deductivist method that Winkler terms the 'applied ethics' model, we must nevertheless concede that his description is closely paralleled by the 1st edition of *Principles*' account of justification in moral thinking, which is described as follows:

1st Edition Model of Ethical Justification



As an example of how such a model may be seen to operate in practice, Beauchamp and Childress offer the case of a doctor who 1. refuses to perform amniocentesis (a prenatal test for congenital defects or the sex of the foetus which may lead to the decision to terminate a pregnancy) citing 2. a 'moral rule against killing innocent human beings', grounded in 3. 'a principle of the sanctity of human life' justified by 4. 'an ethical theory'. It appears to be reasonably clear from this example that the authors intend for the model to apply both to scholarly ethics and to everyday moral decision-making, but they allow that the (unspecified) ethical theory followed by the hypothetical doctor and indeed in the majority of real-life cases is likely to be 'implicit or inchoate'; they also suggest that it is likely this model greatly oversimplifies what is actually going on¹⁵. Despite the similarity between this model and the one which both Winkler and (to a greater extent) Maclean assert most or some philosophers did or do follow when working in applied ethics, it is clear that, even in the 1st edition, Beauchamp and Childress did not intend the four principles to provide an explicit and coherent level 4 theory, nor did they believe that one existed at present. The 1st edition of *Principles* does discuss two main candidates (or kinds of candidate) for the role offered by traditional ethical thought: deontology and consequentialism (or in their terms, utilitarianism), but although each author offers qualified support (as noted above) for one of these approaches, both are willing to concede that '[neither] theory is fully satisfactory on all...tests'¹⁶.

In fact, Beauchamp and Childress appear to envision work in philosophical medical ethics as following something far closer to the method of Wide Reflective Equilibrium described by Rawls and Daniels (or, to some extent, the second kind of moral thinking described by Hare); we should remember that, in the above model, whilst the process of *justification* works only one way, the process of *formulating* an ethical theory is dialectical. As with Rawls, an ethical theory is arrived at by systematising individual judgements and actions, and this theory is then tested, when confronted with new situations, by applying it back ‘down the chain’ and considering the judgements it suggests. When an unacceptable judgement is suggested, rules and principles should then be revised in such a way as to cause the smallest disruption to the theory as a whole, which can then be tested again in new situations and further revised if necessary¹⁷. As the authors note, despite the relative novelty of ‘systematic work in biomedical ethics’, many of the issues have been debated ‘for decades and, in some cases, for centuries’ by philosophers, theologians and in the formulation of professional codes of ethics and research¹⁸. The analysis undertaken in *Principles* can be seen as an attempt to make explicit the task of gathering all of these ‘considered moral judgements’ together with the theories involved and attempting to sort them in such a way as to properly fit this model as far as level 3.

Beauchamp and Childress argue that this is possible because ‘the [practical] differences [between different philosophical approaches] can easily be overemphasised’ and that they can (after a fashion) be used in conjunction. Winkler has suggested that this agreement is largely brought about merely by calling different theoretical approaches ‘principles’:

The principle of autonomy, for example, is an expression of the rights and dignity of the person that forms the foundations for Kantianism and modern forms of deontological theory generally. The principle of beneficence [conflated with nonmaleficence], obviously, has its heritage in classical utilitarianism. And the principle of justice is most naturally connected with contractarian traditions in moral theory¹⁹

This is, however, clearly not the case. Rather, citing the work of the utilitarian R.B. Brandt and the deontologist W.D. Ross, Beauchamp and Childress argue that, regardless which theory one adopts ‘it is possible from both... standpoints to defend the *same rules*... and to assign them roughly the same weight²⁰ (that each principle is

rooted in and/or explored through different approaches to moral theory is something we will consider in more detail below). In Winkler's terms, each appears to have had 'some share of the truth'²¹: whilst neither may lay claim to have discovered *the* absolute moral truth both appear to have produced outcomes which are both true and moral. We may think at this point of Ramsey's contention (as discussed in Chapter 7) that, divine or otherwise, Christ had been able to 'get at' something which was inherently moral *regardless of the validity of the particular world view that got him there* and of principles as described by Hare (in his first sense) and Rawls, as discussed in Chapter 8. On this reading, the four principles describe what is already generally agreed to be the case and comprise 'the points on which the major traditions [are] able to agree... and the 'deal breakers' which any future universal moral theory... needs must satisfy'²². On matters of dispute, philosophers are free to pursue further enquiry on deontological, consequentialist or other lines. However, should any of these approaches ultimately provide a complete and final theory, the principles represent those provisional fixed points which experience suggests would not have to be reconsidered to any great extent (at least with regards to medical matters).

Whether or not Beauchamp and Childress believed it possible that this process might eventually establish a deductivist theory that *should* occupy the fourth tier of their model by reaching a point where it was no longer dialectical (that is, where no further judgement or action could cause theory, principles or rules to be revised) is not immediately clear from the 1st edition of *Principles*. Certainly there is some evidence to suggest that they might, not least in the space left for a Level 4 theory on their model of moral justification itself. Moreover, their account of what might constitute a moral claim includes the Hare-esque stipulation that such claims be universalisable (that is, '[require] that all relevantly similar cases be treated in a similar way') in addition to being '*supreme, final, or overriding* in judgements about actions', not based on 'self interest or personal inclination'²³ and (possibly) having 'some direct relevance to the *welfare of others*' (although this is assumed to always, or almost always, be the case with any specific claim regarding medical matters)²⁴. If we can identify moral claims in this way, then all moral dilemmas should come down to our being able to identify which of two competing claims is truly moral; as Hare puts it: 'in the words of a wayside pulpit reported to me by Mr. Anthony Kenny, "if you have conflicting duties, one of them isn't your duty"²⁵. At most, according to Hare, we

may have a conflict between either a general principle, which may ‘regretfully’ be broken, and a truly universal one.

This view of moral decision-making is open to objection. We may consider, for example, Nussbaum’s account of the dilemma faced by the Greek king Agamemnon between offering his daughter Iphigenia as a sacrifice to the goddess Artemis, or of leaving his fleet becalmed at sea, with the result that all aboard (including Iphigenia herself) will die of thirst and/or starvation²⁶. In such a case, whilst we may accept that saving the lives of the fleet is morally right, saying that Agamemnon kills Iphigenia (as he eventually decided to) for moral reasons does not seem to make the murder itself a moral thing to do (which, on Hare’s account, it would have to, since it is an action Agamemnon feels compelled to carry out, and one which he seems to believe *anyone* should feel compelled to carry out under the circumstances). Nor does it seem to mean that his *reluctance* to sacrifice his daughter was *solely* grounded in something other than a sense of moral obligation not to do so such as, for example, his personal attachment to Iphigenia. Even were we to allow that this reluctance was *not* a moral impulse (which is by no means certain) the fate which eventually befalls him as a result of his actions seems grounded in another universalisable rule (that is: ‘fathers should not kill their own daughters’).

If we allow that this example suggests that some of the gravest moral dilemmas are those that are choices between two ‘goods’ (or perhaps, two ‘evils’), it is quite clear that Beauchamp and Childress’ account of the nature of moral dilemmas in the 1st edition of *Principles* favours Nussbaum’s view over Hare’s. For, although one sort of moral dilemma occurs when ‘[some] evidence indicates that act X is morally right, and some evidence indicates that act X is morally wrong, but the evidence on both sides is inconclusive’ (and may thus be satisfactorily resolved through further analysis or by gathering fresh evidence) another, more serious kind occurs when ‘[it] is clear to the agent that on moral grounds he or she both ought and ought not to perform act X’²⁷. In such cases Beauchamp and Childress note that a moral decision will need to be made but, with reference to Nozick’s conception of ‘moral traces’, note that part of that decision will involve the moral agent ‘not only [approaching] his decision conscientiously, but... also [experiencing] regret and, perhaps, even remorse at having to neglect or violate’ a moral obligation²⁸. We may note that this differs from

Hare's account in according full moral status to the broken principle: the decision involves two competing *moral* claims, rather than a decision between a moral and non-moral claim, or a general and a specific moral claim.

That this reading conforms with Beauchamp and Childress' own views is further supported by the list of five tests that the 1st edition of *Principles* suggested should be applied to any proposed moral theory. The first, second and third of these (that theories should be 'internally consistent and coherent', 'complete and comprehensive' and as simple as possible) recall Rawls' comments regarding establishing the least possible variance, with the third (motivated in part by the need to create 'no more rules, principles and concepts... than people are able to remember and able to apply without confusion') is reminiscent of his contention that a moral theory should be able to be understood by anyone of 'average' intelligence. A theory also needs to fit in with 'ordinary' judgements, and finally must retain enough authority to cause us to question, in cases of conflict, whether it is our judgement *or* the theory that is in error²⁹, a point that at least suggests it is unlikely any theory we are ever likely to establish will provide infallible guidance in every possible situation. This view of theory is, again, essentially similar to Rawls', who, we may remember, sought the 'least possible variance' between judgements but did not rule out the possibility that some differences between moral principles may ultimately remain insoluble.

Given this disparity between the (over)simplicity of the 1st edition's model of moral justification and the ease with which it could be held to represent a deductivist ideal on the one hand, and the complexities of the model of moral reasoning present elsewhere in the text on the other it is perhaps to be expected that later editions of *Principles* have, in their treatment of moral theory, moved towards something much closer to the views we attributed to Rachels in the previous chapter. In the (current) 6th edition, any possibility that *Principles* should be read as expounding the kind of 'model inspired by disciplines such as mathematics' frequently associated with the term 'applied ethics' is firmly rejected³⁰; instead, Beauchamp and Childress advocate the use of a model closer to that found in the natural sciences, that is 'neither strictly inductivist (involving only experimentation and observation) nor strictly deductivist (using mathematics and a priori principles)'³¹ and incorporates reflective equilibrium³² with a set of considered judgements that are found in what the authors

term ‘the common morality’³³. This consists of ‘the set of norms shared by all persons committed to morality’, for example ‘do not cause pain or suffering to others’. As the authors take pains to point out, these should not be thought of as ‘ahistorical or *a priori*’ but rather as ‘a product of human experience and history [that is] universally shared’³⁴; in other words they are those particular moral judgements of which we are most certain (we might say, those closest to the centre of the web of ideas). Moreover, they are *prima facie*, rather than absolutely, binding: that is, they incur obligations ‘that are absolutely binding *unless* a competing moral obligation outweighs them’ (so it may be permissible to inflict pain on another, for example, in performing necessary surgery on them)³⁵.

Although, as with Rawls’, Daniels’ and Rachel’s models, this ‘set of considered judgements that are acceptable initially without argumentative support’³⁶ are unlikely to be perfect, they form ‘an acceptable starting premise’ (as, indeed, they *must* since there does not appear to be another such starting premise available). From these ‘landmark fixed points’ we can proceed to construct more general accounts and ‘to match, prune and adjust considered judgements... to render them coherent with the premises of our most general moral commitments’. From these, theories and general principles can be formulated that will then be tested against other judgements, at which point we are obliged to ‘go back and readjust the guides further’³⁷; in doing so, we are able to guard against the danger present in ‘bottom-up’ theories (that is, those that proceed primarily from decisions made in paradigm cases³⁸) that we are simply ‘applying whatever moral maxims happen to be lying around at hand in [our] culture’³⁹. The authors accept that, in many cases, it is likely that we (as yet) lack the adequate theoretical resources to link together all of our more confident judgements about a particular issue, in which case we will need to attempt to balance the advantageous elements of any relevant theories, principles and/or judgements against each other. With regards to moral status, for example, Beauchamp and Childress consider five candidate theories based on human properties⁴⁰, cognitive properties⁴¹, moral agency⁴², sentience⁴³ and relationships⁴⁴ noting that each ‘has elements that are worthy of acceptance [but] falls into implausibility when it loses sight of the merit in competing criteria’⁴⁵.

Whereas the principles outlined in the 1st edition could be read, as Winkler does, as ‘mid-level’ deductive points that prescribed set actions in all cases except those where they appeared to conflict, the view outlined in the 6th edition therefore necessitates a more complex account. On this view, the principles are not clear and unambiguous action-guides but rather ‘four clusters of... “general norms”’⁴⁶ that experience suggests are most relevant to problems of medical ethics. Although it is still likely that in less problematic cases we can use the principles in the former sense (as part of what Winkler describes as a ‘quasi-deductive syllogism’) ‘moral judgements in hard cases almost always require that we specify and balance norms... not merely that we bring a particular instance under a preexisting covering rule or principle’⁴⁷. However, even in these more straightforward cases we still may need to do some work to specify the *sense* in which a principle is being applied; for example, in the case of triage we can rightfully apply a fairly straightforward conception of justice based on the allocation of resources to those in greatest need that may, nevertheless, not be applicable to questions of justice relating to social provision of healthcare⁴⁸ (so, for example, we may in an emergency prioritise the treatment of a patient in immediate danger of death over that of a patient with a painful, yet non life-threatening skin condition; if, however, we were to apply this to the provision of healthcare as a whole, the latter patient would most likely never be treated – there would always be someone, somewhere, with a more urgent need⁴⁹). Moreover, the specification of justice used in triage may itself vary from situation to situation: although ‘disaster victims are generally sorted according to medical need [if] some survivors are medical personnel who suffer only minor injuries, they justifiably receive priority of treatment if they are needed to help others’⁵⁰. As we might always be faced with a new situation or theoretical example that causes us to question our specification of a principle or its compatibility with specifications of other principles, ‘new contingent conflicts can always arise’⁵¹; as such ‘there is no reason to expect that the process of revising moral judgements and specifying and balancing principles will come to an end... equilibrium is an idealisation that can never be realised’⁵². In order to further illuminate how this process may take place, we will now turn our attention to a more detailed exploration of the principles themselves.

Beauchamp and Childress' Principle of Autonomy from 1st to 6th Editions

Despite Winkler's contention, as noted above, that the 1st edition's principle of autonomy is largely derived from deontological approaches, particularly Kant's⁵³, it is clear that Beauchamp and Childress never intended for it to be interpreted so narrowly. Indeed, they explicitly identified it as a key issue for the majority of moral thinkers in all traditions, citing as examples figures as diverse as 'Nietzsche, Sartre, R.M. Hare and Robert Paul Wolff'⁵⁴. Furthermore, although their initial account does depend heavily upon Kant for one possible definition of autonomy ('freedom of the will', defined as 'governing oneself, including making one's own choices') equal weight is given to Mill with regards to another ('freedom of action', or the ability to act upon those choices, to the extent that one should 'not interfere with a like expression of freedom by others'⁵⁵). As we might expect given their views on the compatibility of different ethical traditions, Beauchamp and Childress are primarily concerned with how these two concepts relate to each other in terms of providing concrete action-guides and it is reasonably clear that, on these terms, the concepts are self-reinforcing. Their account of Mill, for example, effectively presents him as providing an argument for the utility of encouraging individuals to adopt an attitude of practical, reflective engagement with their culture. In other words, Mill is seen to offer utilitarian grounds for behaving in a way which is strikingly similar to Beauchamp and Childress' description of Kantian autonomy (which prohibits 'acting from desire, impulse [or] habit')⁵⁶.

The different ways in which these philosophers are concerned with autonomy, however, lead to subtle differences in the practical consequences of putting their ideas into practice: 'Mill's view leads to a moral demand of non-interference with the autonomy of others in society, while Kant's leads to a moral demand that certain attitudes of respect be framed about the personhood and beliefs of others'⁵⁷. As the 6th edition puts it, the principle can therefore 'be stated as a negative obligation and a positive obligation'; according to the former 'actions should not be subjected to controlling constraints by others [subject to] valid exceptions', whilst the latter 'requires both respectful treatment in disclosing information and actions that foster autonomous decision-making'. However, neither of these senses need be mutually exclusive; rather (as with Hare's contention that consideration for deontological

concerns can help to develop more sophisticated versions of utilitarianism) an appreciation of the more plausible elements of *both* accounts leads us to a richer and more sophisticated understanding of the relevant issues⁵⁸. The *principle* of autonomy, so understood, covers the ‘cluster of concerns’ regarding a patient’s right to make decisions for themselves, with their ability to do so and the extent to which doctors may (or may be *required* to) make decisions on their behalf. Specific examples of situations in which these issues are likely to arise include cases of human experimentation⁵⁹, refusal of treatment for either oneself or others (for example family members)⁶⁰ and suicide⁶¹. The principle, sometimes in conjunction with others, also supports ‘more specific moral rules’ such as truth-telling and respect for privacy⁶².

One obvious area of concern covered by the principle of autonomy is that of informed consent in treatment and/or experimentation, Beauchamp and Childress’ evolving understanding of which between the 1st and 6th editions of *Principles* demonstrates both the principles’ ability to provide firm, specific action-guides and the flexibility of their approach in responding to and incorporating criticisms of their earlier positions. The 1st edition identified four key elements necessary to ensure, as far as possible, that a patient’s decision is autonomous: two ‘Information Elements’ (*disclosure* and *comprehension*) relating to the patients access to relevant and understandable information regarding proposed treatment and/or research and two ‘Consent Elements’ (*competence* and *voluntariness*)⁶³ relating to their ability to make meaningful choices based on this information. On this understanding, *disclosure* requires that patients are in possession of all relevant information concerning any procedure they are to undergo, along with subsidiary questions of what is considered to be ‘relevant’ information and what (if anything) would constitute good reason for withholding it⁶⁴. *Comprehension* requires that patients are, as far as is possible or practicable, able to understand this information⁶⁵. *Competence* requires that patients, once in possession of the information furnished by the first two requirements, are capable of making a rational choice based upon it⁶⁶. *Voluntariness* requires that patients’ decisions are made more or less in line with this information and not subject to either coercion (the ‘threat of harm or forceful manipulation’) or undue influence (‘an excessive reward or irrationally persuasive technique’) from outside⁶⁷.

Whilst providing these particular specifications of the principle of autonomy, the 1st edition explicitly acknowledges that judging just how these criteria are to be applied is likely to prove problematic, especially with regards to competence⁶⁸. In addition, whilst the 1st edition's account may be seen to do an admirable job of identifying several different *philosophical* senses of the principle of autonomy (that is, may be seen as the result of using different philosophical approaches to arrive at a fuller analysis of the concept) these criteria are clearly open to influence from sociological and psychological work into, for example, just how people process information and reach decisions (especially in clinical settings) and legal precedents as to how they are seen to apply in practice. It may be accounted a notable strength of this initial analysis, then, that the 1st edition's account was able to incorporate subsequent investigation of the concept into the revised and deepened version of the principle presented in the 6th. In line with '[legal], regulatory, philosophical, medical and psychological' literature the later edition adopts a seven-element view of 'the building blocks' of informed consent⁶⁹. On this view, *competence* and *voluntariness* are recast as 'Threshold Elements'; a 'presupposition of obtaining informed consent', since their absence rules this out as a possibility⁷⁰. The 'Information Elements' now include *disclosure*, *recommendation* of a plan and *understanding*, reflecting the need for the doctor to offer their honest professional opinion as to the patient's best interests⁷¹. Finally, the 'Consent Elements' include both the patient's *decision* regarding a proposed plan and their *authorization* or *refusal* of said plan⁷².

The 6th edition also explores how several different kinds of substantive concern may affect what is required to apply each of these elements of the principle of autonomy to specific practical cases. So, for example, when recommending a course of action to a patient it may be important for a doctor to highlight any potential conflicts of interest: '[researchers]... may hold stock in a pharmaceutical company that sponsors the research... physicians may have an investment in a radiological centre to which he or she refers the patient'⁷³. There may also be therapeutic reasons for making a more limited form of disclosure, for example where disclosing certain information would cause 'deterioration in the patient's condition' or, more narrowly, likely 'render the patient incompetent to consent to or refuse the treatment'⁷⁴; in possible therapeutic uses of placebos⁷⁵; and in research (although this is categorically ruled as impermissible 'if significant risk is involved and subjects are not informed they are

being placed at risk')⁷⁶. Beyond this, the way in which information is presented needs to take into account the results of linguistic and psychological studies into decision-making: one study, for example, found that 25% of participants would select radiation therapy over surgery for lung cancer when quoted *survival* rates, whilst 46% would make the same choice when quoted *death* rates due to a consequently inflated perception of 'the risk of immediate death from surgical complications'⁷⁷. Finally, there may be more complex societal issues: Beauchamp and Childress' cite the case of a 'poor white woman from Appalachia with a third-grade education' refusing cancer treatment because she did not *believe* she had cancer, due to a misconceived notion of what cancer symptoms 'were like' and her prejudiced view of the (black) doctor making the diagnosis. In this case, distasteful though her views may have been, disabusing her of her false belief about cancer necessarily required the intervention of a white doctor⁷⁸.

Treating autonomy as a cluster of concerns to be explored rather than a single closely-defined principle to be applied also helps to defuse allegations noted in the previous chapter that the principle of autonomy is, firstly, overly dominant in philosophical discussions and secondly, reflects distinctively (and implicitly, white) North American moral and political values. With regards to the first point, Beauchamp and Childress explicitly rule out the 'misguided interpretation [that they] have encountered many times in the past thirty years' that 'autonomy overrides all other moral consideration in [their] work' noting that they have 'always argued' autonomy should not be understood as 'excessively individualistic, absolutistic or overriding... to the neglect... of social responsibilities' (for example in the case of '[choices] that endanger the public health, potentially harm innocent others, or require a scarce resource for which no funds are available') and that in general 'it is usually a mistake... to frame the issues as giving an overriding status to one principle over another'⁷⁹. With regards to the second point, the theoretical underpinnings of the principle in the 1st edition, as Häyry has pointed out:

... originate from Germany and England, and can therefore hardly be seen to impose an external threat to indigenous European moral thinking. And although the authors have, later on, replaced ethical theories with common morality as the proper framework for their

principles, they can hardly be said to have abandoned the Western roots of their model⁸⁰.

We may also recall from the previous chapter Gorovitz' argument that the large amount of work done on autonomy by philosophers in their initial explorations of medical ethics was largely the result of historical circumstances rather than any particular ideological bias. Given that this work needed to be done, and that much of it was done in the United States, we should not perhaps be surprised that we have a great many explorations of the concept from a (white) North American perspective and rather fewer from other cultures.

This criticism might still be sustained if such work unfairly excludes, or were to prove incompatible with, further explorations of the principle from different cultural backgrounds; as it happens, it is quite clear from the 6th edition of *Principles* that this is simply not the case. Indeed, as with their rejection of the idea that autonomy should always override other principles, the authors explicitly engage with two studies that purport to show conflicts between the autonomy that patients supposedly should be granted, and what patients actually want from their encounters with healthcare providers⁸¹. In the first, researchers had asked elderly patients from four different ethnic backgrounds whether they believed doctors should disclose to them 'the diagnosis and prognosis of terminal illness', and about decision-making at the end of life. The results showed, amongst other things, that European Americans and African Americans were 'significantly less likely... to believe that a patient should be told the diagnosis of metastatic cancer' than Korean Americans and Mexican Americans, and that the latter two groups 'tended to believe that the family should make decisions about the use of life support'⁸². In the second, researchers found that traditional Navajo beliefs regarding the ability of language to shape and control events, according to which 'telling a... patient who has recently been diagnosed with a disease the potential complications of that disease may actually produce these complications', meant that some Navajo patients may view disclosure of risk as potentially harmful in itself⁸³. As Beauchamp and Childress point out, however, both studies 'mistakenly view their results as opposing rather than enriching [a] principle of respect for autonomy' that includes a 'right to accept or decline information'⁸⁴. The principle of autonomy confers a right to autonomous choice rather than a duty⁸⁵ and a

patient may always decide to delegate such choice⁸⁶. As such, these studies are in fact a necessary and valuable part of discovering how this principle needs to be applied in different practical cases.

Beauchamp and Childress' Principle of Nonmaleficence from 1st to 6th Editions

Unlike the principle of autonomy, the 1st edition of *Principles* presents the principle of nonmaleficence as originating, not in detailed ethical theory, but in general historical traditions of moral thought both in medicine and elsewhere; as the authors note, the provenance of the popular maxim to 'first, do no harm' is obscure⁸⁷ and (as they point out in the 6th) attempts to locate it securely in Hippocratic writings are contentious⁸⁸. It is possible that this is because the principle seems, at first glance, a simple a matter of common sense. Certainly, any attempt to include *nonmalevolence* (that is, a general disposition to avoid or absence of intention to inflict harm on others) as a principle seems ridiculous. After all, it is unlikely that anyone would enter the medical professions with the *goal* of causing harm, and even if someone *did* we could not expect them to pay much heed to any moral principles at all. At first glance we might also expect this to be the case with nonmaleficence (an obligation not to perform *acts* which cause harm to others⁸⁹) as well. Indeed, the *very existence* of medicine can be seen to result from the principle, given that medicine is explicitly concerned with preventing, avoiding and/or reducing the harm caused by illness, injury and disease⁹⁰. Despite this, however, we may recall that the idea that medicine may in some cases itself prove harmful is not a new one (compare, for example, Plato's account of Herodicus as discussed in Chapter 2) and had become more acute over the course of the 20th Century (we may once again remember Jonsen's colleague's haemodialysis patients as first discussed in Chapter 6).

Working primarily with a physical and psychological concept of 'harm' (as opposed to, for example, damage to 'property, domestic relations, and privacy')⁹¹ the 1st edition's account of nonmaleficence begins with a discussion of those harms that may be caused by incompetence, negligence and/or malpractice, an account retained in largely unchanged form in the 6th edition⁹². In choosing to accept the professional and social position of a healthcare practitioner, Beauchamp and Childress argue, doctors, nurses and others '[create] the expectation that [they] will observe... standards [of

knowledge, skill and diligence]’ and thus incur a *special* obligation to live up to such expectations⁹³. Such concerns are not limited to standards of personal clinical competence: for example, a doctor is required to have an adequate understanding of their own limitations, so as to know when to consult more experienced colleagues or specialists, and to have a good understanding of the *probable* harms associated with a given injury or disease, and the probable benefits and/or harms associated with a course of treatment⁹⁴. We can add to the authors’ own account here by noting that we might firstly (as we have argued is implicitly required by both the *Oath* and Percival) expand doctors’ nonmaleficent obligations to include upholding the reputation of medicine as a whole and secondly, extend similar obligations to non-medical staff working in a medical setting (for example, given the importance of cleanliness in preventing the spread of disease, to hospital cleaners).

More problematic from the perspective of the principle of nonmaleficence are cases (such as Jonsen’s colleague’s) in which treatment itself runs the risk of causing some form of harm to the patient themselves (including the risk of what Illich termed, given that ‘pharmaceutical products [can] make you ill, hospitals [provide] hotbeds of infection, surgery [can be] bungled [and] tests [can be] lacking or misleading’, *iatrogenesis* or ‘doctor-caused illness’⁹⁵). The authors argue, in the 1st edition, for the rejection of ‘vitalism’ that is, the view that ‘metabolism and vital processes [are] good in [themselves]’ should be rejected⁹⁶. Instead, they argue that healthcare professionals ‘should work with a *presumption* in favour of the prolongation of life [my emphasis]’⁹⁷ but that treatment should not be considered obligatory (and may even be considered harmful⁹⁸) in cases where a patient is irreversibly dying, and perhaps in cases where a patient is either completely or largely unable to derive meaning from their continued existence also⁹⁹. As with the principle of autonomy in general, this particular specification of the principle of nonmaleficence is greatly expanded upon in the 6th edition by drawing upon more recent discussions of several elements introduced into discussions of treatment and nontreatment decisions by ‘[religious] traditions, philosophical discourse, professional codes, and the law’, in particular: distinctions between *withdrawing* and *withholding* life-sustaining treatment; between *extraordinary* and *ordinary* treatment; between sustenance technologies and medical treatments; between *intended* effects and *merely foreseen* effects; and between *killing* and *letting die*¹⁰⁰.

Whilst acknowledging that these distinctions have ‘at times [been] influential in medicine and law’, Beauchamp and Childress contend that they ‘are all outmoded and untenable... and some... are morally dangerous’¹⁰¹. For example, in the case of choices between withdrawing or withholding life-sustaining treatment, the authors accept that ‘[many] professionals and family members feel justified in withholding treatments they never started, but not in withdrawing treatments already initiated’, reflecting an ‘understandable’ common-sense view that the latter ‘render them causally responsible for the patient’s death’¹⁰². However, maintaining this distinction in practice runs the risk of both *overtreatment* (‘the continuation of no longer beneficial or desirable treatment’) and also of *undertreatment* since doctors, ‘[patients] and families worry about being trapped by biomedical technology that, once begun, cannot be stopped’¹⁰³. Moreover, it is not always clear what counts as withdrawing treatment (consider, for example, ‘not recharging the batteries that power respirators or not putting the infusion into a feeding tube’¹⁰⁴). Even if the distinction *were* clear, it also seems to be the case that withholding treatment is not always morally acceptable: ‘individuals can commit a crime by omission if they have an obligation to act, just as physicians can commit a wrong by omission in medical practice’¹⁰⁵. This uncertainty also applies to attempts to define differences between ‘extraordinary’ and ‘ordinary’ treatment: do these refer to the ‘usual’ and ‘unusual’, the ‘simple’ and ‘complex’, ‘natural’ or ‘artificial’ and so on? Beauchamp and Childress accept that these definitions may help *point* to relevant factors, but argue that none are sufficient in themselves to rule whether ‘a treatment is beneficial or burdensome’¹⁰⁶.

The question of how an intervention is to be classified also occurs, in a different context, in ‘debates about whether health care institutions can legitimately use the distinction between *medical* technologies and *sustenance* technologies’ when deciding whether to forego life-sustaining treatments. Beauchamp and Childress concede that arguments against withdrawing the latter (‘[supplying] nutrition and hydration using needles, tubes catheters and the like’¹⁰⁷) have a powerful emotional charge: ‘[provision] of nutrition and hydration symbolises the essence of care and compassion’ and, as such, it is ‘intuitively devastating to “starve” someone’¹⁰⁸. Nevertheless, it is not clear that in all cases this intuition is correct. As an example of how this position can break down in complex situations, the authors offer the case of a

79-year-old patient who had suffered progressive loss of her mental abilities, serious heart problems, and inflammation of her veins. Following a massive stroke, the patient violently resisted attempts to insert a 'nasogastric tube... into her stomach to introduce nutritional formulas and water' and managed to remove it once placed. As medical staff ran out of locations to insert an IV, they were faced with the possibility of having to perform a 'cutdown' ('an incision to gain access to the deep large blood vessels'¹⁰⁹) in order to continue treatment. In consultation with the nursing staff and family, doctors decided against further treatment and the patient 'died quietly' the following week'¹¹⁰ (Beauchamp and Childress note elsewhere that withdrawal of sustenance need not mean patient discomfort as '[caregivers] can alleviate feeling of hunger, thirst, dryness of the mouth and related problems by other means'¹¹¹). This not only appears to have been a morally correct decision, but may also be seen a concrete example of our argument against Maclean's position in the previous chapter that existing moral practices and feelings may prove highly misleading in new and difficult contexts.

That traditional or common-sense distinctions may prove to be problematic in certain complex cases is further explored through the 6th edition's account of distinctions between intended effects and merely foreseen effects and between killing and letting die. The former case is considered principally in terms of the rule of double effect (in their term, RDE¹¹²) which is revealed as problematic in two main respects. First of all are problems associated with establishing morally relevant differences between certain acts 'under the abstract conditions that comprise the RDE'. For example, the rule as usually applied would allow a pregnant woman to undergo 'a hysterectomy to save her life [although] this procedure will result in the death of [her] foetus' but not for a doctor to 'perform a craniotomy (crushing the head of the unborn foetus)' when it is the only way to save a woman in difficult labour¹¹³. Yet, as Beauchamp and Childress point out:

[in] neither case does the agent want or desire the death of the foetus, and the descriptions of the acts in these cases do not indicate morally relevant differences between intending, on the one hand, and foreseeing but not intending, on the other. More specifically, it remains unclear why advocates of RDE conceptualise craniotomy as killing the foetus rather than the act of crushing the skull of the foetus with the unintended

result that the foetus dies. Similarly, it remains unclear why in the hysterectomy case the death of the foetus is foreseen but not intended¹¹⁴

The RDE may be more plausible ‘in care of dying patients, where there is no conflict between different parties’, for example in the ‘administration of a medication to relieve pain and suffering... even though it will probably hasten the patient’s death’. Laying aside for the moment the question of how this position might be affected by the development of measures for pain-relief that did not carry the risk of hastening death, this position still allows for dispute as to ‘whether death is good or bad for a particular person’. As the authors note, the RDE cannot settle this question: it ‘applies only in cases with both a bad and a good effect, but determining the goodness and badness of different effects is a separate judgement’¹¹⁵.

This inability of a supposedly relevant distinction to settle questions of right and wrong is further developed with regards to questions regarding the relevance (if any) of drawing a distinction between killing and letting die. Beauchamp and Childress accept that this ‘has long been the most critical [distinction] in law, medicine, and moral philosophy to distinguish appropriate from inappropriate ways to death’¹¹⁶. Nevertheless, they view it as problematic in several respects. First of all, there is the question of whether it is possible to ‘legitimately describe actions that involve intentionally not treating a patient as “allowing to die” or “letting die”, rather than “killing”’ or of whether the former are merely euphemisms for acceptable forms of the latter¹¹⁷. As examples of how such distinctions may be problematic, Beauchamp and Childress consider two cases, one in which the parents and doctors of an infant with Down’s syndrome elected not to undertake a life-saving operation on the grounds that survival was not in the baby’s interests, and of a dermatologist who terminated his extremely premature son’s life-support system after a neonatologist had broken a promise not to resuscitate the infant¹¹⁸. It is not at all clear, they argue, that deciding whether or not these actions fell into either category would settle the morality of the decisions made: whilst ‘[killing] may generally be wrong and letting die only rarely wrong, this conclusion is contingent on the features of particular cases’¹¹⁹.

Beauchamp and Childress acknowledge that their rejection of these traditional distinctions is controversial (for example, with regards to RDE, they concede that it may be possible that subsequent work by its advocates will ‘solve the puzzles and problems that critics have identified’, perhaps by concentrating on the doctor’s ‘motivations and character’¹²⁰). There are both practical and theoretical arguments to be made in favour of each distinction (we may recall Jonsen’s contention that keeping a separation between killing and letting die *in practice* helped to identify problematic cases as doctors would tend to place them in the former category) and some distinctions may be less problematic than others. That there are borderline cases where the distinctions do not offer clear guidance (or may lead further confusion) does not mean that distinctions cannot be drawn, given that there *do* appear to be cases where they can (and thus led to the adoption of these distinctions in the discussion of other cases). The authors themselves suggest that reformulating treatment and nontreatment decisions in terms of whether it is morally *obligatory to treat*, *obligatory not to treat*, or *optional whether to treat* a patient¹²¹ may draw out the kinds of substantive moral questions that tend to be at stake. First of all, on this account, are questions regarding the likely outcome of particular treatments: it seems reasonably clear that where a treatment either will not or is extremely unlikely to benefit the patient, or may impose burdens on them, then it is optional and in many cases should not be carried out; however, this is likely to involve differing clinical judgements and other factors such as the religious beliefs of patients or surrogates¹²². Second are questions concerning quality of life for the patient; again, these are presented as extremely difficult to settle in many cases¹²³.

This distinction expands on the 1st edition’s presumption in favour of prolonging life to establish a *prima facie* obligation to treat (so that, for example, ‘withdrawing treatment from a competent patient is not morally justifiable unless the patient has made an informed decision authorising this withdrawal’¹²⁴) that may nevertheless be overridden in certain cases (for example, ‘pain can be so severe and physical restraints so burdensome that these factors outweigh anticipated benefits’; we may think of the elderly lady mentioned above or the paraplegic refusing food as discussed in the previous chapter)¹²⁵. For the majority of difficult cases, however, it should be noted that neither the principle of nonmaleficence nor any particular specification of it is likely to decisively settle them (we may also include the related question of whether it

can ever be optional or obligatory to hasten the death of a patient)¹²⁶. This need not, however, be construed as a weakness in Beauchamp and Childress' position providing that we accept firstly, that morally difficult cases exist and secondly, that they will (and perhaps should) *remain* difficult even after detailed analysis and careful reflection. The 6th edition of *Principles* provides the reader with a clear summary of many of the arguments (on both sides) as to why these distinctions may be relevant that are likely to arise in practical decision-making concerning difficult cases, and that need to be considered when encountering such cases. Furthermore, in encouraging a critical attitude to these distinctions, the authors emphasise the need for careful reflection on both common-sense moral intuitions and detailed ethical arguments when using them to explore such cases.

As a final point, it is worth noting that contrary to the criticism that philosophical medical ethics considers moral problems in an overly abstract fashion, both the 1st and 6th editions of *Principles* recognise that morality of many decisions cannot be considered in isolation from the societal, professional and legal context in which doctors work; as such, both note that there may be important differences between the morality of individual *acts* and of general *practices*. For example, whilst it *may* be morally permissible to actively cause the death of a patient who is suffering greatly and has very little or no chance of recovery rather than to withdraw life-sustaining treatment and let events run their course (and where the patient is suffering, such an act *may* even be praiseworthy or obligatory) to follow this as a matter of policy would likely result in the deaths of some patients who may have recovered, whilst 'a rule prohibiting killing would save some lives that would be lost if *both* killing and allowing to die were permitted'¹²⁷. We may add that it seems that such concerns can arise outside of matters of life or death. The 1848 *AMA Code*, for example, prohibited rich physicians from offering charitable services to their social peers¹²⁸; although in one sense performing a moral act, its widespread occurrence would run the risk of depriving poorer colleagues of a fee, possibly resulting in a loss of livelihood that would diminish the ranks of the profession. The 6th edition does not offer a comparable hypothetical example (noting, with a similarly narrow focus on hastening or causing death, that 'a practice or policy that allows physicians to intervene to cause deaths runs risks of abuse and might cause more harm than benefit'¹²⁹); this is likely because Beauchamp and Childress were instead able to draw

on a real-world example in the form of the Oregon Dying With Dignity Act (ODWDA), that they note does not appear to have ‘[brought] about unwarranted, involuntary deaths, [reduced] the quality of palliative care [or resulted] in deep-seated and widespread mistrust of physicians’¹³⁰, once again emphasising the importance of research into real-world elements and consequences when using the principles to explore moral issues in medicine.

Beauchamp and Childress’ Principle of Beneficence from 1st to 6th Editions

As noted above, the principle of nonmaleficence was not included in the Belmont Report, and has often been conflated (as we have seen, for example, with Winkler) with beneficence. As Häyry notes, and again as Winkler explicitly argues, conflating the two is largely the result of viewing them as two points on a single continuum of moral obligations derived from utilitarian traditions in moral philosophy. Yet from the 1st edition onwards, Beauchamp and Childress disagree with this supposed pedigree. Whilst they accept ‘there are probably no sharp breaks or transition points on the continuum from the noninfliction of harm to the production of benefit’ they also argue that although utilitarian justifications may be used to describe obligatory nonmaleficent actions, they fail to account for the ‘more altruistic and farther-reaching’ obligations of beneficence¹³¹. They note, for example, that Frankena identifies beneficent actions as morally *desirable* rather than mandatory, and that Singer conceives of ‘obligatory beneficent actions [as] grounded in a requirement to ‘prevent what is bad’’ resulting in the conclusion that whilst ‘society cannot legitimately impose affirmative duties to promote the good [it] may impose negative assumptions not to cause harm’¹³². We should note that there appears to be little doubt in the authors’ minds that healthcare professionals *do* have moral obligations to perform beneficent actions that go beyond what Frankena and Singer suggest (they cite as examples the Hippocratic *Oath*’s requirement for the physician to ‘come for the benefit of the sick’ and the AMA *Code*’s requirement to serve humanity and human dignity). For them, any theory of medical ethics does not need to establish that this *is* the case, but rather *why* this is so¹³³.

From the 1st edition of *Principles* onwards, the theoretical foundations of the ‘farther-reaching’ principle of beneficence are in fact described, not in terms of

consequentialist thinking, but as contractarian, '[arising] from complex social interactions'. On this reading 'we incur obligations to help others because we have willingly received, or at least will willingly receive, beneficial assistance from them'. These obligations can be extended or supplemented by special obligations resulting from 'explicit or implicit commitments' such as promise-making or righting prior wrongs. Although Beauchamp and Childress note that this justification, derived from Hume, is only 'one appropriate way of rooting beneficence in basic ethical theory', the implied alternatives are conspicuous by their absence¹³⁴. This justification is illustrated using the example of differing obligations for individuals involved in an imagined scenario involving a drowning man. As Beauchamp and Childress point out, a 'passerby who is a poor and weak swimmer' is not obliged to swim one hundred yards to save them (although on Frankena's view such an action could be described as morally *desirable*). However, the passerby would be under a moral obligation to do *something* (in the case of the example 'run several yards to alert a lifeguard'¹³⁵); what we may term an 'ordinary' beneficent obligation. The lifeguard, however, as a result of voluntarily accepting his position and the responsibilities which attend it, would have incurred a 'special' beneficent obligation and thus 'has a strong duty to try to rescue a drowning swimmer, even at considerable risk to himself'¹³⁶. The authors argue that it is just these sorts of obligations that healthcare professionals incur. As such, even when there is no legal obligation for a doctor to respond to a request for help (for example, when passing the scene of an automobile accident) there nevertheless exists a moral responsibility for them to do so accrued as a result of their acceptance of a particular professional role and social status¹³⁷.

Where utilitarian or consequentialist concerns *are* of importance in the 1st edition's account of beneficence is in determining the scope of these obligations. This can occur when duties accrued as the result of one social or professional position need to be weighed against those accrued as the result of another. In the above example, for instance, the physician need not stop at the scene of the automobile accident were there to be considerable personal risk or inconvenience involved¹³⁸ (especially if this may result in them becoming unable to perform other duties with regards to, for example, caring for their family¹³⁹). It can also be the case that the probable benefits of a given course of action need to be weighed against the probable harms, with the aim of maximising the former and minimising the latter¹⁴⁰. The subsidiary nature of

utility to other principles (including beneficence but also, for example, autonomy) in making such decisions is emphasised by Beauchamp and Childress, however, when they note that this ‘should not be construed so that it allows the sacrifice of the rights of individuals to the interests of society as a whole’ (which would give beneficence primacy over the other principles)¹⁴¹. Where resources are scarce or finite, concerns of utility may also have implications for costly procedures, especially where the projected likelihood of a beneficent outcome is low and when time or money would more probably lead to a beneficent outcome when invested elsewhere¹⁴².

A further drawback of viewing both nonmaleficence and beneficence in purely utilitarian terms, explored in the 6th edition, is that it tends to group distinct obligations together in a hierarchical order that does not appear to hold in all possible situations. Frankena, for example, divides a single principle of beneficence into four elements, in the following order of priority:

1. One ought not to inflict evil or harm.
2. One ought to prevent evil or harm.
3. One ought to remove evil or harm.
4. One ought to do or promote good.¹⁴³

Beauchamp and Childress’ accept Frankena’s point that ‘obligations of nonmaleficence are more stringent than obligations of beneficence’ *in general*, and note that in some cases the former does override the latter ‘even if the best utilitarian outcome would be obtained by acting beneficently’; in an echo of ‘The Survival Lottery’, they rule out the possibility that it could be moral for a doctor to ‘save two innocent lives by killing a prisoner on death row to retrieve his heart and liver for transplantation’¹⁴⁴. However, their argument that ‘we should be cautious about constructing axioms of priority’ is lent weight by examples in which the reverse is clearly true: for instance, a doctor is obviously correct to inflict ‘a very minor injury (swelling from a needlestick, say)’ to bring about ‘a major benefit (a life-saving intervention, say)’. In such cases, beneficence has priority over nonmaleficence: ‘causing some risks of surgical harm, introducing social costs to protect the public health, and placing burdens on some research subjects can all be justified by the benefits of the actions’¹⁴⁵.

The importance of keeping principles separate in order to better recognise how they may need to be weighed against each other in practical situations is further emphasised in the 6th edition's discussion of medical paternalism, debates as to '[whether] respect for the autonomy of patients should have priority over professional beneficence directed at those patients', which they describe as 'a central problem in biomedical ethics'¹⁴⁶. As the authors point out, proponents of the absolute primacy of one principle over the other sometimes conflate the two (for example, they note that Pellegrino and Thomasma have argued that 'the patient's preferences alone determine the content of the physician's obligation to act beneficently' which 'simply restates' the principle of autonomy¹⁴⁷) whilst others attempt to justify paternalistic intervention through invoking 'rational consent, subsequent consent, hypothetical consent or some other form of consent' (for example, in Dworkin's view of paternalism as 'a "social insurance policy" to which fully rational persons would subscribe in order to protect themselves'¹⁴⁸). Despite acknowledging the attractiveness of such attempts to harmonise the principles, Beauchamp and Childress argue that they ultimately misrepresent the nature of paternalistic interventions: '[we] do not control children *because* we believe they will subsequently consent to... our interventions [but] because we believe they will have better, or at least less dangerous, lives [my emphasis]'¹⁴⁹. As an alternative, the 6th edition proposes justifying paternalistic interventions by balancing them against autonomy interests: '[as] a person's interests in autonomy increase, and the benefits for that person decrease, the justification of paternalistic action becomes less plausible'¹⁵⁰.

As the authors point out, adopting this view can lead to justification even of cases of 'hard' paternalism in which 'the intended beneficiary does not accept the values used to define his or her best interests' (in 'soft' paternalism, by contrast, the patient is acting with a diminished sense of autonomy and there is thus no 'real conflict between the principles'; we may think of the MS sufferer refusing treatment for meningitis whilst depressed in Chapter 9)¹⁵¹. On this view, 'preventing minor harms or providing minor benefits while deeply disrespecting autonomy lacks plausible justification' whereas 'actions that prevent major harms or provide major benefits while only trivially disrespecting autonomy have a plausible... rationale'¹⁵². So, for example, it may be acceptable for a doctor not to disclose to a patient that initial tests have detected a possible serious pathology in order to spare them needless distress and

anxiety whilst a second set are carried out (although things may be different if failing to disclose the possibility led to them to refuse consent for the second set of tests). Similarly, a patient who does not feel drowsy after taking preoperative medication and so requests the side rails on his bed (normally raised to prevent drowsy patients falling out) be left down may be overruled by a nurse whose professional experience leads her to conclude that he is not only likely to become drowsy soon, but has no family present to watch him whilst staff are otherwise occupied. Of course, many cases in real world practice are likely to be significantly more complex; nevertheless, as with nonmaleficence, it is not clear that difficult cases could be made any less so by uncritically championing one principle over the other.

The 6th edition's account of the principle of beneficence, as with its account of autonomy, is further deepened through an exploration of criticism from outside the North American context in which it was first articulated, specifically with regards to the proposed principle (one of several suggested to 'provide [a European] alternative to the ideals underlying the Georgetown model'¹⁵³) of precaution. As Häyry notes, this principle 'is best known in the context of climate change, and the protection of our natural environment' but has 'also found its way into European discussions concerning medicine and health care', first of all with regards to genetically modified organisms and subsequently with blood banking and human genetics¹⁵⁴. Although applied in several different ways by different authors (Häyry counts four uses¹⁵⁵, whilst Beauchamp and Childress report that some studies have identified nineteen¹⁵⁶) one key specification is that 'uncertainty as such can be used as an argument against technological development, and for protective regulations [since if] the unforeseen consequences of our actions could be disastrous, precaution dictates that we should not undertake them'¹⁵⁷. Once again, however, it is questionable whether precaution offers an alternative to the principles or helps instead to further explore issues already implicit within them: as Häyry points out, the 'goals [of the principle] could easily be shared by liberal and utilitarian ethicists'¹⁵⁸ and the principle of beneficence in one specification is concerned with the prevention of harm¹⁵⁹. Beauchamp and Childress do, in fact, argue for the second interpretation and accept that some 'modest' form of the principle of precaution (rather than a general principle in its own right) is a necessary corollary to the principle of beneficence for cases where 'risks cannot be quantified and an appropriate benefit-risk-cost analysis is not possible'¹⁶⁰ and where

continued vigilance is required as to the possible effects of a particular policy (for example the ODWDA)¹⁶¹.

Beauchamp and Childress' Principle of Justice from 1st to 6th Editions

Just as Winkler's description of autonomy as primarily Kantian was undermined by the 1st edition's description of a principle supported and expanded upon in different ways by both deontological and consequentialist theories, and his description of beneficence (and, thus, nonmaleficence) as 'classically utilitarian' did not match up with principles rooted in contractarian thought and medical traditions, so his description of the principle of justice as contractarian is rather at odds with what is written on the pages themselves. Instead, Beauchamp and Childress start from Aristotle's 'rather minimal' definition that 'equals ought to be treated equally and unequals unequally'¹⁶² (restated in the 6th edition of *Principles* as the 'principle of formal justice'¹⁶³). Theoretical approaches to justice are presented by the authors as ways of articulating this formal principle into material rules; a process which (like that of competence with regards to the principle of autonomy) Beauchamp and Childress acknowledge is highly problematic¹⁶⁴. The 1st edition considered four different kinds of approach: *Egalitarian* theories, emphasising equal access to rationally-desired 'goods'; *Marxist* theories, emphasising allocation of resources on the basis of fundamental 'needs'; *Libertarian* theories, emphasising the receipt of resources as the just reward for contribution and/or merit; and *Utilitarian* theories, emphasising a mixture of criteria necessary to maximise public and private utility¹⁶⁵ (the 6th edition, reflecting currents in contemporary thought, replaces Marxist theories with a discussion of *Communitarian* approaches).

In terms of content, Winkler describes the principle of justice as 'mostly a mystery'¹⁶⁶. Certainly, the 1st edition does not go into a great deal of detail beyond distinguishing between examples of two kinds of problem that are likely to arise in medical settings, namely *comparative* questions (in which 'what one person deserves is determined by balancing the competing claims of other persons against his [or her] claims')¹⁶⁷, generally concerning 'microallocation' (that is, questions regarding 'which person(s) will receive some scarce preventative or therapeutic procedure'¹⁶⁸) and *distributive* questions (those regarding 'the proper distribution of social benefits

and burdens [such as] paying taxes [or receipt of] welfare cheques')¹⁶⁹, generally concerning 'macroallocation', or the socio-economic provision of healthcare¹⁷⁰ (although they can also refer to, for example, questions regarding the distribution of risk in nontherapeutic research and the consequences of individual behaviour, such as whether smokers should pay higher health insurance premiums¹⁷¹). Despite Winkler's claims, the principle of justice as presented by Beauchamp and Childress does not lead to any specific normative suggestions with regards to macroallocation. Rawls is mentioned only in the context of providing an illustration of one such theory and how (as a critique of the *status quo* in the United States at the time of writing) it *might* lead to specific policy decisions, but these are not specifically endorsed¹⁷².

A little more guidance is provided for questions of microallocation: the authors argue that these decisions typically take place before funds for a new procedure have been macroallocated (for example, kidney dialysis had not been widely available in the United States until Federal funding was provided for a nationwide programme) but they can also apply to situations (for example the allocation of transplant organs) where the pool of resources is necessarily limited. Using this last example, Beauchamp and Childress suggest that two sets of rules or procedures are required. First of all, there is the need to determine 'the relevant pool of potential recipients' (for example, those who are eligible to receive a transplanted kidney); secondly, there is the need to determine rules or procedures concerned with 'final selection' (those who would actually receive a kidney)¹⁷³. The first criteria are easier to choose, being based largely on medical acceptability and the possibility that a patient will benefit from the treatment (the authors suggest that this should be done as though the resource is unlimited to help screen out 'covert value judgements'). The second are more problematic as they require widespread social acceptance of a comprehensive theory of justice¹⁷⁴. Whilst conceding that some theories *may* be suitable in limited circumstances (for example, as noted above, with a need-based system in triage, a closed system in which all patients share an immediate set of medical priorities¹⁷⁵) this is clearly beyond the scope of what *Principles* was likely to achieve.

The apparent paucity of specifications of the principle of justice in the 1st edition, like the abundance of specifications regarding autonomy, can and should be considered in the context of why and where philosophers first came to consider questions of

medical ethics in the mid- to late 20th Century. For one thing, questions of allocating healthcare resources were not as readily apparent or pressing as more immediately obvious matters of life and death. For another, those philosophers employed as part of state-sponsored bodies such as the President's Commission were not asked to consider them: the Reagan administration in the United States, for example, may have been happy to have philosophers 'decide' when a person was dead, but it is unlikely to have asked philosophers to decide how best to spend taxpayers' money, especially when their conclusions may not have matched its own political ideology. Indeed, that the principle existed in its initial 'mysterious' form seems less like a criticism of the 1st edition of *Principles* than a timely insight into where more work needed to be done. At the time, as Beauchamp and Childress acknowledge, then-recent literature tended to exist as a subset of existing political philosophy, with its 'focus on considerations of fair *economic* distribution'¹⁷⁶ (leaving questions of organ allocation and the like less fully explored). We should note that not all questions of socio-economic provision centre on the principle of justice: for example, the AMA's argument (mentioned in Chapter 6) that government money is better spent on medical research than on social provision of healthcare appears to concern how best to maximise goods and thus seems more properly dealt with under the principle of beneficence (since it assumes that the government should be spending money on healthcare *per se* and is not concerned with *how much* money should be spent) although the distinction is not immediately clear from *Principles* itself (the authors describe a just allocation of beneficence, but this does not appear to be meaningfully distinct from beneficence guided by utility¹⁷⁷).

Just as Beauchamp and Childress' approach allowed the other principles to be revised and expanded, however, the 6th edition takes advantage of subsequent scholarship to consider several kinds of situation where questions of justice might be raised in addition to the examples offered above (and, in replacing discussion of Marxist theories with discussion of Communitarian theories, different ways to approach them: for example by considering questions of solidarity¹⁷⁸, initially developed as a European alternative to justice itself¹⁷⁹). For example, the authors note the importance of social research indicating that 'in the United States... blacks and women have poorer access to various forms of health care in comparison to white males' (indicating the likelihood that 'racial and gender inequalities in employment' have an

impact on possession of health insurance), and that ‘the race and gender of physicians often [plays] a role in the quality of patient-physician interaction’¹⁸⁰, in raising issues that the principle of justice requires we find ways to address¹⁸¹. The authors also consider cases in which ‘[some] persons report feeling heavily pressured to enrol in clinical trials, even though their enrolment is correctly classified as voluntary’, due to a ‘desperate need for money’¹⁸². This is explored with a discussion of possible *constraining situations* such as lack of food or shelter, of cases of *undue inducement*, when extra benefits and/or the increased disadvantages of patients need to be weighed against increasing risks, and of *undue profit*, when a company’s financial benefits from developing a new product greatly outweigh those provided to research subjects¹⁸³ (as the authors note, it may also be possible for payments to be too high in the former sense and still too low in the latter: ‘\$25/hr. or \$10/hr. might be irresistibly attractive [to the needy] while distributively unfair’¹⁸⁴). On a wider scale, they also consider how the principle of justice might be applied to global inequalities in health and healthcare, arguing that ‘[while] it remains unclear what would constitute an adequate strategy for attacking these problems’ attempts to do so ‘are amongst the most urgent for a theory of justice to address’¹⁸⁵.

In addition to these new questions, the 6th edition of *Principles* also attempts to offer stronger practical guidance regarding the socio-economic provision of healthcare. The impetus to do so is provided by both a moral argument (that ‘[policies] of just access to health care, strategies of efficiency in health care, and global needs for the reduction of health-impairing conditions dwarf in social importance every other issue considered in [the 6th edition]’) and an economic one (that ‘[countries] lacking a comprehensive and coherent system of health care financing and delivery... are destined to continue on the trail of higher costs’)¹⁸⁶. Their proposed solution is that ‘society recognise global rights to health and enforceable rights to a decent minimum of health care’¹⁸⁷. Recognising that, barring major changes to the world’s economic system, the concept of a universal right ‘to every good and service that is available to anyone’ is ‘utopian’, they instead propose a ‘two-tiered system of health care’ in which ‘basic and catastrophic health needs’ are subject to ‘enforced social coverage’ whilst ‘better services, such as luxury hospital rooms and optional, cosmetic dental work, are available for purchase at personal expense’¹⁸⁸. The authors’ suggestion that this might ‘[offer] a possible compromise among libertarians, utilitarians,

communitarians, and egalitarians, because it incorporates some moral premises that each stresses'¹⁸⁹ may, in light of recent events in the United States, seem somewhat overoptimistic (and we may also note that, should someone be more comfortable during a hospital stay, or have a more uniform smile than another, based on nothing more than, say, inherited wealth, it is likely to strike us as, if not *unjust*, then at the very least *unfair*). Nevertheless, Beauchamp and Childress demonstrate both the complexity of the issue (since '[we] do not now have – and are not likely ever to have – a single viable theory of social justice'¹⁹⁰) and the importance of finding a way to address it.

Conclusions

In evaluating the changes made to Beauchamp and Childress' account of the four principles between 1st and 6th editions, it may be useful to consider them in two distinct yet complementary senses. The first of these are changes to the principles themselves. In the 1st edition, it may have been plausible to view them as attempts to specify in more detail precise mid-level action guides that could (and/or should) apply in more or less the same way to all relevant decisions in medical ethics: so, for example, on the 1st edition's account autonomy could be seen as a more-or-less straightforward combination of Kantian and Millian perspectives that is, as comprising the positive and negative duties that each account emphasises. Whilst this reading is still present to an extent in the 6th edition, the more complex account of autonomy generated by including (for example) social research into the context provided by social class and/or cultural and ethnic backgrounds presents autonomy, like the other principles, as a 'cluster of concerns' that is both less specific and (perhaps surprisingly) more generally applicable. Winkler conceded that one strength of the 1st edition's view was that it appeared to '[provide] the basic framework for a coherent perspective on virtually the whole range of moral issues in medicine'¹⁹¹; this assessment may now be more correct, but in a different way.

The principles, so conceived, do not provide a fully coherent perspective on what actions should be taken in the whole range of moral situations in medicine, but rather a coherent framework highlighting the *kinds* of moral concerns raised by 21st Century medicine and how they should be approached in terms of the arguments *on all sides*

that need to be considered when attempting to come to a decision on specific issues. In some cases (for example in the retention of both the positive and negative obligations of the principle of autonomy) considering these arguments may provide a new practical synthesis. In others, for example with regards to the principle of justice and socio-economic provision of healthcare, it may be seen as a prompt that further theoretical work is required: *ignoring*, for example, libertarian objections to communitarian perspectives (and vice versa) is unlikely to get us anywhere beyond a rancorous argument. *Considering* the objections on each side, together with (for example) social and economic research, may yet enable us to come up with a more acceptable arrangement (that Beauchamp and Childress' own proposed synthesis of these ideas for the United States has, quite clearly, not been able to win widespread approval, however, highlights both how difficult such a process may be and, perhaps, how vulnerable such debates are to outside interests). Finally, in certain cases, for example in the most difficult treatment and nontreatment decisions, it may not be possible to arrive at a single, unambiguous action-guide (or set of action-guides) to be applied in all cases; nevertheless, it may be possible to establish a set of concerns that need to be conscientiously addressed in order to make the best possible decision given the circumstances.

These changes in the nature of the principles may be seen to follow from the developments in (they may prefer 'clarification of') Beauchamp and Childress' view of moral theory between the 1st and 6th editions. Whilst some 'principlist' writers retain a deductivist approach (often counting one principle as having overriding authority over the others, for example autonomy in the work of Downie and Calman¹⁹² and, arguably, beneficence in the work of Gillon¹⁹³) the authors now claim explicitly to be following a model that incorporates Wide Reflective Equilibrium as a way of exploring the application of the norms they identify as part of the 'common morality'¹⁹⁴. However, as suggested above, a development of this approach in line with Rachels' suggested 'web of ideas' may in fact be a better fit. First of all, it seems reasonable to suggest that the common morality also contains in addition to *prima facie* norms representing considered judgements what we may refer to as *theoretical* norms, for example: 'do the greatest good for the greatest number' or 'treat people as ends not means'. On this view, these elements would also be close to the centre of the web of ideas, however, judgements in particular cases and/or further reflection on the

norms themselves may cause us to revise their position and/or become more certain of a particular specification of them (so, for example, we may become more certain that a general account of justice requires discussions of solidarity, or that, as in triage, a specific account of justice is particularly suited to a certain specific set of circumstances). Again, as with the judgement norms that the authors identify we should (and, in general, do) find that we have to provide a reason for going against these theoretical norms in practice if our actions are to be considered moral; that is, that we have to take them into account.

The 'web of ideas' model may also be more suited to Beauchamp and Childress' approach in that the principles and specifications of them will be influenced not only by developments in philosophical moral thought but by also by developments in other spheres, be they medical (in either a clinical or institutional sense), social, psychological, legal and/or political. So, for example, difficult decisions regarding medical nutrition and hydration only arise once such measures are possible (and, arguably, will be influenced by whether it is possible to alleviate feelings of hunger and thirst should they be withdrawn). Nonmaleficence may need to include the possible harm to patients and to medicine of the medicalisation of conditions such as 'restless leg syndrome'; in doing so it may lead us to further examine the relationship between medicine and commercial business. New questions regarding autonomy will be specified by research not only into the way different patients from different backgrounds may respond to certain information, but also into the ways that human beings process information and make decisions generally. Legislation such as the ODWDA, or to enable doctors to treat some competent patients against their will, is likely to provide new evidence and new examples to consider in terms of physician-assisted dying and paternalism. Debates concerning the socio-economic provision of healthcare will depend upon what different states provide for their citizens, and perhaps on what those citizens (for whatever reason) decide that they want.

Whilst the principles themselves may be seen, together with the various specifications and arguments used to explore them in the main body of the text, as a 'snapshot' of the current state of the 'web of ideas', at least as with regards to medical ethics, it is clear that they have changed and may change in the future. Moreover, as we can see from the examples above, they help to suggest some *ways* in which they may need to

be further developed. In one sense, this model does commit both medical ethics and moral philosophy in general to a form of context-dependence; it is, however, a rather trivial form, namely that the kinds of problems that medical ethics deals with are the kinds of ethical problems that medicine, in its current form, brings up. Moreover, we should remember that the ‘web of ideas’ allows that philosophy does not just depend on context, but *drives* it as well: as arguments and concepts are subjected to analysis, as thought-experiments are created and inspire responses to them, and as theories are constructed, applied to cases and criticised, they (together with the influence of outside events) both reshape the web and cause it to be reshaped in turn. Indeed, the concepts of Wide Reflective Equilibrium and the web of ideas may *themselves* be seen to emerge from just this type of interaction between philosophers, philosophical methods and theories, and concrete issues both within the discipline and without. However, just – as Häyry has pointed out – ‘[the] Georgetown principles do not hold the monopoly of truth in health-care ethics’¹⁹⁵ so this view of the approach that generates them may be charged with omitting certain key aspects of our moral lives; it is criticisms of this nature that our next chapter will move on to consider.

¹ Winkler, E.R. ‘From Kantianism to Contextualism’ p.349

² Erin, C.A. ‘Who Needs the Four Principles’ in Häyry, M. and Takala, T. (eds.) *Scratching the Surface of Bioethics* p.79

³ Herissone-Kelly, P. ‘The Principlist Approach to Bioethics and it’s Stormy Journey Overseas’ in *ibid.* p.65

⁴ Winkler, E.R. ‘From Kantianism to Contextualism’ p.350

⁵ *Ibid.* pp.30-1

⁶ Herissone-Kelly, P. ‘The Principlist Approach to Bioethics and it’s Stormy Journey Overseas’ p.65

⁷ Maclean, A. *The Elimination of Morality* p.200 n.33

⁸ Winkler, E.R. ‘From Kantianism to Contextualism’ p.349

⁹ Erin, C.A. ‘Who Needs the Four Principles’ p.79

¹⁰ *Ibid.* p.79

¹¹ Jonsen, A.R. *The Birth of Bioethics* p.332

¹² Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (1st Edition)* (Oxford: Oxford University Press, 1979) p.vii

¹³ *Ibid.* p.vii

¹⁴ Häyry, M. ‘European Values In Bioethics: Why, What, and How to be Used?’ in *Theoretical Medicine* 2003; 24 (3) 199–214 p.200

¹⁵ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (1st Edition)* p.5

¹⁶ *Ibid.* p.20

¹⁷ *Ibid.* p.13

¹⁸ *Ibid.* p.9

¹⁹ Winkler, E.R. ‘From Kantianism to Contextualism’ p.351

²⁰ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (1st Edition)* pp.40-1

²¹ Winkler, E.R. ‘From Kantianism to Contextualism’ p.351

²² Waltho, S. ‘Response to Westin and Nilstun’ in *Health Care Analysis* 2006; 14 (2) 119-120 p.120

²³ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (1st Edition)* p.4

²⁴ *Ibid.* pp.14-16

²⁵ Hare, R.M. ‘Abortion and the Golden Rule’ p.63

²⁶ Nussbaum, M. *The Fragility of Goodness* (Cambridge: Cambridge University Press, 2001) p.34

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- ²⁷ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (1st Edition)* p.4
- ²⁸ Ibid. p.47
- ²⁹ Ibid. p.13
- ³⁰ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (6th Edition)* p.369
- ³¹ Ibid. p.384
- ³² Ibid. p.381
- ³³ Ibid. p.387
- ³⁴ Ibid. p.3
- ³⁵ Ibid. p.15
- ³⁶ Ibid. p.385
- ³⁷ Ibid. p.382
- ³⁸ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (6th Edition)* p.375
- ³⁹ Arras, J. 'Getting Down to Cases: The Revival of Casuistry in Bioethics' in *Journal of Medicine and Philosophy* 1991;16 (1) 29-51 p.33
- ⁴⁰ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (6th Edition)* p.67
- ⁴¹ Ibid. p.71
- ⁴² Ibid. p.74
- ⁴³ Ibid. p.75
- ⁴⁴ Ibid. p.79
- ⁴⁵ Ibid. p.81
- ⁴⁶ Ibid. p.13
- ⁴⁷ Ibid. p.370
- ⁴⁸ Ibid. p.279
- ⁴⁹ I am grateful to Mr. Harry Lesser for the use of this example, taken from a forthcoming work
- ⁵⁰ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (6th Edition)* p.279
- ⁵¹ Ibid. p.382
- ⁵² Ibid. p.383
- ⁵³ Winkler, E.R. 'From Kantianism to Contextualism' p.351
- ⁵⁴ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (1st Edition)* p.56
- ⁵⁵ Ibid. p.57
- ⁵⁶ Ibid. pp.57-8
- ⁵⁷ Ibid. p.59
- ⁵⁸ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (6th Edition)* p.104
- ⁵⁹ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (1st Edition)* p.62
- ⁶⁰ Ibid. p.82
- ⁶¹ Ibid. p.85
- ⁶² Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (6th Edition)* p.104
- ⁶³ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (1st Edition)* p.67
- ⁶⁴ Ibid. pp.70-1
- ⁶⁵ Ibid. p.77
- ⁶⁶ Ibid. p.67
- ⁶⁷ Ibid. p.81
- ⁶⁸ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (1st Edition)* p.70
- ⁶⁹ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (6th Edition)* p.120
- ⁷⁰ Ibid. p.121
- ⁷¹ Ibid. pp.120-1
- ⁷² Ibid. pp.120-1
- ⁷³ Ibid. p.122
- ⁷⁴ Ibid. p.124
- ⁷⁵ Ibid. p.125
- ⁷⁶ Ibid. p.125-6
- ⁷⁷ Ibid. p.130
- ⁷⁸ Ibid. p.131
- ⁷⁹ Ibid. p.viii
- ⁸⁰ Häyry, M. 'European Values In Bioethics' p.200
- ⁸¹ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (1st Edition)* p.105
- ⁸² Ibid. pp.105-6
- ⁸³ Ibid. p.106
- ⁸⁴ Ibid. p.107

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- ⁸⁵ Ibid. p.107
⁸⁶ Ibid. p.106
⁸⁷ Ibid. p.97
⁸⁸ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (6th Edition)* p.149
⁸⁹ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (1st Edition)* p.98
⁹⁰ Ibid. p.99
⁹¹ Ibid. p.99
⁹² Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (6th Edition)* p.155
⁹³ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (1st Edition)* p.100
⁹⁴ Ibid. p.101
⁹⁵ Porter, R. *The Greatest Benefit to Mankind* p.687
⁹⁶ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (1st Edition)* p.124
⁹⁷ Ibid. p.122
⁹⁸ Ibid. p.121
⁹⁹ Ibid. pp.119-20
¹⁰⁰ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (6th Edition)* p.155
¹⁰¹ Ibid. p.155
¹⁰² Ibid. pp.155-6
¹⁰³ Ibid. p.157
¹⁰⁴ Ibid. p.157
¹⁰⁵ Ibid. p.157
¹⁰⁶ Ibid. p.159
¹⁰⁷ Ibid. p.159
¹⁰⁸ Ibid. p.161
¹⁰⁹ Ibid. p.156
¹¹⁰ Ibid. p.160
¹¹¹ Ibid. p.161
¹¹² Ibid. p.162
¹¹³ Ibid. p.163
¹¹⁴ Ibid. p.163
¹¹⁵ Ibid. pp.163-4
¹¹⁶ Ibid. p.172
¹¹⁷ Ibid. p.173
¹¹⁸ Ibid. pp.172-3
¹¹⁹ Ibid. p.174
¹²⁰ Ibid. p.166
¹²¹ Ibid. p.166
¹²² Ibid. pp.168-9
¹²³ Ibid. p.170
¹²⁴ Ibid. p.175
¹²⁵ Ibid. pp.166-7
¹²⁶ Ibid. p.180
¹²⁷ Ibid. p.114
¹²⁸ American Medical Association *Original Code of Medical Ethics* p.104
¹²⁹ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (6th Edition)* p.177
¹³⁰ Ibid. p.179
¹³¹ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (1st Edition)* p.135
¹³² Ibid. pp.138-9
¹³³ Ibid. p.142
¹³⁴ Ibid. pp.141-2
¹³⁵ Ibid. p.140
¹³⁶ Ibid. p.142
¹³⁷ Ibid. pp.142-3
¹³⁸ Ibid. p.143
¹³⁹ Ibid. p.140
¹⁴⁰ Ibid. p.143
¹⁴¹ Ibid. pp.143-4
¹⁴² Ibid. pp.144-5
¹⁴³ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (6th Edition)* p.150

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- ¹⁴⁴ Ibid. p.150
¹⁴⁵ Ibid. p.150
¹⁴⁶ Ibid. p.207
¹⁴⁷ Ibid. p.207
¹⁴⁸ Ibid. p.214
¹⁴⁹ Ibid. p.214
¹⁵⁰ Ibid. p.214
¹⁵¹ Ibid. p.210
¹⁵² Ibid. p.214
¹⁵³ Häyry, M. 'European Values In Bioethics: Why, What, and How to be Used?' p.205
¹⁵⁴ Ibid. p.205
¹⁵⁵ Ibid. pp.205-6
¹⁵⁶ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (6th Edition)* p.228
¹⁵⁷ Häyry, M. 'European Values In Bioethics: Why, What, and How to be Used?' p.206
¹⁵⁸ Ibid. p.205
¹⁵⁹ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (6th Edition)* p.151
¹⁶⁰ Ibid. p.228
¹⁶¹ Ibid. p.179
¹⁶² Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (1st Edition)* p.171
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¹⁶⁵ Ibid. p.173
¹⁶⁶ Winkler, E.R. 'From Kantianism to Contextualism' p.361
¹⁶⁷ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (1st Edition)* pp.169-70
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¹⁷⁰ Ibid. p.188
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¹⁷² Ibid. p.175
¹⁷³ Ibid. p.193
¹⁷⁴ Ibid. p.194
¹⁷⁵ Ibid. p.195
¹⁷⁶ Ibid. p.169
¹⁷⁷ Ibid. p.189
¹⁷⁸ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (6th Edition)* p.246
¹⁷⁹ Häyry, M. 'European Values In Bioethics: Why, What, and How to be Used?' p.206
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¹⁸¹ Ibid. p.253
¹⁸² Ibid. p.255
¹⁸³ Ibid. p.255
¹⁸⁴ Ibid. p.257
¹⁸⁵ Ibid. p.266
¹⁸⁶ Ibid. p.280
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¹⁸⁸ Ibid. p.260
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¹⁹⁰ Ibid. p.261
¹⁹¹ Winkler, E.R. 'From Kantianism to Contextualism' p.349
¹⁹² Downie, R.S. and Calman, K.C. *Healthy Respect: Ethics in Health Care* (London: Faber and Faber, 1987) p.50
¹⁹³ Erin, C.A. 'Who Needs the Four Principles' p.80
¹⁹⁴ Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics (6th Edition)* p.381
¹⁹⁵ Häyry, M. 'European Values In Bioethics: Why, What, and How to be Used?' p.208

Chapter 11: Further Criticism of the Four Principles in the Teaching and Practice of Medical Ethics

As we have seen in the previous chapter, many criticisms of the four principles – especially the belief ‘particularly in Continental Europe... that the values of the Old World are under attack’ and that ‘the Georgetown principles... are the invader’ – are, as Häyry acknowledges ‘in many ways mistaken and misleading’¹. Far from representing an attempt to promote North America ideals of individual liberty and social, economic and political justice as a universal program, we have seen that their roots lie in both earlier European philosophy (for example in the case of autonomy) and traditions of medical ethics (for example in the case of nonmaleficence), that the emphasis on North American values in ancillary work was most likely the result of historical circumstance and does not preclude exploring (indeed, in some senses *requires* exploring) the principles from other standpoints (for example with regards to different conceptions of autonomy in different cultures and with regards to issues of race and gender in justice), and that such exploration results in a richer understanding of the principles themselves, arguing for the success of Beauchamp and Childress’ chosen method. Nevertheless, when the 1st edition of *Principles* was published, ‘it was customary to think, at least in the English-speaking academic world, that the “deontological” and “consequentialist” moral views... were the only viable options in normative ethics’. The authors neglected ‘a third alternative... namely virtue ethics, which started to (re)emerge in the 1980s and became instantly popular in Continental Europe’²; as a result it has been argued that the use of the principles in the teaching of medical ethics both misrepresents the nature of moral reflection and, regardless of the authors intentions, discourages such reflection in practice. The purpose of this chapter is to consider whether these criticisms are fatal to the use of the principles in the teaching and practice of medical ethics, or whether they too can be incorporated into the kind of approach we have argued the 6th Edition suggests.

The Four Principles and Virtue Ethics Approaches

On one (very broad) definition, a virtue is simply a trait or quality that renders something valuable (so, for example, we can speak of inanimate objects, systems or

institutions in such terms³: it might be a ‘virtue’ of a particular car that it is reliable and easy to maintain, or a ‘virtue’ of the rule that all London black-cab drivers must take ‘The Knowledge’ that they are generally better at getting one to one’s destination than yellow-taxi drivers in New York); in slightly more narrow human terms, ‘[a] *virtue* is a trait of character that is socially valuable, and a *moral virtue* is a trait of character that is morally valuable’⁴. As Häyry notes, the tradition of virtue ethics in moral thought has its roots in Aristotle⁵, and a distinction between a *right* action and a (morally) *virtuous* one: ‘some people who perform just acts are still not just (for example those who carry out the requirements of the law unwillingly, or through ignorance, or for some ulterior purpose and *not for what they are* [my emphasis])’. On this view, even though they ‘are doing what is right, and all that a good man is bound to do’ these agents lack the ‘state of mind in which a person can perform the various kinds of act in such a way as to be a good man’⁶. Virtues should not, in this sense, be confused with utilitarian requirements (such as some of Hare’s general principles) to habituate certain dispositions because they will *result* in certain kinds of actions. Rather, they are dispositions that, once habituated, themselves help to establish the moral character of the agent performing the action: ‘what makes the agent just or temperate is not merely the fact that he does such things, but the fact that he does them in the way that just and temperate men do’⁷. As MacIntyre puts it (and as we shall explore in more detail in a moment), ‘Aristotle’s view is teleological, but it is not consequentialist’⁸.

For Aristotle, virtues are not simply dispositions that one possesses or lacks as a matter of course: although we may possess the *potential* to be virtuous (or vicious), ‘none of the moral virtues is engendered in us by nature, since nothing that is what it is by nature can be made to behave differently by habituation... a stone, which has a natural tendency downwards cannot be habituated to rise’. Rather, the virtues require cultivation: ‘their full development in us is due to habit’⁹ and, since ‘like activities produce like dispositions’ we must exercise the kind of actions associated with a virtue if we are to habituate ourselves to the degree that we may be considered to possess it: ‘[the] man who shuns and fears everything and stands up to nothing *becomes* a coward; the man who is afraid of nothing, but marches up to every danger, *becomes* foolhardy [my emphasis]’¹⁰. Similarly, as is apparent from this quotation, whilst no-one is born vicious, acting in a vicious way over a prolonged period of time

will eventually undermine our capacity for virtue: ‘people get into this condition through their own fault... they *make themselves* unjust or licentious by behaving dishonestly or spending their time in drinking and other forms of dissipation [my emphasis]’¹¹. Worse, it may in fact *destroy* our capacity for virtue, ‘no more than a sick man can become healthy, even though (it may be) his sickness is... the result of incontinent living... [there] was a time when it was open to him not to be ill; but [he threw] away his chance’¹².

The repeated performance of virtuous actions, according to Aristotle, itself leads to a greater likelihood of performing similar actions in the future: ‘[it] is by refraining from pleasures that we become temperate, and it is when we have become temperate that we are most able to abstain from pleasures’¹³. This is important since a virtuous act, for him, must not only be consciously chosen for its own sake but also result ‘from a fixed and permanent disposition’ towards such actions¹⁴. Actions alone, however, are not in themselves a guarantee of acquiring such a disposition, since ‘it is in the field of actions *and feelings* that virtue operates [my emphasis]’¹⁵. They are necessary (‘there [is not] the smallest likelihood of any man’s becoming good by not doing them’¹⁶) but not sufficient: it is possible to consistently perform virtuous actions, and to do so because we know them to be virtuous, yet nevertheless not *be* virtuous if we do not feel pleasure in performing these actions: ‘[a] man who abstains from bodily pleasures and enjoys the very fact of doing so is temperate; if he finds it irksome he is licentious’¹⁷. Since ‘to feel pleasure or pain rightly or wrongly has no little effect upon our conduct’¹⁸ if we are to become virtuous, we must not only take care to perform the right actions, but to train our emotions so as to be properly disposed towards them.

Whether conscious direction of our action alone will be enough to accomplish the task of developing of a ‘fixed and permanent’ disposition towards virtue is open to question (it is not, as we shall see below, for Aristotle a task that everyone can accomplish). Moreover, many of us will not get the chance to do so (we are not, for example, often called upon to be courageous in our daily lives; similarly, people in a happy marriage seem less likely to be tempted into adultery). Perhaps consequently, Murdoch has suggested that, in addition to virtuous action a kind of emotional (rather than intellectual) reflection on the virtues and the virtuous may also be required:

[human] beings are naturally ‘attached’ and when an attachment seems... bad it is most readily displaced by another attachment, which an attempt at attention can encourage... our ability to act well ‘when the time comes’ depends partly, perhaps largely, upon the quality of our habitual objects of attention¹⁹

So, by ‘focusing our attention’ on virtuous things (be they exemplary figures, ‘great art’, especially – as we shall explore further in our section on narrative ethics, below – literature, and ‘perhaps... the idea of goodness itself’) we may develop an emotional attachment to virtuous conduct and thus habituate ourselves to certain dispositions and actions²⁰. It is important to note that simple imitation or inspiration at the level of action (‘What would Jesus do?’, ‘What would my wife think?’) would probably not qualify as virtuous on Aristotle’s terms (since there seems to remain an element of temptation to perform another action, and the actions are performed for another’s sake and not their own). Rather, through such reflection, we may aspire to *be* the kind of person (we think) that Jesus was, or to *have* those qualities that someone saw in us when they fell in love.

If the virtuous moral agent is so disposed towards virtuous action that they are no longer tempted to perform vicious actions (so, for example, have no need to remind themselves that they *should* be just, or courageous, or temperate) they will still need to exercise judgement in determining *what* is just, courageous and so on in a given situation. For Aristotle, this must be done by establishing (in terms of both feeling and action) the appropriate response to a given set of circumstances:

It is possible, for example, to feel [emotions] too much or too little, and both of these are wrong. But to have these feelings... in the right way is to feel them to an intermediate, that is to the best degree... Similarly there are excess and deficiency and a mean in the case of actions... [a virtue] is a mean between two kinds of vice, one of excess and the other of deficiency... virtue discovers the mean and chooses it²¹

We should note that, for Aristotle, ‘not every action or feeling admits of a mean’; there are some that are by their nature vicious, for example ‘[among feelings] malice, shamelessness and envy, and among actions adultery, theft and murder’²². More importantly, the mean in a moral sense is not ‘[the] mean in relation to the *thing* [that

is] whatever is equidistant from the extremes'; rather it is 'the mean in relation to *us* [that is] that which is neither excessive nor deficient, and this is not one and the same for all'²³. So, for example 'there are some things at which we actually ought to feel angry'²⁴, but we must strive to be angry for the right reason (so, for example 'the man who feels righteous indignation is distressed at instances of undeserved good fortune, but the envious man goes further and is distressed at any good fortune'²⁵) and to the right extent (for example, to be more angered by a rich man escaping justice through his connections than by a spendthrift friend winning the lottery). Unlike the mean in relation to the thing, the mean in relation to us cannot be precisely calculated²⁶; as MacIntyre puts it 'what it is to fall into a vice cannot be adequately specified independently of circumstances: the very same action which would in one situation be liberality could in another be prodigality and in a third meanness'²⁷. As such, virtue requires judgement (*phronēsis*, that is, 'prudence [or] practical wisdom'²⁸): 'virtue ensures the correctness of the end at which we aim, and prudence that of the means towards it'²⁹ and 'the man of good character judges every situation rightly'³⁰.

Being virtuous, on Aristotle's account, is in fact extremely difficult; moreover, though it is something to which we should all properly aspire, it is not something that everyone can achieve: 'it is easy to get angry – anyone can do that – or to give and spend money; but to feel or act toward the right person to the right extent at the right time for the right reason in the right way – that is not easy, and it is not everyone that can do it'. Indeed, for Aristotle, it is *because* of this difficulty that those who attain virtuousness are so highly praised³¹. Nevertheless, in aspiring to become virtuous, we may guard against falling into viciousness and, in many cases hope to become 'continent', that is, the kind of person '[who] acts from choice but not from desire'³² and, though tempted, is able to resist and instead follow their better judgement. To become so, Aristotle suggests we should follow three particular guidelines. First of all, although 'between the extremes [that is, vices] there is always the maximum dissimilarity', in some cases the mean is not equidistant between them: 'some extremes seem to bear a resemblance to a mean e.g. rashness seems like courage, and prodigality like liberality'³³. Consequently, we should (like Odysseus steering towards the less dangerous Scylla and away from the more dangerous Charybdis), seek always to avoid the extreme that is furthest from the mean. Secondly, we should pay attention to what gives us pleasure and pain, and take precautions to avoid those vices to which

we discover we are particularly susceptible. Finally, we should guard most especially against pleasure, since in this regard ‘we are not impartial judges’ and are most liable to error³⁴.

Whether we accept the entirety of Aristotle’s account of the virtues or not, it seems reasonable to suggest that if we return to Rawls’ conception of the web of ideas we would, in fact, find something resembling virtues making up those *kinds* of moral elements that would be closest to the centre of the web, together with some resembling particular judgements, and some resembling kinds of processes for arriving at judgements. For example, it seems reasonably certain that (in some, maybe the majority of cases, at least) the outcome of our actions has some effect on their moral quality or lack thereof; similarly, it seems reasonably certain that by accepting certain roles (that of a lifeguard, say, or of a doctor) we incur certain kinds of moral obligation; and it is also reasonably certain that some actions, either general (the gratuitous infliction of pain) or specific (the actions of the Manson family) are morally wrong, whilst some are morally right. That being the case, it *also* seems reasonably certain that our character and motivations are an important element of the moral quality (or lack thereof) of our actions and that our character and motivations are (*together* with our actions) an important element of how we act and are judged as acting as moral agents. For this reason, it is hardly surprising that, in the 6th Edition of *Principles*, the common morality that grounds the principles themselves is described as containing not only a set of what the authors term *standards of action* (the norms mentioned in the previous chapter) but also a set of virtues (such as ‘nonmalevolence’, ‘honesty’ and ‘kindness’) without which ‘a person is deficient in moral character’ (Beauchamp and Childress indicate that neither set of examples should be taken as a complete list)³⁵.

As Beauchamp and Childress point out, incorporating virtues into the common morality also appears to capture an important part of our moral lives that is not fully accounted for by the kinds of approaches we have so far encountered in our discussion of the four principles. Although we can ‘define moral virtue as a disposition to act... in accordance with moral principles, obligations or ideals’, this would not account for the fact that ‘[we] care morally about people’s motives, and we care especially about their *characteristic* motives’³⁶. So, for example, ‘[when] a friend

performs an act of “friendship”, we expect it not to be motivated entirely from a sense of obligation to us, but because the person has a desire to be friendly, feels friendly, wants to keep friends and values friendship³⁷. Similarly, an emphasis on moral character can help to account for why, in some cases, we may regard someone as moral even when they perform what seems to be a morally wrong act. Beauchamp and Childress give the example of a doctor in the Jewish ghetto established in Krakow under the Nazis during World War II:

...faced with a grave dilemma: either inject cyanide into four immobile patients or abandon them to the SS, who at that moment were emptying the ghetto and had already demonstrated they would brutally torture and kill captives and patients³⁸

Eventually, ‘with uncertainty and reluctance’, the doctor elected to administer to each patient, without their knowledge or consent, a fatal dose of hydrocyanic acid. Although such an act would be ‘almost universally denounced by the canons of professional ethics’, Beauchamp and Childress seem correct in arguing that ‘no reasonable person would make a judgement of blame or demerit directed at the physician’s motives or character’³⁹. Even when such action proves misconceived (as with the European settlers fed poison to prevent their torture during the Boxer Rebellion by a man ‘ready to stand at the Divine bar for a thousand [such] murders’⁴⁰, only for a night attack to unexpectedly relieve their settlement as they lie dying⁴¹, in Conan Doyle’s *The Pot Of Caviare*) the effect is one of pity rather than moral opprobrium.

Despite these advantages, settling on those dispositions that may and/or should be seen as moral virtues is not entirely straightforward; as MacIntyre notes in *After Virtue*, Aristotle’s account of particular virtues is largely tied to the ‘ahistorical character of his understanding of human nature’⁴². However, different conceptions of human (moral) excellence have historically depended on the importance of particular social roles and have therefore been subject to variation: so, for example, the Homeric virtues (centred on an ideal of the warrior-king and his household) could include physical strength: ‘[to] excel is to excel at war or in the games, as Achilles does, in sustaining a household, as Penelope does, in giving counsel in the Assembly, as Nestor does’⁴³; by contrast, for the Aristotelian virtues ‘the paradigm of human

excellence... is the Athenian gentleman'⁴⁴, and for Jane Austen 'a certain kind of *English* naval officer'⁴⁵. With regards to the virtues expected of members of the medical profession, Beauchamp and Childress note that earlier traditions of medical ethics incorporated virtues to a greater extent than modern professional codes, but these too have altered. The version of the *AMA Code* in use from 1957 to 1980, endorsed several 'Hippocratic' virtues, some of which (sobriety, patience) seem to remain relevant to doctors' conduct. Others, such as piety, *might* be relevant (some doctors may derive a caring attitude from religious faith, others may not) and others, such as promptness, might be vicious in some circumstances (for example, premature diagnosis) and virtuous in others (such as in assuring swift treatment in life-threatening situations).

We should note here that, as with the seemingly unfamiliar moral elements of the Hippocratic and professional traditions, the unfamiliarity or apparent irrelevance of certain virtues may reflect changes in social and clinical context as much as any shift in underlying moral values. In the case of those virtues considered proper to nursing, for example, the change is if anything more pronounced than is the case for doctors: traditional (for which we may read 'Victorian') 'passive' virtues emphasised the nurse's role as the "handmaiden" of the physician' and thus included obedience and submission; in the 20th and 21st Centuries, a new emphasis on the nurse as an advocate of patients' interests replaced these with 'active' virtues (such as 'respectfulness, considerateness, justice, persistence, and courage')⁴⁶. However, the precise nature of the nurse's role has itself gone through comparably significant changes over the same period. At the start of the 19th Century, with 'drunkenness and theft... the most commonly recorded complaints', hospitals were concerned mainly with ensuring their nurses were sober and honest; the role of senior nursing staff was primarily a matter of housekeeping: matrons were 'responsible for the domestic bills, as well as controlling... the porters and other hospital servants'⁴⁷. Following Florence Nightingale's recognition of the importance of tackling squalid hospital environments, however, nurses became 'ministers of hygiene', capable of doing 'more good than the physician' through careful regulation patients' diet and environment, and cleanliness and discipline became paramount⁴⁸. At the same time, emotional relationships with patients (especially male patients) were discouraged (Nightingale's counterpart in the American Civil War, Dorothea Dix, initially recruited only 'very plain-looking

women' for the role⁴⁹). Whilst this may have made sense in the context of 19th Century field hospitals, given the possibility of nurses either being taken advantage of or moonlighting as prostitutes, the 20th Century emphasis on caring may be seen in context as a reaction to both changing circumstances and the scales having tipped too far to one side.

Although MacIntyre recognises that virtues depend on a particular socio-historical context, and '[stresses] the degree to which they vary diachronically and synchronically', he nevertheless argues that it is possible to identify 'certain basic (universal?) virtues'⁵⁰. This is possible, on his view, because the virtues are inextricably linked to human social interaction, and in particular to the operation of what he terms *practices*, defined as:

...any coherent and complex form of socially established cooperative human activity through which goods internal to that activity are realised in the course of trying to achieve those standards of excellence which 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 extended⁵¹

So, for example, 'throwing [an American] football with skill' is not a practice, but 'the game of [American] football is'⁵². Whilst institutions (for example, chess clubs and orchestras) may be required to ensure practices continue by distributing to participants goals external to that practice (for example, the 'money, power and status' accorded to grandmasters and first violinists)⁵³ these rewards differ from those 'internal goods which may reward not even very good chess-players or violinists'⁵⁴ (we may, in the case of medicine, compare this view with the one we have argued is expressed in the professional regulations established by Percival and the AMA).

In order to ensure, however, that these external goods offered by institutions do not *corrupt* practices (as they might in the case of a quarterback who plays 'only for the money', or a surgeon who is concerned only with his status within the medical profession in contrast – and the qualification is important, since external goods are *genuine* goods⁵⁵ – to a quarterback who plays 'for the love of the game', or a surgeon who is concerned to benefit his patients *as well*), in order, that is, that practices may

continue to provide internal goods, MacIntyre argues for the necessity of three basic virtues: '[without] justice, courage and truthfulness, practices could not resist the corrupting powers of institutions'⁵⁶. These particular virtues are required because of the necessarily cooperative nature of practices, both synchronically ('[to] enter into a practice... is to subject my own attitudes, choices, preferences and tastes to the standards which currently and partially define the practice'⁵⁷) and diachronically ('[to] enter into a practice is to enter into a relationship... with those who have preceded us... particularly those whose achievements extended the reach of the practice'⁵⁸). And these relationships, MacIntyre argues, cannot be sustained without 'fairness in judging oneself and others... [a] truthfulness without which fairness cannot find application... and from time to time the taking of self-endangering and even achievement-endangering risks'⁵⁹. Without these virtues, and the relationships they sustain, the internal goods of the practice cannot be realised⁶⁰ and we have instead merely 'a set of technical skills, even when [these are] directed towards some unified purpose and... can on occasion be enjoyed for their own sake'⁶¹.

This ability to sustain practices is important, but it is only one of three elements that MacIntyre believes are needed if we are to truly claim a disposition as virtuous; as he notes in the postscript to the 2nd Edition of *After Virtue*: 'I did *not* intend to suggest... that the initial account of virtues in terms of practices provides us with an adequate conception of a virtue'⁶². In addition to this quality, (moral) virtues must also satisfy two further criteria. Firstly, they must be 'qualities contributing to the good of a whole life'⁶³. So, for example, 'Hector exhibited one and the same courage in his parting from Andromache and on the battlefield with Achilles'⁶⁴ (that this conception requires, as MacIntyre puts it, 'a concept of self whose unity resides in the unity of a narrative which links birth to life to death as narrative beginning to middle to end'⁶⁵ is something that we will explore in more detail below). Secondly, virtues must be related to 'the pursuit of a good for human beings the conception of which can only be elaborated and possessed within a particular social tradition'⁶⁶. MacIntyre argues that 'all reasoning takes place within the context of some traditional mode of thought, transcending through criticism and invention the limitations of what had hitherto been reasoned in that tradition'; more importantly, however, 'when a tradition is in good order it is always partially constituted by an argument about the goods the pursuit of which gives to that tradition its particular point and purpose'⁶⁷.

Although we must submit to the established view of internal goods present in a practice at the time that we enter into it, these goods can (and should) be continually redefined by excellence *in* it: '[traditions], when vital, embody continuities of conflict'⁶⁸ (we may note this is a substantially different view of practices from Maclean's apparently static account as discussed in Chapter 9). Murdoch may be seen to develop this point further in her discussion of what she terms the 'transcendent' quality of goodness⁶⁹. For her, 'in the moral life the enemy is the fat relentless ego [and] moral philosophy is properly... the discussion of this ego and of the techniques (if any) for its defeat'⁷⁰. This should not be read as a simple condemnation of selfishness but rather as a repudiation of the human tendency to substitute fantasy for reality, that is to mistake what is good *for us* individually for what is good itself (in Aristotelian terms, perhaps, to claim that the mean in relation to us in a given place at a given time is in fact identical to the mean in relation to the thing). For Murdoch 'good is non-representable and indefinable'⁷¹, nevertheless, it remains useful as an ideal that can be worked towards:

The idea of perfection is... a natural producer of order. In its *light* we come to see that A, which superficially resembles B, is really better than B. And this can occur, indeed must occur, without our having the sovereign idea 'taped'. In fact it is in its nature that we cannot get it taped... [it] lies always beyond, and it is from this beyond that it exercises its *authority*⁷²

So, for MacIntyre (whose examples tend to favour games where Murdoch's favour art), we might say that whilst the idea of there ever being a 'perfect' match of association football is clearly absurd, some matches are not only better than others, but may (through being so) cause us to question and redefine the standards by which matches are judged (scoreless draws, for example, are often considered boring; however, the semi-final of the 2006 World Cup between Italy and Germany remained scoreless at full-time and was nevertheless an exciting display of individual skill and tactical discipline, played in a fair yet competitive spirit between two teams close to the peak of their abilities).

It is important to remember that the importance of recognising those elements of the moral life that the virtues represent does *not* mean that moral norms and rules are not required. As Beauchamp and Childress point out, without some kind of rules, virtues

are likely to prove insufficient as moral action-guides: the question ‘what would the virtuous health care professional do?’ is, in a given situation, likely to require specification both in terms of particular virtues (such as honesty or charity) and in terms of the situation (such as, for example, disclosing information to a patient), something that will ‘render virtue ethics very similar to the theory of moral norms’ they themselves provide⁷³. In addition if, as Aristotle notes, ‘it is from the repeated performance of acts... that we acquire virtues’⁷⁴, and if virtues require cultivation (that is, if they can only be learnt and exercised in terms of performing certain actions) this will require the kind of structure that rules provide: we will need to establish what virtuous conduct *is* so that we may train ourselves to it (we may think back – although he may have taken issue with our so doing – to Hare’s description of moral philosophy as a ‘set of remedial exercises’: a way of encouraging us to think morally, rather than moral thought itself). Moreover, if very few moral agents are, in fact, virtuous it will be necessary for the great majority to have an idea of the conduct a virtuous individual would follow as well as what would constitute the content of a virtuous emotional state: since many of us will not be able to *feel* courageous or compassionate in every situation, we will need to know when we should *act* as courage or compassion would dictate, so as to resist the temptation not to do so.

On both Aristotle and MacIntyre’s accounts, however, the exercise of the virtues will not only require *some* rules, but rules of a specific kind and (in Aristotle’s case, at least) a specific *attitude* to them. First of all, as we mentioned briefly above, for Aristotle, ‘the branch of philosophy on which we are at present engaged is not, like the others, theoretical... we are not studying to know what goodness is, but how to become good men, since otherwise it would [as a practical science⁷⁵] be useless’⁷⁶. Although ‘[action] according to the right principle is common ground and may be a basis for discussion’, Aristotle argues that moral rules must necessarily be of a general sort: ‘any account of conduct must be stated in outline and not in precise detail... questions of conduct and expedience have as little fixity about them as questions of what is healthful [both vary with circumstances⁷⁷],’⁷⁸. Although virtuous action may in outward appearance seem identical to acting ‘as principle directs’ in many cases⁷⁹, the two should not be confused; indeed, congratulating oneself on acting rightly simply because one is obedient to rules is an obstacle to becoming truly virtuous: ‘most people... have recourse to their principle, and *imagine* that they are being

philosophical and that in this way they will become serious-minded [but they] will get no benefit from... philosophy [my emphasis]⁸⁰. To be truly virtuous on Aristotle's account requires, as we have seen, judgement rather than simple obedience: 'agents are compelled at every step to think out for themselves what the circumstances demand'⁸¹.

The relationship between virtue and moral rules is developed further in MacIntyre's discussion of the role of rules with regards to practices. Learning a practice involves submitting to the rules of that practice as agreed by current practitioners, and as established by the excellences of past practitioners. In other words, since '[a] practice involves standards of excellence and obedience to rules [to] enter into a practice is to accept [initially, at least] the authority of these standards'; so for example, '[if], on starting to play baseball, I do not accept that others know better than I when to throw a fast ball... I will never learn to appreciate good pitching, let alone to pitch'⁸². However, it also the case that we cannot *excel* at the practice simply by following rules, and that excellence in a practice will in some way involve these rules being revised (so, for example, 'when Turner transformed the seascape in painting [his] achievement enriched the whole relevant community'⁸³). MacIntyre's account actually involves two different kinds of rule, with differing degrees of flexibility. First of all are 'rules of thumb' that are necessary in order to learn how to play the game: these are not in theory absolutely binding, but are seldom a good idea to break in practice ('never pass the ball across your own area' in association football, for example). Secondly, there are the rules of the game itself, the breaking of which deserves to incur some form of penalty but which may, nevertheless, sometimes be changed or revised (so, for example, it was not always the case that a goalkeeper could not collect a pass back to him in his hands; however, the development of certain defensive tactics, and a consequent decrease in the entertainment value of games, led to it being prohibited).

Both Aristotle's and MacIntyre's accounts of rules may be seen to share certain important similarities with the account of rules and principles presented by Beauchamp and Childress in the 6th Edition of *Principles*. The status of principles and rules as *prima facie* obligations does not, as we have noted in the previous chapter, give them absolute weight (they may be broken if we have a sufficiently good reason

to do so), but it does give them more weight than they would have under an account such as Fletcher's in that we must not only account, but sometimes pay (through guilt and/or regret), for breaking them when we do so. *Principles* does seem to allow that *some* moral rules may be similar to rules in MacIntyre's first sense of the word, or may be so in some circumstances; conceivably some of the moral norms (such as 'tell the truth') could fall into this category, together with very general and rather weak specifications of the principles (nonmaleficence, for example, in the case of putting in stitches or removing a sticking-plaster). It may not be possible to distinguish fully between what, in a moral sense, constitutes a 'rule of thumb' and what constitute the 'rules of the game'. One *possible* way of distinguishing between the two may be to consider as 'rules of thumb' those norms we can go against without severe disruption to the web of ideas, whilst the 'rules of the game' are those that are supported by multiple elements and cannot be changed without revising our conception of morality as a whole. So, for example, it is relatively easy to think of how we might account for a trivial falsehood, and how we might do so for moral reasons (to spare someone's feelings, say) whereas it is extremely difficult to understand how we could account for the gratuitous infliction of pain.

Whether MacIntyre's distinction can be salvaged in this way or not, however, his description of medicine as one example of a practice⁸⁴ and his account of what would represent a 'vital' tradition within it (for example, hospitals – for which we may fairly substitute 'professional bodies' or 'the NHS' – continually engaging in debate over 'what good medicine is'⁸⁵) compares with our own account of both the history of medical ethics, and of some of the shortcomings of certain approaches to it. Indeed, whether or not his account of the basic virtues is complete *in general* (and, as we shall see in the subsequent section, MacIntyre has been accused of omitting at least one virtue – in the shape of empathy or caring – that can be seen as crucial to our moral lives), it may in fact be easier to specify those virtues particularly relevant to the practice of medicine than to specify those that are relevant to human life as a whole. Whilst there is likely to be some overlap between both spheres (as the elements of 'the good life' in general are likely to – indeed must – be elements of 'the good life' for doctors and/or patients as well) there are, if we are correct to argue that healthcare practitioners do sometimes have moral obligations *as* healthcare practitioners, also likely to be some virtues that are of particular importance in the discharge of these

obligations. And, in fact, Beauchamp and Childress do provide, in the 6th Edition of *Principles* a more specific (though explicitly not exhaustive⁸⁶) list of these kinds of virtues in addition to the incomplete list of examples given for those virtues present in ‘the common morality’ (which may itself now be understood, not as those elements that ‘social groups approve [of] and regard... as moral’⁸⁷ but as a vital tradition of morality in MacIntyre’s sense of the term).

The first of these specific virtues is *compassion*, defined as ‘a need to understand the feelings and experiences of patients [in order] to respond appropriately to them and their illnesses and injuries’ and ‘expressed in acts of beneficence that attempt to alleviate the misfortune or suffering of another person’ (so as, for example, not to lose sight of the ‘sick person’ beneath Foucault’s ‘endlessly reproducible pathological fact’)⁸⁸. The second is *discernment*, or ‘the ability to make fitting judgements and reach decisions without being unduly influenced by extraneous considerations, fears, personal attachments and the like’; closely linked to the Aristotelian virtue of *phronēsis* and the ‘understanding both *that* and *how* principles and rules apply in a variety of these circumstances’⁸⁹. The third is *trustworthiness*, or to act in such a way that ‘is to merit confidence in one’s character and conduct’ (we may think back to our discussion of the relationship between ‘outward show’ and ‘inward duty’ in the Hippocratic tradition in Chapter 3)⁹⁰. The fourth is *integrity*, the need to faithfully adhere to a set of moral norms and not, for example, indulge in ‘hypocrisy, insincerity, bad faith, and self-deception’⁹¹; significantly, remembering our account of the Hippocratic and (especially) Professional traditions in medical ethics, breaches of integrity can involve ‘violations of professional standards of conduct’ as well as matters of personal conviction⁹². The final focal virtue is *conscientiousness*: ‘a form of self-reflection on, and judgement about [one’s actions]’. This ‘critical reflection’ bears interesting comparison with the requirements of Hare’s and Rawls’ models of moral reasoning examined in Chapters 8 and 9; moreover, it may include feelings of ‘remorse, shame, disunity, or disharmony’ appropriate to the recognition by a person of ‘strong moral character’ that they have performed (or must perform) a morally bad action⁹³ (the doctor in the Krakow ghetto mentioned above and Maclean’s ship’s captain as discussed in Chapter 9, for example, are conscientious; the ship’s doctor, and Aeschylus’ Agamemnon, are not).

Many of these virtues are linked to an emphasis on the single ‘fundamental orienting virtue’ of care⁹⁴ supposedly missing from MacIntyre’s account; as we shall see below, however, this emphasis may rightly be considered one consequence of pursuing virtue ethics approaches. Despite being linked together in this way, however, many must still – like the principles themselves – be specified in particular situations and balanced against each other and against other virtues, as placing undue emphasis on certain virtues may itself be detrimental. As an example of the former, Beauchamp and Childress give an example of a case where excessive compassion ‘may cloud judgement and preclude rational and effective responses’:

...a long-alienated son wanted to continue indefinitely a futile and painful treatment for his near-comatose father in an intensive care unit (ICU) to have time to “make his peace” with his father... Some hospital staff argued that the patient’s grim prognosis and pain, combined with the needs of others waiting to receive care in the ICU, justified stopping the treatment, as had been requested by the patient’s close cousin and informal guardian. Another group... regarded continued treatment as an appropriate act of compassion towards the son⁹⁵

Clearly, compassion here needs to be both specified, to consider what is compassionate behaviour towards the son, the father, the guardian and other patients, and balanced (for example with discernment) to decide on the best course of action (it should be noted that things may be different did the father not lack the ‘cognitive capacity’⁹⁶ to effect a reconciliation with his son, in which case justice may entitle them both the chance to do so). For an example of the latter, the authors note that ‘virtues of patience, humility, and tolerance can ameliorate... problems’ between healthcare practitioners with differing conceptions of their personal and professional obligations⁹⁷ (we may think back to what qualities might be helpful in resolving the differences between doctors and nurses in neonatal ICUs in Hoffmaster’s example from Chapter 9). Similarly, kindness and loyalty to an incompetent colleague do not mean that he should not be reported as such, as per the demands of professional integrity⁹⁸. Neither the principles nor virtues can, in isolation, ensure moral conduct: as Beauchamp and Childress point out, ‘the limitations of principles, rules and so on... does not prove some sort of triumph of virtues over principles and rules of obligation [rather] it shows their close connection’⁹⁹.

The Importance of Care and Narrative in a Virtuous Account of the Principles

In her article ‘North American Bioethics: A Feminist Critique’, Farley notes that, whilst the various ‘normative [approaches] in North American bioethics’, including the four principles, can be subjected to such a critique¹⁰⁰, exactly how this may be done is not easy to define, since ‘[feminist] theory... is not in every way independent of other theories; nor is there one definitive form of [it] that represents all of the implications for bioethics’¹⁰¹. She is, however, able to identify ‘three themes – women’s experience, autonomy and relationality, and evaluations of embodiment – [that give] some sense of the concerns that feminists bring to bioethics’¹⁰². Of these themes, the first derives from two general claims: that ‘it is impossible to dismiss the importance of experience in both the development and application of ethical principles’¹⁰³ (and thus the importance of experience inclusive of ‘gender... age, class, race and disability’¹⁰⁴) and that ‘it is impossible to dismiss the concrete particular *always* in favour of the abstract universal’¹⁰⁵. The latter point is clearly already compatible with the view of theory, judgement and principle present in the 6th edition of *Principles*, whilst the specific work suggested by the former (for example, research into differing experiences of women both as health care professionals and as patients¹⁰⁶) mirrors concerns expressed, as noted in the previous chapter, in the 6th edition’s discussion of the principles of justice and (in terms of race) autonomy. The third theme, including the claim that ‘the ways in which individuals receive medical care will depend importantly both on their own interpretation of their bodyliness and on the interpretations they receive from the providers of their care’¹⁰⁷ will be explored more fully in our discussion of narrative ethics, below.

The second theme, concerning autonomy and relationality, is concerned with several other issues that Farley contends ‘have become crucial for feminist ethics generally and feminist bioethics in particular’, including ‘questions of the relative importance of freedom and relationship... the nature of the human self [and] the dynamics of power in interpersonal and social relations, and so on’; more importantly for our purpose here, they are also concerned with ‘questions of an “ethics of justice” versus an “ethics of care”’¹⁰⁸. This latter distinction draws upon a body of philosophical work developed in response to Gilligan’s *In A Different Voice*, which, in 1982, had ‘launched a new debate, not only among theorists generally but among feminist

theorists in particular'¹⁰⁹. Gilligan's empirical research identified 'two modes of moral thinking: an ethic of care and an ethic of rights and justice'¹¹⁰. The latter, generally advanced by men, 'uses quasi-legal terminology and impartial principles, accompanied by dispassionate balancing and conflict resolution'; the former, generally advanced by women, is centred 'on responsiveness in an interconnected network of needs, care and prevention of harm'¹¹¹. It should be noted that Gilligan did not contend that men and women *exclusively* think in these terms, or that all men and all women display identical moral thinking; she did, however, suggest that the different voice expressed by ethics of care had been 'drowned out' by (predominantly masculine) traditions in ethical theory¹¹².

As Tong has argued, ethics of care can be seen as an expression of virtue ethics, and of a virtue ethics of a certain kind. On this view, as with Aristotle, virtues do not exist simply as a prompt to a certain kind of action but are rather an integral part of moral action: 'How one does what one does is just as important as what one does; and who one is determines how one acts. Thus, in order to act in a truly caring way, for example, one must, as Aristotle implies, be a caring person'¹¹³. Despite sharing this concern for the importance of moral character, however, ethics of care can be distinguished from other (masculine) accounts of the virtues thanks to their particular emphasis on the importance of an *affiliative* virtue that:

asserts the importance of an active concern for the good of others and of community with them, of a capacity for sympathetic and imaginative projection into the position of others, and of situation-attuned responses to others' needs¹¹⁴

(We may note at this point that this *virtue* of empathy should not be confused with 'the epistemological skill of empathy... which can be used for good or ill'; rather, it is specifically aimed at care for the other¹¹⁵). As Tong points out, MacIntyre's 'masculine' account of the virtues does not include this quality amongst them, identifying instead, as we have seen, justice, courage and honesty¹¹⁶ (although we should note that MacIntyre's account of courage explicitly presupposes caring about those for whom we risk our safety and our achievements¹¹⁷). This is contrasted with Nodding's 'feminine' account that places it at the centre of moral relationships, emphasising 'that feelings of sympathy or fellow-feeling are *innate* in all human

hearts [and] must be *cultivated* lest they fail to guide one's actions', a position Noddings compares with Hume's¹¹⁸.

Ethics of care approaches tend to emphasise two particular criticisms of traditional theoretical approaches. First of all, it is argued that these approaches overemphasise concepts of impartiality or detached fairness. For example, as Farley puts it, 'a sole or even central emphasis on informed consent can result in a thinning of relationship; paternalism [can yield] to an impersonal, distanced negotiation of rights and duties between strangers'¹¹⁹. Whilst impartiality is undeniably useful in certain situations (for example in delineating legal or professional duties), it may be less useful in others; as Carse puts it:

If one is contemplating what responsibilities one has as a nurse to one's patients, appeals to impartially justified principles may be illuminating and appropriate. If one is trying to decide how to respond to a particular patient's refusal of treatment, attunement to the peculiarities of individual need and to the vagaries of circumstance may be essential to sound moral judgement¹²⁰

Secondly, ethics of care approaches tend to emphasise the importance of 'mutual interdependence and emotional responsiveness'¹²¹. With regards to the first point, as Beauchamp and Childress note, we may agree that '[a] person seems morally deficient who acts according to the norms of obligation without appropriately aligned feelings'¹²²; as Farley puts it when in considering the relationship of autonomy to what she terms 'relationality' 'what is at stake here is a view... in which the capacity for relationship is *as significant*... as the capacity for self-determination [my emphasis]'¹²³.

As Beauchamp and Childress accept, ethics of care approaches are able to expand on important moral concerns that are not expressed by the principles or by other virtues: 'experience suggests we often do rely on our emotions, our capacity for sympathy, our sense of friendship and our sensitivity to determine appropriate moral responses'¹²⁴. Nevertheless, as the above quotation from Carse suggests, it should not be forgotten that such approaches may speak in a *different* voice, but not one that is necessarily more *right* or more *true*. As Tong has pointed out, it is possible to read Noddings' account of the virtue of caring (and thus, given its centrality to her thought,

or virtue itself) as *feminine* rather than *feminist*¹²⁵; on this view ‘all too many men will be willing to confess, as they did during Mill’s time and later, that women are more virtuous than men... and therefore that it is up to women ... to do all of society’s emotional work’¹²⁶. Similarly, as Carse implies and Lesser has pointed out, the cultivation of personal relationships, whilst important, is not sufficient to guarantee moral behaviour: ‘The Cosa Nostra would be an obvious modern example of great generosity within the family and organisation being combined with total unscrupulousness outside it’¹²⁷; there will be areas (and medicine is plausibly one of them) where personal feelings will quite properly sometimes need to be left to one side.

It is hardly surprising, then, that many proponents of an ethics of care approach do, as Carse’s contention that ‘there is no *single*... privileged... standpoint in ethics [my emphasis]’¹²⁸ suggests, also rule out the possibility that ‘care’ is the one value or virtue under which all others must be subsumed. As Beauchamp and Childress put it ‘[proponents] of care ethics do not recommend a general abandonment of principles so long as principles allow room for discretionary and contextual judgement’¹²⁹. Indeed, principles may be a necessary counterweight to some of the disadvantages mentioned above. Farley notes that a principle of autonomy can protect women (and others) from ‘submersion in roles, the tyranny of traditions, and the potential for oppressiveness in closed communities’; similarly ‘[without] justice at least in a minimal sense, self-sacrificial caring can harm the one caring; without a just appropriateness in care, caring can harm the one cared for’. As a result, she argues, ‘[feminist] theory... *needs*... autonomy [my emphasis]’¹³⁰ (we should note that avoiding assent to the kind of situations Farley describes seems to be what, for Tong, distinguishes feminist from feminine approaches to ethics¹³¹). As with other approaches to virtue ethics described above, then, ethics of care approaches may be seen as complementary (perhaps even necessary) to the four principles, rather than as in competition with them.

If the concerns expressed by proponents of care ethics are of particular importance to *medical* virtues, then narrative, as MacIntyre argues, may be of importance to conception of virtue as a whole. For MacIntyre, that this is the case follows from his analysis of what makes an action intelligible (so, for example, to break six eggs and

mix them in a bowl whilst following a cake recipe is intelligible because the recipe presupposes a certain narrative beginning with obtaining ingredients, proceeding through preparing and cooking them, and ending in the enjoyment of said cake; by contrast, the same action, performed without explanation whilst delivering a lecture on Kantian ethics, would be unintelligible¹³² and as a result both fictional and historical stories (for example, the epics of Homer, the novels of Austen and the life of Eleanor Marx) as well as philosophical accounts such as Aristotle's may provide us with examples of virtues. The particular emphasis that virtue ethics placed on the narrative and interpretative elements of moral thought was subsequently taken up in several different fields, amongst a 'growing company of cognitive psychologists, psychiatrists, theologians, historians... literary theorists, and fellow [Anglo-American] philosophers'¹³³, and also ethnographers such as Hoffmaster and continental European philosophers such as Ricoeur (who advocates a method that is 'hermeneutical, linking scientific, clinical and narrative histories')¹³⁴.

As Montello has pointed out, 'research in the cognitive sciences... to analyse the psychological processes at work in moral reasoning' has not only emphasised 'the essential role of the imagination in ethical deliberation' but revealed that many of the 'tools that we use for moral reflection' (such as 'metaphor, prototypes, frame sentences [and] basic lived experience') are closely related to those involved in the creation of narratives,¹³⁵. From these elements, she is able to identify how 'the act of reading sets into motion three core processes' required for moral reflection: 'departure, performance, and change'¹³⁶. On this view, reading brings about *departure* in those instances in which we find ourselves 'lost in [the world of] a book'; reading both takes us away from our own lives (and narratives) and in doing so requires that we project upon to the world of the narrative our own knowledge and experiences of the world. A sufficiently skilful writer can 'convincingly render a common humanity... [for] generations of readers from every culture... in a Russian axe-murderer tormented by conscience (*Crime and Punishment*) or... a barnyard pig pursued by fear of becoming sausage (*Charlotte's Web*)'¹³⁷. Reading requires *performance* in that narratives are (Montello borrows Eco's phrase) 'lazy machines'. On this view, 'reading is an active process in which the reader participates in discovering a meaning in a work', and doing so requires that 'we... adopt the role which the text asks us to assume'¹³⁸; in other words, a reader must constructively

engage with rules of a narrative in much the same way that MacIntyre argues we must constructively engage with the rules of a practice. Finally, reading can bring about *change* in that the experiences that we submit to in reading a narrative can bring about an appreciation of ‘new environments, cultures, values and behaviours’ and ‘reveal hidden primary values’ or implicit judgements in our everyday thinking¹³⁹.

Montello is fully aware that any argument that the practice of reading *will* make us more moral is (just as Bronowski’s belief that science will make us more moral *was*, or Maclean’s parody-philosophers’ belief that philosophy will make us more moral *would be*, if anyone actually held it) both naïve and plainly false: after all, ‘a good number of Nazi SS officers loved their Goethe and Strauss’¹⁴⁰. It is not reading *per se* that aids the development of moral reflection; rather, it is the opportunity reading affords us to develop what Montello refers to as ‘narrative competence’. This skill is composed of two elements. First of all, and linked to the need to submit to a narrative before attempting to construct meaning from it, is the need to develop an ability to resist placing one’s own narrative onto another, to ‘[listen] for a story to emerge from [a] rendition of events’; in a specifically medical setting, for example, to make sure the patient’s story is not replaced by the doctor’s agenda¹⁴¹. The second element of narrative competence that ‘proves so essential to moral reasoning’ is empathy: ‘the ability to enter another person’s world, to see from that perspective’¹⁴². Montello does not suggest these skills can *only* be acquired through reading fictional texts¹⁴³, and we should add that her account only seems to hold for certain *kinds* of fictional work (what she terms ‘genuine’ literature¹⁴⁴), something she admits when noting that without sufficient skill, an author’s attempt to inculcate the effects described above will probably cause us to ‘put a narrative down’¹⁴⁵.

Perhaps, given our own reading of his *Antigone* in Chapter 2, it hardly surprising to find that Montello’s conception of ‘genuine literature’ in this sense extends to Sophocles¹⁴⁶. That she mentions Dostoevsky also seems to tie her account of the importance of narrative to Murdoch, who (as mentioned above) regarded art, and especially literature, as essential to human flourishing (even going so far as to describe it as ‘doubtless more important than philosophy’¹⁴⁷). For Murdoch, the creation of art is one (perhaps *the*) paradigm of virtuous activity: ‘obedient to a conception of perfection ... beyond the details of craft and criticism... the magnetic

non-representable idea of the good which remains not 'empty' so much as mysterious'¹⁴⁸. However, it is also the case that, whilst 'there are several starting-points'¹⁴⁹, it is 'the *appreciation* of [art that] is the easiest available... entry into (and not just analogy of) the good life, since it *is* the checking of selfishness in the interest of seeing the real [my emphasis]'¹⁵⁰. We should remember that this 'selfishness' is not (just) that expressed by the everyday sense of the word, rather, it extends to 'the almost irresistible human tendency to seek consolation in fantasy' (that is to take ourselves as the measure of all things). For Murdoch, 'art presents the most comprehensible examples... of the effort to resist this and the vision of reality that comes with success'¹⁵¹ and Dostoevsky perhaps presents this best of all. As Bakhtin has argued 'Dostoevsky, like Goethe's Prometheus, creates not voiceless slaves [but a] *plurality of independent and unmerged voices and consciousnesses, a genuine polyphony of fully valid voices*'¹⁵²; for him, human beings (much like Murdoch's conception of the good) were defined by their indeterminacy and resistance to simple and/or definitive representation.

As we shall see below, such an approach does not need to be antagonistic to one that incorporates a certain view of rules and principles. Nevertheless, although Montello concedes that 'judicious applications of general rules remain valuable guides to action and safeguards for personal rights'¹⁵³ she does, as Forrow points out in his response to her article, at times come close to giving an inaccurate view of what more traditional philosophical approaches do or attempt to do. In particular, her claim that 'real ethical issues in medicine... do not arise in the abstract, free from the subjective and contingent nature of the moral agents' beliefs background and character [and the] particular context of family, community and history'¹⁵⁴ is one that he argues would be denied 'by few, if any, serious ethical theorists'¹⁵⁵ (we may also think back to our own arguments against the supposed dominance of the 'applied ethics' model in Chapter 9). In addition to emphasising the importance of the qualities Montello describes (in particular, attentiveness to understanding the patient's 'story') to 'good principle-based moral reasoning'¹⁵⁶, Forrow also highlights some important reservations. First of all, it is not clear that reading will develop the skills Montello contends that it can in the absence of a skilled classroom teacher; it is also possible that doctors who display the kinds of skills she describes seek out and appreciate 'genuine' literature precisely because they have these skills already, rather than in

order to develop them (although it is conceivable that this could be investigated empirically, something Forrow appears to agree would be worthwhile)¹⁵⁷. Secondly, and following on from this, it may be better for medical students to consider, not fictional examples, but examples of real-world case studies describing patients ‘whose illnesses and lives present... sought-after learning opportunities’¹⁵⁸. Finally, it is conceivable (and, in one example he quotes from, demonstrable) that narrative accounts, whilst ‘absolutely crucial’ for understanding certain cases, may also implicitly or explicitly refer (when used in medical ethics) to norms or principles such as ‘autonomy’ and ‘beneficence’¹⁵⁹.

Although, unlike the previous approaches discussed in this chapter, narrative ethics is not explicitly referenced in the 6th Edition of *Principles*, Forrow’s criticisms (together with his acknowledgements of the importance of the kinds of skills and dispositions Montello endorses) are similar to ideas explored by Childress in his article ‘Narrative(s) Versus Norm(s): A Misplaced Debate in Bioethics’. For him, differences between the kind of principled approach he (and, presumably, Beauchamp) advocate and proponents of some forms of narrative ethics occur primarily because of misconceptions each side has (in some cases quite understandably) caused about the kind of moral norms (including both principles and more specific rules¹⁶⁰) the four principles are intended to represent. Childress acknowledges his own culpability in this, admitting (as we have already argued) that the early editions of *Principles*’ use of ‘theory, applied ethics, application [and] charts... appear to involve only top-down justification [my emphasis]’¹⁶¹. However, he also points out that some opponents of the principles have ‘[unfurled] such banners as “the tyranny of principles,” when, in fact, they oppose only certain *conceptions* of principles, that is... as absolute, invariant and eternal [my emphasis]’ that are not universally shared¹⁶². For Childress, certain kinds of narrative approach are likely to complement that of the 6th edition of *Principles*¹⁶³ (on which view, of course, the principles can themselves – as *prima facie* binding and requiring specification – be argued to possess that inner ambiguity of struggle that Dostoyevsky identified in living beings).

As Childress points out, the principles will not complement every kind of narrative approach; after all, it is just as possible to impose a narrative structure onto cases as it is to impose principles onto them: one can ‘neglect the narrative quality of cases... by

forcing them into “boxes”... such categories as patient preferences, quality of life, and external factors’¹⁶⁴. Although he concedes (in an echo of Winkler’s point that, having made a moral judgement, we can almost always come up with a quasi-deductivist justification for it after the fact) that ‘appeals to norms are [not] indispensable for every particular judgement or decision’, he points out they remain useful in ‘many judgements and decisions, in moral education, and in moral justification in a communal setting’¹⁶⁵. Although norms are generated and interpreted through reflections on cases and narratives¹⁶⁶, they may be both features of those cases and narratives (in terms of ‘unarticulated assumptions’ that might cause us to present a case in a certain way either by characterising agents within it or choosing to highlight certain elements) and tools for articulating narratives in new cases¹⁶⁷. Interpreting a norm will always involve some kind of narrative (some way of putting it into context)¹⁶⁸, but no form of narrative needs must be prioritised as more valuable than another: case-studies may be useful to illustrate norms in some ways, fictional examples (including thought-experiments) may be useful in others (Childress offers Thomson’s ‘A Defence of Abortion’ as one possible example)¹⁶⁹.

The close correlation between principle and narrative for which Childress argues is exemplified through a comparison of two responses to a particular case: one that begins with norms (that of Childress and Campbell) and one that begins with narratives (that of May). The case in question is that of Don Cowart:

...a very athletic man in his twenties who is severely burned in an accident that kills his father and who over time indicates that he does not want to continue the treatment necessary to save his life¹⁷⁰

According to May, ‘conventional frameworks’ of medical ethics are unable to cope with situations such as Cowart’s: ‘the catastrophe is so devastating that the terms life/quality of life cannot adequately express it’¹⁷¹. By contrast, he suggests that ‘[the] dramatic, narrative language of life/death/rebirth... better expresses what is involved’. Eventually, however, a decision has to be made as to whether Cowart can be ‘[brought] to a new life “without his consent”’. May takes a pro-autonomy line that Childress identifies as basically utilitarian: by empowering the patient to refuse treatment, he argues, his caregivers can empower him, should he wish, to undergo his transformation to a new life (the only way, May believes, his condition can be

overcome)¹⁷². Campbell and Childress' account did not use the language of narratives, but Childress feels that it does not take too much effort to incorporate it (indeed, he feels 'it is consistent with and further explicates what we argued'):

[we] start with debates about the meaning and weights of the principles of beneficence and respect for autonomy in conflicts about paternalistic interventions; but we then attempt to show how difficult it is to respect persons in their concreteness, because they are temporal creatures (past present, and future) and because they are social creatures (community). We cannot respect others without listening to their narratives in order to determine what their wishes, choices, and actions really are¹⁷³

So, as Childress puts it, one approach 'begins with narratives but moves to norms' whilst another 'begins with norms but moves to narratives'; moreover, both approaches arrived at the same substantive conclusion, that 'after enough time had elapsed to determine [the patient's] prognosis, his competence and his settled wishes... paternalistic interventions were unjustified'¹⁷⁴. As he suggests, 'the important but difficult task' is not to choose between norms and narratives 'but to determine how they function together in a rigorous and imaginative ethical perspective'¹⁷⁵.

Childress offers two compelling reasons for adopting his (and Campbell's) approach to balancing narrative and norm over May's. The first, more general point, concerns the types of narrative that May brings to Cowart's cases (life/death/rebirth, Christian conversion and Greek tragedy). As Childress points out, '[such] broad narrative categories can be illuminating... but [also] confusing and even dangerous... [archetypal] narratives may obscure individual narratives' and may be inappropriate (for example, Christian narratives 'may be quite out of context for a patient who is atheistic'). Rather:

[physicians] and other health care professionals should attend to the patient's *own* narrative... rather than construing that narrative as a mere instance of a grand pattern of life/death/rebirth or even of a set of substantive beliefs, such as a religious community's core convictions [my emphasis]¹⁷⁶

After all, as Childress points out (with reference to the Navajo, as per their possible cultural aversion to discussing risk, discussed in the previous chapter) a member of a

particular culture ‘may largely reject [its] grand narrative or worldview’¹⁷⁷. The second, more specific, concern relates to how this may have happened in Cowart’s case. As Childress puts it, conflicts between autonomy and beneficence can ‘arise at the level of narrative, just as they do at the level of concrete decision-making’. Although Cowart did change his forename, it is debateable whether he conceived of himself as the ‘new man’ May describes: functionally, he found his new name easier to hear, he did not seem to appreciate any meaningful distinction between his ‘former life’ and his current one (insisting that, though glad to be alive, his doctors had been wrong to treat him against his will) and appeared to generally view the case as a straightforward issue of paternalism¹⁷⁸. Although useful in showing ‘what went wrong ... over the first ten months of [Cowart’s] treatment’¹⁷⁹, May’s account ultimately *imposes* a narrative onto a particular situation. Childress and Campbell’s, by contrast, ‘suggested the difficulty of interpreting what is heard’ and stressed the need ‘to be as careful as possible to hear what [a] particular person is saying’¹⁸⁰.

A Virtuous Account of the Principles and Criticisms of their Use in the Teaching of Medical Ethics

In order to demonstrate how a caring, virtuous approach to the principles that incorporates the complexities of narrative differs from a simpler ‘principlist’ approach that disregards these elements, it may be worth considering criticisms of the four principles that assume their use either always falls into the second category, or encourages medical professionals unused to the complexities of academic moral theory to think in this fashion. For one example of such an approach we may consider what Clouser and Gert (who coined the term ‘principlism’, one Beauchamp and Childress reject for just this reason) criticise as the ‘checklist ethics’ they see the four principles as encouraging¹⁸¹. On this view, ‘principles function like names, checklists or headings for values worth remembering, but lack deep moral substance’¹⁸²; moreover, since the principles are ‘clusters of concerns’ rather than unambiguous moral directives, Clouser and Gert argue that agents ‘may give a principle whatever weight they wish, or none at all’¹⁸³. As long as autonomy, nonmaleficence, beneficence and justice are ‘ticked off’ the checklist in *some* way, a decision can be *called* ‘moral’. It is certainly the case that some examples of works using the

principles *appear* to promote such an approach. We may consider the following example from English's *Bioethics: A Clinical Guide for Medical Students*:

General Process for Case Analysis

Review of Clinical Facts

- I. Clarification of definitions (terminal, competent, surrogate etc.).
- II. Obtaining of missing pertinent information.

Identification of Ethical Problems or Conflicts

- I. Are there competing ethical principles or values?
- II. Who are the interested parties (patients, family members, health professionals, courts)?

Options

- I. Take one plausible position, identifying the results and ethical implications.
- II. Consider other possibilities with their outcomes.

Ethical Assessment

- I. Choose an ethical position.
- II. Defend that choice, including arguments for and against.

Resolutions¹⁸⁴

At first glance, this appears to place us back in the realm of deductivist approaches to ethics as discussed in Chapter 9. A 'principlist' doctor trained to approach ethical problems in this way would, it seems, expect to be able to put the details of any given

moral situation through this general process and, at the end, come out with the right moral answer. They would, as Aristotle might say, have recourse to their principle and *imagine* that they were being philosophical.

Despite our argument that a careful reading of the 1st edition does not endorse such a position, however, principled approaches have still been criticised for misleading medical professionals into thinking that ethical decision-making is a matter of following this kind of mechanical procedure. Winkler argues that scepticism amongst philosophers about the adequacy of the ‘applied ethics’ model of moral reasoning was matched by its enthusiastic acceptance, in the form of the principles, by health care professionals: ‘because of its attractiveness and teachability, and because... so many health care professionals... attended bioethics conferences, classes, workshops and programs in which [it reigned] supreme’ philosophers became victims of the principles’ success, ‘working and thinking along [other] lines, while all around... [were] heard nothing but invocations of autonomy, beneficence, and justice’¹⁸⁵. The criticism that principles were or are often simply ‘invoked’ with little or no reflection brings us back to one made by Maclean that, even if they do not intend to, by describing familiar elements of everyday moral life in ‘technical’ language, the principles create the *impression* that morality is the proper subject of a technical skill possessed and defined by ‘experts’, and that our moral judgements can be delegated to them.

Maclean emphasises this point by drawing an analogy with Kennedy’s *The Unmasking of Medicine*, and in an echo of Foucault’s view as discussed in Chapter 4, argues that a ‘medical’ model of illness (one which views all ill-health as ‘a matter of objective scientific fact’ in terms of deviation from a biological norm¹⁸⁶) carries with it the danger of allowing doctors to engage in activity which ‘masquerades as... apolitical and value-free’ despite unavoidably involving value judgements¹⁸⁷. For Maclean, to speak of beneficence, nonmaleficence and autonomy rather than ‘*doing good... doing harm [and] allowing patients to make up their own minds*’ misrepresents ‘familiar elements of our everyday moral lives’ as ‘the private property of a set of experts, to be used as they prescribe’¹⁸⁸. This analogy, however, betrays a weakness in her argument, and one that leads us back to a consideration of the virtues. Whilst, as we saw in Chapter 6, it is certainly true that medicine can conceal value

judgements behind supposedly objective clinical decisions, and can lose sight of the person behind the illness, these are unavoidable *dangers* of a scientific approach to medicine, not *necessary* elements of it. Moreover, they are certainly dangers worth risking (and guarding against) given the significant and quite remarkable benefits such an approach has brought in general.

Whilst there is clearly a possibility of the principles being used (as we have seen) as the moral jargon of ‘checklist ethics’, this too is by no means a necessary outcome. Just as we have argued that the virtue of compassion *demand*s that doctors remember that scientific abstractions are properly made for the benefit of the patient as a person, not for their own sake, so the virtues of discernment and conscientiousness require them to remember that the objective of medical ethics lies not in *justifying* the rightness of actions, but in judging and acting rightly, and the very things that Maclean criticises the principles for may be seen instead to encourage these two virtues. Why, for example, in the case of beneficence, should we use such an unusual term instead of merely talking about ‘doing good’? *That is precisely the point*. First of all, it captures some important distinctions: for example that (as discussed with regards to special obligations in the previous chapter) the ethical demands of medicine may *not* be the same as those of everyday life. Similarly, as we mentioned in our discussion of nonmaleficence, whilst we should of course expect that doctors and other healthcare professionals *mean* well, this principle reminds us that in medicine *good intentions are not enough*. Whilst one *could* draw the rather facile conclusion that the principle of beneficence is that which ‘commands us to do good’, the recognition of these distinctions suggests another possible conclusion can and has been drawn. On this view, the principle of beneficence is that which demands that we think and continue to think, carefully and in detail, about what ‘doing good’ actually *means* in a given context, just as the principle of nonmaleficence demands we consider how this may be different to ‘avoiding harm’.

Maclean argues that the process of placing the human back at the centre of medicine is identical with ‘the recovery... of the values which form the framework of [our] life as [moral beings]’¹⁸⁹ (we may add that this seems very similar to appreciating a patient’s narrative in the way that we have seen Childress describe). This is a strikingly similar position to that articulated by Richard Cabot in opposition to the

'professional ethics' of his day. Yet it should also be remembered that for both Bacon and Percival, and the Hippocratic tradition also, the effective care of the patient was the key concern that drove (indeed, made necessary) the establishment of medicine as both a profession and a scientific discipline. Maclean is right to agree with Kennedy that the majority of decisions made in medicine are ethical ones (we have seen as much over the course of this thesis); the important thing is to ensure that this is *remembered*. We have argued that a shortcoming of historical traditions in medical ethics is not that they caused this to be forgotten but rather that a certain approach to them *allowed* for this to happen. Relying on Hippocratic and/or professional ethics as the kinds of 'principle' that Aristotle derides, rather than recognising in them a conscientious expression of what MacIntyre would term a 'vital tradition' has, throughout history, *let doctors and patients down*. It is not in doubt that doctors who ruled that abortions were not necessary on 'medical' grounds *felt* that they were doing the 'right thing'; nor that those complicit in marching soldiers through clouds of radiation *felt* that the Nuremburg Code was only necessary for 'barbarians'. Rather, their failure lay in not *reflecting* on these feelings; by contrast, as we have seen in this and the previous chapter, the 'framework of our life as moral beings' provided by Beauchamp and Childress' account of the principles has, as befits a 'vital' tradition, continued to grow and evolve.

Beauchamp and Childress make explicitly clear, in the 6th edition, that without this compassionate, discerning and conscientious approach, the framework provided by the principles will be little more than the kind of checklist Clouser and Gert criticise: 'until we analyse and interpret the principles... and then specify and connect them to other norms... it is unreasonable to expect much more than a classification scheme that organises the normative content and provides very general moral guidance'¹⁹⁰ (although we may note that even in the absence of these steps this scheme would at least be likely to render the 'raw data' of moral experience and reflection more intelligible). Beauchamp and Childress point to the chapters outlining specific elements of each principle as performing these steps in their own work¹. We may add that the example from English, above, is also explicitly identified as a starting-point for moral reflection on cases, not a substitute for it. The text itself makes clear that the outline procedure will not and is not meant to solve ethical problems for doctors; rather (and here an analogy with diagnosis may be an apt one) it is designed as a tool

to help the doctor (or other professional) explore what is going on in such dilemmas. As English notes, ‘*some* structure is required for the actual thinking-through of the moral conflicts that are so common in medical care... attention to *some* outline is *useful* [my emphases]’. The principles, on this view, are not intended to settle questions so much as to ensure that they are raised and considered¹⁹¹; to ensure a continuing argument about those goods the pursuit of which gives to medicine its particular point and purpose.

Of course, as Maclean notes, we should be wary of overplaying the dangers of relying on our ordinary moral judgements¹⁹²; but we should also be wary of overplaying the dangers of ethical theory as a consequence. As is often the case with the principles (which, as we saw in the previous chapter, are frequently the target of mutually exclusive criticisms) they have also been accused of doing the latter. Maclean has a second explicit criticism of the principles that draws upon her equation of them with everyday moral language, namely that they do not add anything new to the kinds of concerns they represent¹⁹³. As we have already argued, this does not appear to be the case, nevertheless her point is taken up in a subtly different way by Erin, who argues that the principles downplay for healthcare professionals the importance of disagreements between moral theories and moral philosophers. On Erin’s view, that the principles can bridge gaps between, for example, utilitarians and Kantians is of little importance: ‘...so what? ...I fear that for those who have yet to fully develop their considered view, enthusiasm for the four principles approach will not facilitate that development... it is more likely to incline the student to take a seat on the fence between theories’¹⁹⁴. Laying aside for the moment Erin’s rather odd implication that in order to do moral philosophy one must first pick a side in debates between deontologists and consequentialists we may agree that there is a possibility that, once again, students will settle for the easy option of invoking principles rather than the difficult task of making judgements. On the other hand, it is reasonably clear from the 6th edition (if not in the work of Gillon who, Erin notes, does not consider it necessary for health care professionals to become involved in philosophical debates¹⁹⁵) that the four principles are to provide a *start* in approaching these problems, rather than a solution.

It may of course be the case, as Maclean suggests, that bioethics courses claim to teach ‘moral expertise’ as the particular property of the philosopher in the manner she criticises¹⁹⁶; similarly, it is likely that students other than Erin’s own:

feel that they have done all that is required of them when they submit an essay that contains a brief introduction, an even briefer conclusion, and four intervening sections that, if they are titled, bear the heads “autonomy”, “beneficence”, “nonmaleficence” and “justice”¹⁹⁷

Yet these are pedagogical, not philosophical criticisms: of badly designed courses and students who require improvement, not of the principles themselves. Indeed, Beauchamp and Childress have done everything we might reasonably expect to prevent this. The 6th edition is much lighter on jargon than the first (‘microallocation’ and ‘macroallocation’, for example, have been excised from the text) and examples are drawn from medicine, the law and (as we have seen) social research as well as philosophy, four disciplines that we might reasonably expect should (at least) be able to *inform* our moral thinking. In addition, the importance of both theoretical debate and reflection on specific cases is emphasised, for example in their criticism of casuistry¹⁹⁸. We may recall also their discussion of the principle of justice and the problem of how to agree on socio-economic provision of healthcare in the absence of a widely-accepted comprehensive theory and note that, when discussing different theoretical implications for the principle of autonomy, they provide references to more detailed analyses elsewhere¹⁹⁹. In addition, relying on *any* theory as a sufficient guarantee of moral conduct is ruled out, with the authors arguing that ‘neither morality nor any ethical theory has the resources to provide a single solution to every moral problem’²⁰⁰ and that ‘general ethical theories should not be expected to yield concrete rules or judgements capable of resolving all contingent moral conflicts’²⁰¹. In all these ways, Beauchamp and Childress appear to argue that the four principles be used as a starting point for debate; a way to exercise (in both senses of the word) certain virtues.

Conclusions

As with the various kinds of criticisms of the four principles considered in our discussion of their development from 1st to 6th Editions in the previous chapter all

three approaches discussed above can not only be incorporated into the framework Beauchamp and Childress offer, enriching the principles' account of and ability to deal with concrete moral issues, but can themselves benefit from doing so. As Childress puts it with reference to narrative ethics: '[each] plays a corrective, enriching, enhancing role in relation to the other'²⁰². Over the course of the last two chapters, we have argued that the reading of the four principles that results, and that we have suggested is present in the 6th edition, constitutes the best available method for engaging with moral issues in medicine; in our concluding chapter we will consider how this reading may also be supported by the genealogical approach to medical ethics that we have pursued throughout the course of this thesis. However, as Forrow has pointed out, 'just as real ethical issues in medicine do not arise in the abstract, assessments of the effectiveness of alternative analytic models cannot be done in the abstract'²⁰³. For this reason, demonstrating the value of this approach requires that we consider the principles in action; as a result, we will also move on to consider two particular case studies in their use.

¹ Häyry, M. 'European Values In Bioethics' p.199

² Ibid. p.201

³ Beauchamp, T.L and Childress, J.F *Principles of Biomedical Ethics (6th Edition)* p.31 n.4

⁴ Ibid. p.31

⁵ Häyry, M. 'European Values In Bioethics' p.201

⁶ Aristotle *Nicomachean Ethics* p.163

⁷ Ibid. p.38

⁸ MacIntyre, A. *After Virtue (3rd Edition)* (London: Duckworth, 2007) p.150

⁹ Aristotle *Nicomachean Ethics* p.31

¹⁰ Ibid. p.34

¹¹ Ibid. p.62

¹² Ibid. p.63

¹³ Ibid. p.35

¹⁴ Ibid. p.37

¹⁵ Ibid. p.41

¹⁶ Ibid. p.38

¹⁷ Ibid. p.35

¹⁸ Ibid. p.36

¹⁹ Murdoch, I. 'On 'God' and 'Good'' in *The Sovereignty of Good* (London: Routledge & Kegan Paul, 1970) p.56

²⁰ Ibid. p.56

²¹ Aristotle *Nicomachean Ethics* pp.41-2

²² Ibid. p.42

²³ Ibid. p.40

²⁴ Ibid. p.54

²⁵ Ibid. p.46

²⁶ Ibid. p.40

²⁷ MacIntyre, A. *After Virtue (3rd Edition)* p.154

²⁸ Tredennick, H. 'Glossary of Greek Words' in Ibid. p.312

²⁹ Ibid. p.163

³⁰ Ibid. p.60

³¹ Ibid. p.48

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- ³² Ibid. p.55
³³ Ibid. p.47
³⁴ Ibid. pp.48-9
³⁵ Beauchamp, T.L and Childress, J.F *Principles of Biomedical Ethics (6th Edition)* p.3
³⁶ Ibid. p.31
³⁷ Ibid. p.32
³⁸ Ibid. p.33
³⁹ Ibid. p.33
⁴⁰ Conan Doyle, A. *The Pot of Caviare* Available at <http://www.horrormasters.com/Text/a1970.pdf>
[first retrieved 27 November 2010] p.4
⁴¹ Ibid. p.8
⁴² MacIntyre, A. *After Virtue (3rd Edition)* p.159
⁴³ Ibid. p.187
⁴⁴ Ibid. p.182
⁴⁵ Ibid. p.186
⁴⁶ Beauchamp, T.L and Childress, J.F *Principles of Biomedical Ethics (6th Edition)* p.35
⁴⁷ Lane, J. *A Social History of Medicine: Health, Healing and Disease in England, 1750-1950*
(London: Routledge, 2001) p.127
⁴⁸ Porter, R. *The Greatest Benefit to Mankind* p.378
⁴⁹ Ibid. p.378 n.1
⁵⁰ Tong, R. 'The Ethics of Care: A Feminist Virtue Ethics of Care for Healthcare Practitioners' in
Journal of Medicine and Philosophy 1998; 23 (2) 131-152 p.145
⁵¹ MacIntyre, A. *After Virtue (3rd Edition)* p.187
⁵² Ibid. p.187
⁵³ Ibid. p.194
⁵⁴ Ibid. p.193
⁵⁵ Ibid. p.196
⁵⁶ Ibid. p.194
⁵⁷ Ibid. p.190
⁵⁸ Ibid. p.194
⁵⁹ Ibid. p.193
⁶⁰ Ibid. p.196
⁶¹ Ibid. p.193
⁶² Ibid. p.275
⁶³ Ibid. p.273
⁶⁴ Ibid. p.205
⁶⁵ Ibid. p.205
⁶⁶ Ibid. p.273
⁶⁷ Ibid. p.222
⁶⁸ Ibid. p.222
⁶⁹ Murdoch, I. 'On 'God' and 'Good'' p.58
⁷⁰ Ibid. p.52
⁷¹ Ibid. p.74
⁷² Ibid. p.62
⁷³ Beauchamp, T.L and Childress, J.F *Principles of Biomedical Ethics (6th Edition)* pp.46-7
⁷⁴ Aristotle tr. Thomson, J.A.K. rev. Tredennick, H. and Barnes, J. *Nicomachean Ethics* pp.37-8
⁷⁵ Tredennick, H. n.1 in *ibid.* p.33
⁷⁶ Ibid. p.33
⁷⁷ Tredennick, H. n.5 in *ibid.* p.33
⁷⁸ Ibid. p.33
⁷⁹ Ibid. p.68
⁸⁰ Ibid. p.38
⁸¹ Ibid. p.33
⁸² MacIntyre, A. *After Virtue (3rd Edition)* p.190
⁸³ Ibid. p.191
⁸⁴ Ibid. p.222
⁸⁵ Ibid. p.222
⁸⁶ Beauchamp, T.L and Childress, J.F *Principles of Biomedical Ethics (6th Edition)* p.38
⁸⁷ Ibid. p.31

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⁸⁹ Ibid. p.40
⁹⁰ Ibid. p.41
⁹¹ Ibid. p.42
⁹² Ibid. p.42
⁹³ Ibid. p.44
⁹⁴ Ibid. p.38
⁹⁵ Ibid. p.39
⁹⁶ Ibid. p.39
⁹⁷ Ibid. p.43
⁹⁸ Ibid. p.33
⁹⁹ Ibid. p.47
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¹⁰³ Ibid. p.139
¹⁰⁴ Ibid. p.138
¹⁰⁵ Ibid. p.139
¹⁰⁶ Ibid. p.136
¹⁰⁷ Ibid. p.143
¹⁰⁸ Ibid. p.140
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¹¹⁰ Beauchamp, T.L and Childress, J.F *Principles of Biomedical Ethics (6th Edition)* p.36
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¹¹² Ibid. p.36
¹¹³ Tong, R. 'The Ethics of Care' p.136
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¹¹⁵ Ibid. p.134
¹¹⁶ Ibid. p.145
¹¹⁷ MacIntyre, A. *After Virtue (3rd Edition)* p.187
¹¹⁸ Tong, R. 'The Ethics of Care' p.147
¹¹⁹ Farley, M.A. 'North American Bioethics: A Feminist Critique' p.142
¹²⁰ Carse, A.L. 'Impartial Principle and Moral Context: Securing a Place for the Particular in Ethical Theory' in *Journal of Medicine and Philosophy* 1998; 23 (2) 153-169 p.166
¹²¹ Beauchamp, T.L and Childress, J.F *Principles of Biomedical Ethics (6th Edition)* p.37
¹²² Ibid. p.37
¹²³ Farley, M.A. 'North American Bioethics: A Feminist Critique' p.141
¹²⁴ Beauchamp, T.L and Childress, J.F *Principles of Biomedical Ethics (6th Edition)* p.37
¹²⁵ Tong, R. 'The Ethics of Care' p.148
¹²⁶ Ibid. p.150
¹²⁷ Lesser, H. 'Anne Maclean's Criticism of Bioethics' p.62
¹²⁸ Carse, A.L. 'Impartial Principle and Moral Context' p.166
¹²⁹ Beauchamp, T.L and Childress, J.F *Principles of Biomedical Ethics (6th Edition)* p.37
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¹³³ Montello, M. 'Medical Stories: Narrative and Phenomenological Approaches' in Grodin, M.A. (ed.) *Medical Meta-Ethics* p.112
¹³⁴ Grodin, M.A. 'Introduction' p.20
¹³⁵ Montello, M. 'Medical Stories' p.113
¹³⁶ Ibid. p.116
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¹³⁸ Ibid. p.117
¹³⁹ Ibid. p.118
¹⁴⁰ Ibid. p.121
¹⁴¹ Ibid. p.119
¹⁴² Ibid. p.120

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¹⁴⁴ Ibid. p.121
¹⁴⁵ Ibid. p.117
¹⁴⁶ Ibid. p.115
¹⁴⁷ Murdoch, I. 'On 'God' and 'Good'' p.76
¹⁴⁸ Ibid. pp.62-3
¹⁴⁹ Ibid. p.75
¹⁵⁰ Ibid. pp.64-5
¹⁵¹ Ibid. p.64
¹⁵² Bakhtin, M. tr. and ed. Emerson, C. *The Problems of Dostoevsky's Poetics* (Manchester: Manchester University Press, 1984) p.6
¹⁵³ Montello, M. 'Medical Stories' p.110
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¹⁵⁵ Forrow, L. 'Commentary on 'Narrative Ethics': The Case of the Missing Cases' in Grodin, M.A. (ed.) *Meta Medical Ethics* p.125
¹⁵⁶ Ibid. pp.125-6
¹⁵⁷ Ibid. p.126
¹⁵⁸ Ibid. p.127
¹⁵⁹ Ibid. p.130
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¹⁶² Ibid. p.255
¹⁶³ Ibid. p.255
¹⁶⁴ Ibid. p.255
¹⁶⁵ Ibid. p.258
¹⁶⁶ Ibid. p.257
¹⁶⁷ Ibid. p.259
¹⁶⁸ Ibid. p.257
¹⁶⁹ Ibid. p.259
¹⁷⁰ Ibid. p.260
¹⁷¹ Ibid. p.260
¹⁷² Ibid. p.261
¹⁷³ Ibid. pp.260-1
¹⁷⁴ Ibid. p.261
¹⁷⁵ Ibid. p.268
¹⁷⁶ Ibid. p.262
¹⁷⁷ Ibid. p.262
¹⁷⁸ Ibid. p.263
¹⁷⁹ Ibid. p.262
¹⁸⁰ Ibid. p.264
¹⁸¹ Beauchamp, T.L and Childress, J.F *Principles of Biomedical Ethics (6th Edition)* p.373
¹⁸² Ibid. p.372
¹⁸³ Ibid. p.372
¹⁸⁴ English, D.C. *Bioethics: A Clinical Guide for Medical Students* (London: Norton, 1994) p.46
¹⁸⁵ Winkler, E.R. 'From Kantianism to Contextualism' p.352
¹⁸⁶ Maclean, A. *The Elimination of Morality* p.190
¹⁸⁷ Ibid. p.189
¹⁸⁸ Ibid. pp.200-1
¹⁸⁹ Ibid. p.199
¹⁹⁰ Beauchamp, T. and Childress, J. *Principles of Biomedical Ethics (6th Edition)* p.373
¹⁹¹ English, D.C. *Bioethics: A Clinical Guide for Medical Students* pp.45-6
¹⁹² Maclean, A. *The Elimination of Morality* p.24
¹⁹³ Ibid. p.200
¹⁹⁴ Erin, C.A. 'Who Needs the Four Principles' p.85
¹⁹⁵ Ibid. p.87
¹⁹⁶ Maclean, A. *The Elimination of Morality* p.199
¹⁹⁷ Erin, C.A. 'Who Needs the Four Principles' p.83
¹⁹⁸ Beauchamp, T.L and Childress, J.F *Principles of Biomedical Ethics (6th Edition)* p.381

¹⁹⁹ Ibid. p.100 n.2

²⁰⁰ Ibid. p.24

²⁰¹ Ibid. p.397

²⁰² Childress, J.F. 'Narrative(s) Versus Norm(s)' p.268

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Chapter 12: Genealogy and the Four Principles: Two Case Studies in their Application

At the start of this thesis, we posed three questions regarding Beauchamp and Childress' decision to distance the philosophical reflection they present in the 6th edition of *Principles* from historical traditions of medical ethics. First of all, we asked what it was that constituted these historical traditions, and made up what Jonsen refers to as their 'remarkable continuity'. Secondly, given the changes and developments that these traditions made over time, we asked why it was that they had apparently been unable to continue this growth in the mid- to late-20th Century, necessitating the kind of philosophical reflection that Beauchamp and Childress claim to supply. Finally, given the parallel growth of philosophy and medicine from Antiquity to the present, we asked just what kind of philosophical reflection the four principles were supposed to provide, and why it had not been present before. We may now, in our concluding chapter, aim both to answer these questions, and to demonstrate their relevance in supporting the adoption of a method that we will then explore further with regards to two particular cases. In order to do so, it may be helpful to revisit two distinctions: that made in the introductory section between what Morrice terms 'the content of medical ethics' and the 'underlying continuity of function', and that made in the concluding section of Chapter 10 between the principles themselves and the 6th edition's approach to ethical theory.

Genealogy and the Four Principles

In answering the first question, we may identify two different *kinds* of element that comprised the historical traditions of medical ethics. The first are those familiar to us from traditional histories such as Jonsen's and Grodin's: the great canonical works of historical medical ethics found in the Hippocratic Corpus and *Oath* and in the codes of professional ethics established by Percival and the AMA and applied by bodies such as the Central Ethical Committee. These works and others like them may be seen broadly to comprise what Morrice terms 'content'. The second kind of element is that we have attempted to draw out in our discussion of the different ways these works and actions can be described as ethical when viewed historically in the context of the

cultures that produced them, and the state of medical knowledge and organisation that we have argued they respond to. In the case of the Hippocratic *Oath*, for example, we have attempted to argue that, whether or not it was (as Nittis claimed) a legally sanctioned and binding document or the product (as Edelstein maintained) of an obscure philosophical-religious cult, it can (together with relevant passages from works of the Corpus) be seen as a response to the moral concerns raised by doctors' behaviour and methodology given the circumstances of naturalistic medicine in Ancient Greece. Similarly, we have argued that Percival's *Medical Ethics* does not merely contain a set of rules relating to organisational etiquette, but rather provided the socio-economic and organisational framework to establish and sustain the kind of collective professional and scientific endeavour that was morally required by the goal of establishing medicine on a sure footing in the era it was written. In both cases, the moral reflection on issues of the time that caused these works to be produced may be seen to represent Morrice's 'continuity'.

The answer to the second question is tied to the necessarily historical character of the content of medical ethics revealed through our answer to the first. From Chapter 1 onwards, we have argued that there exist certain moral elements without which it is impossible to meaningfully discuss questions of medical ethics. Chronologically, the first amongst these was competence: as soon as the healer is established as a socially recognised figure possessed of certain skills and abilities, he or she incurs a moral obligation to train these skills, to apply them to the best of his or her ability and, perhaps, to strive to excel in and extend them. But, as we have also argued, the precise *nature* of these moral elements depends to a great extent on changing, non-moral counterparts. In the case of competence, for example, this moral obligation would take very a different form for the shaman in prehistory than it would for the Hippocratic doctor of Ancient Greece. As a result, as Murdoch might put it, these obligations elude definitive representation. Viewed *ahistorically* – that is, viewed in the absence of the continuity identified above – many particular expressions of the content of medical ethics risk becoming meaningless or even harmful, especially since responses to moral concerns in one era can store up problems for the next. As we argued in Chapter 6, this is precisely what occurred with professional ethics. Doctors' reticence in discussing medical matters with those outside the profession, to take one example, was explicable given the somewhat embattled position of late-17th Century

medicine as discussed in Chapter 5; following new moral dilemmas thrown up by the advances made in the aftermath of the Second World War, however, it became in many cases (for example, with regards to potential conflicts of interest in research) increasingly inappropriate.

Following on from this, we may now attempt to answer the third question in light of our responses to the first two. In the previous chapter, we suggested that both Aristotle and MacIntyre's account of the virtues required both rules and a certain attitude to those rules that Beauchamp and Childress' account of the four principles in the 6th edition provides (we may add, of course, that this account itself requires some form of virtue element, particularly, as we went on to suggest, in terms of discernment and conscientiousness). And it is just such an account as this that our genealogy suggests is likely to be required to avoid the kinds of problems encountered by other historical traditions of medical ethics. On this view, the four principles themselves, and the rules created through specifying and balancing them, may be seen as forming the current content of medical ethics; the evolving theoretical approach that we have argued underpins them may be seen as a recognition for the need of an ongoing continuity of moral reflection (and as such, perhaps, after a fashion be seen to *continue* historical traditions). Both the principles (together with their particular specifications) and this theory are of course themselves responses to given historical situations; both can and are likely to change, perhaps as a result of new technology or new case studies (with regards to the former) or new thought-experiments or theoretical approaches (with regards to the latter). This is, in fact, something that suggests the plausibility of this approach: it is one that *recognises* the historical character of moral reflection and, as such, does not merely allow for change; as we have suggested in our discussion of the difference between the 1st and 6th editions, and of the ways in which it can incorporate elements of several different theoretical approaches, it allows for *growth*.

The following case studies are intended to demonstrate the value of the use of this approach to the four principles in dealing with specific cases and kinds of case that may arise in the course of early 21st Century medical practice. The first deals with an explicit criticism of Beauchamp and Childress' approach, namely Westin and Nilstun's contention that, whilst the principles can help to uncover the attitudes and

arguments present in a problematic situation, they are unable to provide non-arbitrary action guides for healthcare professionals in handling them. In considering their arguments, we will attempt to demonstrate that several features of their own account in fact indicate quite the opposite and provide several concrete recommendations at the level of both the specific clinical encounter and in terms of wider health and social policies. The second considers an explicit conflict between principles in the form of the paternalistic interventions apparently endorsed by the Israel Patients' Rights Act of 1996. Again, we will argue that using Beauchamp and Childress' four principles not only helps to make sense of the moral elements of several specific cases, but that their conscientious application indicates how such conflicts may, even when apparently insoluble, still point towards the morality of particular actions.

Westin and Nilstun's 'Principles Help to Analyse But Often Give No Solution – Secondary Prevention after a Cardiac Event'

The stated purpose of Westin and Nilstun's paper 'Principles Help to Analyse But Often Give No Solution – Secondary Prevention after a Cardiac Event' is 'to investigate whether or not ethical conflicts can be identified, analysed and solved using ethical principles'¹. To do so, they offer as an example the case of the relationship between doctor and patient when lifestyle changes are recommended for the latter following a major cardiac event such as 'acute myocardial infarction, coronary artery by-pass grafting (CABG), and percutaneous coronary intervention (PCI)'². On their analysis, there is a clear conflict between (at least) two principles should they be used in an attempt to provide moral guidance in such cases: '[the patient's] autonomy is challenged by the suggested lifestyle changes, the purpose of which is to promote the future wellbeing and health of the patient [that is, beneficent]'; they also argue that there is potential for further conflicts once we acknowledge that '[the patient's] spouse is [also] involved in and affected by the process'³. Whilst agreeing that 'most (if not all) physicians would strongly encourage life style changes', they claim that 'surprisingly there is no uncontroversial justification for this conclusion using principles'⁴.

In order to determine what use of the principles would recommend a doctor advise their patient following a cardiac event, Westin and Nilstun combine them in 'a two

dimensional model': for each of the three individuals involved (patient, doctor and spouse) a set of recommendations is produced through an '[investigation of] what would happen if [only] one principle [were] utilised'. Their method results in the following table which, they contend, shows that the use of such a method inevitably leads to conflict when deciding the most ethical course of action:

Table 1 A matrix table for ethical analysis in two dimensions: affected persons and ethical principles (the letters A to F denote the different combinations)

Affected persons	Autonomy	Beneficence	Justice
Patients	A	B	C
Spouses	D	E	F

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The authors argue that there is the potential for ethical conflict between 'each of the cells in the matrix table'⁶ both horizontally (that is, between the demands of each principle with regards to actions taken with respect to a single person affected, for example A and B) and vertically (that is, between the demands of a single principle with regards to actions taken with respect to each person affected, for example A and D). It is also possible that conflicts may occur diagonally (for example, between B and F). Westin and Nilstun offer several examples to illustrate conflicts that they claim occur in the kind of situation under discussion.

Were autonomy to be 'applied as the only principle relevant' Westin and Nilstun argue, 'the conclusion would be to respect the patient's right to self-determination... [one] could even question whether any recommended life-style [sic] changes would be compatible with this principle'. By contrast, should beneficence be applied in the same way 'the conclusion would be to minimise harm and maximise benefit... the doctor should be forceful if necessary [and] relevant guidelines should be followed regardless of the patient's [wishes]'⁷. One seemingly straightforward resolution of this conflict, in keeping with the principle of autonomy's requirement that 'only the fully

informed patient is truly autonomous', is to ensure that the patient is made aware that lifestyle changes may be required to improve their health whilst respecting any subsequent decision on the patient's part not to implement these changes⁸. Westin and Nilstun argue, however, that this still leaves scope for conflict, due to the patient and doctor having different views of the significance both of the cardiac event⁹ and the importance of the patient's lifestyle to their own sense of self (they note Solzhenitsyn's remark "[fumo] ergo sum' (I smoke, thus I exist)'¹⁰. As a result, the patient sees the doctor's recommendation as an attempt to take control of their decisions: 'the [patient feels] that his or her autonomy is diminished [and] sees the doctor as acting, prescribing, and ordering'¹¹. The authors argue that this 'may in part' lead to low compliance with regards to the suggested changes¹²: '[albeit] smoking cessation is associated with a reduced mortality... only approximately one third of the patients [advised] quit smoking after such an event'¹³.

This is not the only (potential) conflict that Westin and Nilstun purport to identify. For example, they argue, the principle of autonomy, applied to the *spouse* as the only principle relevant, would suggest that doctors 'respect the spouse's right to self determination' and 'ideally... be interested in the information that spouses could provide... thereby [showing] them respect as persons'¹⁴. Similarly, with regards to beneficence, the authors note that spouses often suffer adverse effects as a result of the patient's condition of which the doctor is unaware (with 'the equilibrium in the family... affected if one of its member has to change life style') and that, were this the only principle relevant, the doctor should strive to ensure these are minimised¹⁵. Finally, they suggests that, were justice the only principle relevant, the spouse 'should be allowed to state his or her experiences and views of the situation to the doctor without any limits'¹⁶. According to Westin and Nilstun, each of these obligations can conflict with those of doctor and patient: for example, the wishes of the spouse could conflict with those of the patient (in which case, the authors agree, the primary ethical obligation of the doctor remains to the latter)¹⁷; furthermore, the doctor is under 'no obligation to *generally* benefit the spouse [my emphasis]' and as such may prescribe changes that have a negative impact on them¹⁸; finally, they suggest, the disclosure of information they feel justice may require to the spouse may conflict with requirements established to benefit patients in medicine as a whole (they note that spouses making

attempts ‘to get in direct contact with caregivers [are] usually rejected with reference to medical confidentiality’)¹⁹.

The method Westin and Nilstun use to identify these supposed conflicts seems to imply a ‘top-down’ application of the principles in the manner of the first edition with each seen as prescribing a single, narrowly-conceived obligation which must be balanced against the other. Certainly, this would seem to account for the extremely strict definitions of each of the principles (notably autonomy) used in creating the table²⁰. The authors deny this, noting that they are referring instead to the method suggested in the then-current 5th edition²¹; in fact, they argue that ‘the conflict [they identify] between the principles derives from the fact that they have no common root, but are founded in what is called ‘a common morality’²². On Westin and Nilstun’s view, such conflicts can only be resolved by adopting a yet *more* narrow ‘top down’ theory: ‘[if] we start with a [single] moral theory, Kant’s deontological ethics or Sartre’s existentialism we [would] have a fairly good chance of getting rules that are reconciled with each other’²³. We may of course object that both these theories *also* have their roots in the kind of norms that Beauchamp and Childress argue make up the ‘common morality’, indeed ‘[it] is difficult to see how one could come to any ethical conclusions whatsoever... without first considering... situations and decisions that are felt to be ‘moral’ or ‘ethical’... and working back from these’²⁴. More importantly, in practical terms, it is far from clear whether, firstly, adopting such a theory would in fact lead to a situation any different from the one Westin and Nilstun describe, and secondly, whether the principles are, in fact, quite so impotent as they claim.

According to Westin and Nilstun, the need to produce more straightforward action-guides often leads, in their Orwellian turn of phrase, to counting one principle as ‘more equal than others’²⁵ (most likely – as they note, and as we mentioned in Chapter 10 has indeed been advocated by some principlist writers – autonomy). However, since they subsequently argue that they would be against such a step²⁶, we may instead consider what would happen if we instead replaced the principles *en masse* with one of the theories they suggest would give us more consistent rules, namely deontological Kantian ethics. The authors seem to contend we would end up with new table looking something like this:

Table 2 A matrix table for ethical analysis in two dimensions: affected persons and Kantian Ethics (the letters A and B denote the different combinations)

Affected persons	Kantian Ethics

Patients	A
Spouses	B

Were such a table an accurate reflection of the situation, the doctor may indeed have one unambiguously clear obligation to the patient, perhaps with some subsequent or consequent obligations to the spouse. However, given that the authors acknowledge the existence of at least one other ethical theory, Sartre's existentialism²⁷, and that no extant theory has attained sufficient status amongst philosophers (let alone doctors or the general population) to allow us to honestly omit all others from consideration, it would perhaps be more correct to describe this approach as resulting in a table like this:

Table 3 A matrix table for ethical analysis in two dimensions: affected persons, Kantian Ethics and Sartre's Existentialism (the letters A to D denote the different combinations)

Affected persons	Kantian Ethics	Sartre's Existentialism

Patients	A	B
Spouses	C	D

The picture becomes even more complicated when we consider whether or not the existence of Tables 2 and/or 3 would mean that the various obligations that Westin and Nilstun identified in their original table had as a consequence ceased to exist or

were, in fact, *merely being ignored*. If we allow that anyone could hold instead the positions described in Table 1, or some combination thereof, and still be regarded as neither immoral nor insane, which seems to be a reasonable assumption to make, then it seems we are forced to conclude it is the latter. In fact, given the existence of other ethical theories than those mentioned, and given (since their recommendations would necessarily be those produced by one group or person's interpretation of the theory in question) different specifications of the *same* theories, Table 3 would properly include not only these initial combinations but an almost infinite number of possible moral obligations. A universally acceptable moral theory may, of course, avoid such problems, as Beauchamp and Childress point out, '[if] we could be confident that some abstract moral theory was a *better* source for codes and policies... we could work constructively on... that theory [my emphasis]'; the problem, however, is that '*we have no such theory* [my emphasis]',²⁸.

So it does not seem that adopting any (currently available) 'top-down' moral theory is likely to improve the situation. But is Table 1 a fair reflection of how the principles are supposed to be applied? Westin and Nilstun concede that use of the principles has its advantages, noting that they 'share [Beauchamp and Childress'] opinion about the usefulness of the principles in the identification and analysis of ethical conflicts' and that it is a strength of this analysis that 'arguments [are] made explicit'²⁹. What they do not recognise is that it is such analysis can and does provide concrete ethical action-guides and in fact *does so in their own paper*. First of all, we may turn our attention to the central conflict identified by Westin and Nilstun, which pits the beneficent requirement to advise the patient to make changes to their lifestyle against the infringement of their autonomy these changes supposedly necessitate. Such a conflict appears to have its roots in the narrow definitions of the principles that the authors adopt, something they defend by noting that 'if we want to assess the use of principles in a concrete setting you [sic] have to illuminate one principle after another to see what the consequences would be'³⁰. The authors are surely correct that, in analysing a situation, it makes sense to start with a narrow definition of each principle (and articulating present behaviour in this form would seem a good place to begin). Yet there is no compelling reason why these definitions must be rigidly adhered to indefinitely; indeed, we should *expect* our specification of the principles involved to change even as our initial definitions help us to explore what is happening.

So, with a little reflection, it is clear that the supposed conflict between beneficence and autonomy exists primarily because, at present, neither is properly articulated: '[as] Westin and Nilstun point out, low compliance is... a major problem in the treatment of IHD following a cardiac event; they also point out, however, that it is the likely result of a patient feeling they are a passive rather than an active agent in their own treatment'³¹. In other words, beneficence may be seen to be hindered, *not* because respect for the patient's autonomy necessitates allowing them to ignore the advice given by their doctor, but because the nature of the clinical encounter does not leave the patient feeling that their autonomy has been respected *enough*. So, in the course of the very analysis which Westin and Nilstun claim offers 'no solution' the principles appear to have already produced one clear practical recommendation: autonomy and beneficence *both* seem to require that, where possible and/or necessary, patients should be encouraged by their doctor to feel 'responsible for their own care'³² (of course, what this means in practical terms with regards to interpersonal skills or 'bedside manner' would require further research, but these are things that can be identified and passed on to doctors as 'best practice' in the course of their training, a need which could itself be expressed as an ethical requirement for the medical profession as a whole).

This more complex account of autonomy also has implications for the involvement of the spouse in the decision-making process. Indeed, we can conclude from their analysis (although they do not) that in the majority of the type of cases they are considering, respect for the patient's autonomy seems to hinge, at least partly, on involving rather than excluding the spouse when giving advice. In fact, there are several different ways in which autonomy can (or cannot) involve other parties. Some patients may be quite comfortable taking decisions on their own, but this may require that they consult others and consider their interests as well (for example, it is clear that if a patient who does not prepare their own food 'is advised to change their diet and is fully willing to do so [they are] in fact having their autonomy *infringed* if such a measure is not made practical by failure to disclose requisite information to all the individuals involved [my emphasis]'³³). In some cases, couples may prefer to take all decisions jointly, in which case respecting a patient's autonomy may include respecting that portion of it they have delegated to their partner. In others, as we may recall from our earlier discussion of differing cultural attitudes to autonomy in

Chapter 10, decisions may be taken (as was often the case with Korean Americans and Mexican Americans) by the family group as a whole. What counts as respecting a patient's autonomy in each case requires sensitivity to such background elements.

That Westin and Nilstun only consider the first of these models may in fact be a consequence of their attention to what may be one source of relevant information: research indicates that, in Northern Europe, '[most] patients suffering from IHD are male, often middle-aged or older... [in] the involved population the female spouse usually prepares food in the household [thus] changes in diet also involve the spouse'³⁴. So, as suggested above, respecting such patient's autonomy is likely to necessitate involving the spouse. This would also seem to be required by beneficence (since it is necessary in order to improve the patient's health) and, insofar as it requires doctors to take into account likely socio-economic situation of those patients most at risk from IHD in making decisions about what constitutes effective care *for them*, justice as well. Another related recommendation would be for the doctor to remember that beneficence towards both patient and spouse are to a degree intertwined and thus to remain conscious of the fact that the effect of a patient's lifestyle changes on the spouse may themselves affect the patient in turn (again, further research would seem necessary, which, in fairness to Westin and Nilstun is something they appear to endorse³⁵). We should recall from the discussion of Navajo attitudes to autonomy, however, that appreciation of these elements does *not* mean making assumptions about patients based on class or ethnic background; rather, respecting a patient's autonomy requires (and Beauchamp and Childress' account of the virtue of discernment may be important here) careful judgement as to what autonomy means in each particular context.

It is important to note that adopting a more complex account of autonomy does not mean, as Westin and Nilstun suggest (with reference to the Humpty-Dumpty of Carroll's *Alice Through the Looking Glass*), that specifying principles in these ways is somehow arbitrary³⁶. Rather, the various senses of autonomy, beneficence and justice that are revealed (without their apparent cognisance) through their analysis draw both on the context provided by the kinds of cases they describe and from careful consideration of what each principle *might* mean in these cases (it is worth noting that the deeper sense of autonomy we have argued the analysis suggests is somewhat *less*

arbitrary than the authors' own concept, which appears to be: 'autonomy is the principle that people should be allowed to do whatever they want' – a concept for which virtually no-one, least of all Beauchamp and Childress, would argue). We may recall from the previous chapter that this fuller analysis of the concept is just what we should expect from a virtuous (that is, conscientious and discerning) attitude to the principles; we may note also their evident concern that invoking a conception of autonomy that defines 'every man, from a biomedical-ethical point of view, [as] an island'³⁷ might be an obstacle to patients' well-being seems rooted in compassion. As such, it is something of a shame that Westin and Nilstun do not realise that they are, in attempting to criticise the principles, providing an analysis of just the sort that Beauchamp and Childress appear to recommend.

Clearly, as Westin and Nilstun point out, '[everyday] medical practice can be very challenging... not least from an ethical point of view'; whether ethical reflection *on* everyday practice (as they feel it necessary to concede) 'may be very dull' is another matter³⁸. In fact, their analysis seems to show how interesting such reflection can be, not only in terms of individual cases or types of cases, but of the way in which these can show the need to address wider issues that impact on moral decisions in them. The principles do not, on this view, provide a solution 'in the sense of... one clear and unambiguously 'right' course of action'³⁹; they are not intended to. Instead, they provide a set of tools for helping to work out what should be done in a given situation. And, in the course of Westin and Nilstun's analysis, the principles do indeed appear to be doing everything which we may reasonably ask a philosophical ethical theory to do in such a situation. Judgement is passed on certain forms of behaviour (for example, the doctor should not enforce lifestyle changes on the patient); existing conclusions are challenged, if not definitively subverted (for example, non-disclosure of information may need to be rethought in certain circumstances) and possibilities for improving doctors' dealings with their patients are opened up (for example, in further considering the needs of the spouse).

Moreover, whilst it would seem fair as a result of this analysis to hold the doctor responsible for acting in such a manner as to include the patient in the decision-making process and thus raise the likelihood of their compliance with medical advice, and to include the spouse where permitted, individual doctors cannot be held

responsible for ‘improving the dietary habits of a society, correcting the harmful impression that the medical profession exists to offer ‘silver bullet’ solutions to complex health [or social] problems, or regulating the relationship between a patient and their spouse’⁴⁰. It may, however, be incumbent upon doctors who notice (as Westin and Nilstun do) that present practice could be improved upon to raise awareness of its limitations and suggest how these could be addressed, but we should also note that bringing about such change implies an ethical obligation not only for the individual doctor, but a related obligation for the profession of which he or she is part, to promote and respond to ethical concerns. In addition, there are more elements relevant to medical ethics than those relating to doctors or the profession (for example, as we first argued in our discussion of the Hippocratic tradition in Chapter 3, certain questions are inextricably bound up with the public perception of medicine) and for this reason, some discussion must refer to morally relevant elements outside of the professional sphere (for example in considering social policy, or media reporting of health-related stories).

The Israel Patient’s Rights Act (IPRA) 1996

Whilst the apparent conflicts that Westin and Nilstun claimed to identify in the above example are largely, if not wholly, the result of inadequate specification of the principles and as such easily overcome, conflicts between principles (even well-specified ones) can and do occur. One obvious area of potential for conflict occurs in cases of paternalism, which has often been cast as a conflict between autonomy and beneficence. We may remember from Chapter 10 that Beauchamp and Childress argue that acts of ‘soft’ paternalism (that is, taking decisions in the best interests of a patient who is either lacking the capacity to make autonomous decisions or whose autonomy is diminished) can often be justified under the four principles approach, together with some acts of ‘hard’ paternalism (overruling the wishes of a competent patient) where the infringement of the patient’s autonomy is trivial (we may recall the example of a nurse putting up guard rails on a patient’s bed). Even in cases of ‘soft’ paternalism, however, ‘the decision to treat any patient by force’ has been described as ‘wrenching [and, as a result] there are very few instances where one might imagine treating a competent person in defiance of his or her express wishes’; indeed, in many countries ‘statutes protecting patient rights... expressly [forbid] coerced treatment’.

However, on the grounds that it was justified ‘in the spirit of a communitarian democratic state’, the Israel Patient’s Rights Act (IPRA) of 1996 ‘codified a wide range of fundamental patient rights while providing for a mechanism to violate them at the same time’⁴¹.

Whilst the IPRA does enshrine the right to informed consent, and obliges doctors to ‘provide [patients with] a wealth of information about risks, benefits, and alternative treatments’, it also makes provision under certain circumstances for doctors ‘to override the right of informed consent and to forcibly treat competent patients against their will’⁴². Of course, as Gross has pointed out, in most cases ‘competent patients gladly accept medical treatment’, and where they refuse it is often the case that ‘the treatment does not offer significant benefits over the alternative the patient prefers’. Nevertheless, it is not unknown for some patients to reject ‘clearly beneficial treatment and, despite every reasonable effort, [continue] to reject appropriate care’. ‘In those cases’ Gross speculates ‘one could well imagine physicians simply wanting to tie down their patients and treat them anyway. Well, the Israeli law allows just that’⁴³. In fact, Gross somewhat overstates the case: under the IPRA, it is not enough for a doctor to simply decide that his patient is making the wrong decision. Under the provisions of the act ‘statutory ethics committees [were established] to consider a physician’s request to forcibly treat a competent patient who refuses medical care’ (it is interesting to note that these committees’ permission must also be sought to ‘withhold medical information from competent patients’ under therapeutic privilege)⁴⁴.

In order to receive approval, a doctor’s request must satisfy three criteria. First of all is ‘informed consent or more precisely, “informed refusal”’: the doctor must demonstrate that the ‘patient [has received] the information necessary to make an informed choice’ and been able to understand and make decisions based on it (intentionally or not, this would seem to act as a safeguard against those doctors who, lacking the time or inclination to explain treatments to their patients and address any fears they may have, might be tempted to go straight to the committee for permission to apply whatever treatment they felt best)⁴⁵. Secondly, the doctor needs to demonstrate that the treatment will ‘[yield] significant, rather than simple or marginal,

healthcare benefits'. This precondition is in obvious need of further specification; as Gross points out, the IPRA:

demands that a patient face "grave danger"... a broad term meaning simply that the disease will kill if left untreated [that] says nothing about the quality of life a patient may endure [and] leaves the uncomfortable impression that one cannot treat a patient by force if the only purpose is to prevent extreme disability⁴⁶

Gross suggests that the adoption of quality adjusted life years (QALYs) may be a 'useful device' in balancing any urge to prolong life against the probable impairment of normal biological function⁴⁷. This is not without problems of its own, however: first of all, as he notes, any such calculus will on occasion return a result where the numbers on both sides add up equal (as Gross puts it, taking 1A as the general absence of disability and distress, 'there is a point of indifference where x years at 1A= $x+n$ years at a lesser state'⁴⁸); moreover, there is the question of how precise a value can be placed on particular losses to particular individuals (we may think of the Italian doctor in Hemingway's *The Sun Also Rises* who tells the protagonist, rendered impotent by war wounds: "'You, a foreigner... have given *more than your life* [my emphasis]'"⁴⁹). Even laying aside these concerns for one moment, there is another criterion that must be satisfied before the committee can authorise treatment, namely: 'that there must be reasonable grounds to suppose that, after receiving treatment, the patient will give "retroactive consent"'⁵⁰.

Gross, as his comments regarding 'violation' and 'simply tying patients down' suggests, clearly finds the provisions of the IPRA for forcible treatment of competent patients suspect, although not necessarily wrong in principle (we shall examine his two specific concerns, perhaps the most important of which he does not fully develop, in more detail below). His, however, is not the only opinion, and the Act has its defenders. Glick, for example, describes it as the product of a recognition that:

it is high time that the pendulum which has swung from overbearing, autocratic and insensitive paternalism to an often cruel and dangerous autonomy, be allowed to swing back to a more moderate and sensible balance between autonomy and beneficence⁵¹

His defence of the IPRA's provisions came in response to an article in the *Journal of Medical Ethics* in which a 'Dr. Brian Hurwitz... almost apologetically reported the successful intimidation of an elderly competent widow into accepting badly needed therapy for a huge ulcerated basal cell carcinoma'⁵². Glick has little time for those who would judge Hurwitz' actions wrong on the grounds that 'they violated this woman's precious autonomy'; rather, he feels that 'Dr. Hurwitz is to be congratulated for his courage'⁵³. To properly assess Glick's judgement, then, it will be worthwhile to consider for a moment the case that prompted it.

As Hurwitz himself describes it, the case began when he was called to attend a patient he had not met before, and found:

Mrs Thomas (not her real name)... an elderly widow living with her bachelor son who had given up work in order to look after her. She had developed a huge basal cell carcinoma on her umbilicus, a slow-growing skin cancer that never invades distant sites and is almost always curable with radiotherapy treatment⁵⁴

Mrs. Thomas had rejected an initial offer of outpatient treatment, citing her fear of hospitals, and 'preferred to live with the skin cancer which was not causing her too much difficulty at the time'⁵⁵. As the carcinoma became larger and began to ulcerate, however, she began to require 'daily district nursing help in an area with greatly overstretched community care resources'⁵⁶. Her refusal to accept treatment was also having a negative impact on her son, who Hurwitz found 'an anxious, frightened man... desperately trying to do his best for his mother'⁵⁷. There was no doubt that Mrs. Thomas was competent: she was not delusional, her fear of hospitals was not at the level of a phobia, and she had shown herself able to retain and process the relevant information provided her⁵⁸. Nevertheless, 'the absurdity of the situation' with 'more and more community resources likely to be committed ... to the palliation of an entirely curable condition'⁵⁹, not to mention the continued distress to her son, caused Hurwitz to overrule her decision: he 'ordered her to attend hospital, and would hear nothing of her refusals'. Mrs. Thomas willingly went with the ambulance when it arrived, and within six weeks had 'healed completely', giving her son the chance to '[retrieve] a life for himself'⁶⁰.

In such cases, Glick asks, ‘when the magnitude of the beneficence is huge, and the weight of the autonomy consideration weak, why not let beneficence “override” autonomy?’⁶¹. Although he admits that he had at first regarded the IPRA with ‘derision’, Glick now argues that it contains ‘Solomonic wisdom’, an opinion he formed in response not only to Hurwitz’ account above, but also to the following case:

a young Bedouin man was admitted [to an Israeli hospital] with pneumococcal pneumonia (generally a highly treatable disease in this age group, with reasonable expectation of complete recovery). He was having trouble with adequate oxygenation... [intubation] and mechanical respiration were medically indicated. The patient, fully “competent” by the usual standards, was adamant in his refusal to be intubated. The physicians attempted to persuade the patient, using family members... but to no avail... [and] treated him without intubation. The patient died.⁶²

Glick’s reaction to this case (the kind he describes, in somewhat questionable, impersonal language, as ‘permitting a salvageable patient to die’⁶³) was further complicated when he read, ‘in a non-medical magazine’ of a similar case in the United States. In this case, whilst doctors had honoured their patient’s refusal of intubation so long as he remained conscious, ‘immediately upon [his] loss of consciousness [they] intubated him, attached him to a respirator and sedated him’. When, within 24 hours, the patient had recovered sufficiently to be taken off from the respirator and have the tube removed, he expressed his gratitude to the doctors who had disregarded his wishes⁶⁴.

Despite Glick’s dismissive sneer at notions of ‘precious autonomy’, his griping about ‘the civil libertarians [who] argued vigorously for the... view that no competent person could ever be treated against his/her will’⁶⁵ and his stubborn insistence (in spite of the geographical circumstances of his example cases) that ‘militant exponents of autonomy’⁶⁶ express a characteristically ‘Western’ attitude⁶⁷, his views are perhaps not quite so radical (nor so distinct from ‘Western’ approaches) as he would apparently like to think. Rather, he is arguing that a narrow conception of the principle of autonomy ‘as an all or none phenomenon’ should not be regarded ‘as an absolute trump over all other values’, a position perfectly in keeping with the view of

the principles that we have argued for over the past two chapters⁶⁸. Indeed, his description of an ethics committee considering such a case, weighing and balancing:

the quality of the competence of the patient, the degree of his/her autonomy, the potential for risk and suffering in the procedure, the likelihood of its success, the danger of refusal and the likelihood of the patient's subsequent reversal of his earlier refusal⁶⁹

seems to find them engaged in the kind of reflection the 6th edition of *Principles* seeks to promote (Glick does, in fairness, concede that 'the "four principles" method... in its original form, does not necessarily give automatic priority of one principle over another'⁷⁰). Glick's examples are persuasive and lend weight to his argument that autonomy 'is not the ultimate end [but] must be considered in the context of its broader goals and evaluated on a case by case basis'⁷¹ but of course, as we may recall from the previous two chapters, this is just what we would expect if the principles are to be thought of as clusters of concerns that must be weighed and balanced against each other, if the good that medicine aims for is not fully representable, and if medical ethics is to consist of the kind of ongoing argument that characterises a vital tradition.

This does not mean, however, that if we agree with Glick's position we must also agree with either the IPRA itself or the way that it allows for some decisions to be overridden, something that brings us back to Gross' two concerns about the Act in its current form. The first of these is that the Act does not appear to make a distinction between two quite different possible sources of conflict between a patient's wishes and doctor's preferred course of action: 'on closer examination, it is apparent that these disagreements turn on either disputed *facts* or disputed *values* [my emphasis]'⁷². Disputes of the first sort can occur for a variety of reasons: 'patients refuse medical treatment because they do not fully understand the risks of nontreatment, overestimate pain, or ignore (or discount) pertinent information'; they are usually easier to resolve than conflicts of the second sort since '[once] the factual issue is resolved, a reasonably intelligent patient will usually adopt the course of treatment his physician proposes'⁷³. Disputes of the second sort occur when a patient '[understands] the issues at stake and prefer alternative treatment or no treatment at all'; these can occur when 'the costs in terms of curtailed lifestyle... lead a patient to prefer a shorter life under some conditions rather than a longer life under others' or when a patient's religious

beliefs preclude certain forms of treatment, for example blood transfusions in the case of Jehovah's Witnesses (although arguably only in the case of those Jehovah's Witnesses aware that others of their faith have argued against the prohibition⁷⁴).

For Gross, an appreciation of this distinction 'is pivotal for any attempt to justify treating a competent patient by force', partly because disputes of fact themselves limit the patient's autonomy (since a refusal made on the basis of a misconception is not, in one sense, 'informed') and partly because '[informed] refusals stemming from disputed values immediately invoke the protection that respect for autonomy provides'⁷⁵; where disputes turn on matters of fact, however, the situation may be quite different. Gross illustrates this distinction through two examples. In the first, a woman is admitted to hospital and diagnosed with:

a large tumour in her bladder. The preferred treatment is excision of the entire bladder... requiring a urine bag to collect and pass urine. In all likelihood her vagina will be removed as well thereby preventing normal sexual relations... Her life expectancy without surgery could be a matter of several years occasioned by intermittent bleeding and hospitalisation until the tumour in her bladder causes more severe complications. Surgery, on the other hand, offers the prospect of a longer, pain free life⁷⁶

When first referred to an ethics committee, Gross reports, several members felt that this case was clear-cut, since 'a longer, pain free life' seemed to be an obviously significant improvement over a few years of life marred by bleeding and hospital visits. As Gross points out, however, it is not 'that [the patient] did not *understand* that her postoperative handicaps *were* offset by the prospect of a much longer life [my emphases]', rather she did not *agree* that the extra years of life did, in fact, offset the consequent 'lack of normal sexual functioning'⁷⁷. In other words, it is a dispute of value and difficult (more than likely impossible) to objectively decide: 'the observer... must ask whether it is self evident that this person's life will be significantly improved by treatment *and* whether it is conceivable that a reasonable person could think otherwise'⁷⁸.

The second of Gross' examples, perhaps not coincidentally, is fairly similar to the two cases described by Glick:

A 65 year old man enters the hospital for routine hernia surgery but following complications requires artificial ventilation. The patient pulls at his tubes [and] resists the ventilator vigorously [thus] making it difficult to wean him... the team decides that a tracheostomy will make the patient more comfortable and greatly increase the chances of successfully weaning the patient from the ventilator... However, it is difficult to communicate with the patient... Although... he understands his condition and is aware that he might die without intervention [he] seems distracted by discomfort. Without the tracheostomy the medical team sees little chance of successfully weaning the patient from the ventilator⁷⁹

In contrast to the first case, coercive treatment is, for Gross, acceptable for this patient because his refusal of treatment stems from a dispute of fact: '[the] patient has not rejected his post-treatment state because he is revolted by the quality of life it presents but because he is marginally competent [and] does [not] fully understand the implications of nontreatment' (namely, that a tracheostomy will help to wean him from the ventilator he finds so distressing); indeed, he will not give himself the opportunity to understand the implications (he 'dismisses his doctors with a wave of the hand' when they attempt to discuss the matter with him). As Gross puts it, treating this patient 'does not mean violating autonomy as much as it marks a refusal to surrender to ignorance'⁸⁰.

Gross at times writes as though this distinction is the only relevant one to be made in deciding whether to coercively treat a patient; his chief criticism of the IPRA is that '[as] it is written [it] does not distinguish between disagreements of fact and value, and... tends to ignore the former'⁸¹. In doing so he seems to suggest he still holds the view, unlike Glick, that where it is not diminished autonomy will still 'trump' other values. On this view, coercion is acceptable in the second case because the patient is 'marginally competent': '[he] has shown no ability to recount, explain, and defend his decision' and it is 'inconceivable that a reasonable person could think' that treatment is not the best option⁸². Similarly, it is not acceptable in the first case because the patient is acting with a full autonomy that offers 'compelling grounds for respect'⁸³. As it happens, Gross is probably correct that, in a conflict of a values and/or when a patient's autonomy is not significantly impaired by an inability or unwillingness to understand the nature of a proposed treatment, there can be no moral grounds for coercive treatment. However, he is more than likely incorrect to suggest that the

wrongness of such actions results from the violation of autonomy alone; instead, they may be seen to turn on a second concern that he identifies in considering coercive treatment under the IPRA: namely the possible harm done to the patient⁸⁴.

To illustrate this point further, we may recall our earlier discussions of treatment and nontreatment decisions, in particular that of the paraplegic motorcyclist refusing food and water in Chapter 9, and the elderly patient resisting attempts to provide medical nutrition and hydration in Chapter 10. In the latter, it is clear that the patient's progressive loss of mental ability means that her autonomy is at *best* marginal: it is highly unlikely that her violent resistance to and subsequent removal of a nasogastric tube expresses a decision that she could recount, explain and defend. In the former, the patient might (saving his depression) arguably be seen as engaged in what Gross would term a dispute of values with his doctors (it is certainly conceivable that a reasonable person could accept that *some* paraplegic people are able to find enjoyment and value in their lives, and still hold that this is and/or will not be possible *for them*). In neither case, however, does the decision not to treat centre around discussions of the principle of autonomy; rather, treatment does not go ahead because (in light of the patient's likely resistance in the first case, and both the patient's resistance and the possible need to perform cutdowns occasioned by the state of her arteries in the second) it would be, in Winkler's terms, brutal and without foreseeable end. The key principle in *these* dilemmas is, in fact, the much-neglected one of nonmaleficence.

Nonmaleficence is clearly not the only relevant principle in the cases discussed by Gross and Glick; nevertheless, we may argue that autonomy's *apparent* ability to 'trump' beneficence stems, not from considering this principle to be 'more equal than others', but from a (perhaps implicit) realisation that a patient's resistance to treatment is *likely to increase the level of harm involved*. It is perhaps not surprising that the three cases presented in these two articles in which coercive treatment seems most justified (and the two cases that we have considered in which it does *not* seem justified) involve similar kinds of intervention. In all of the former, the intervention does involve *some* harm to the patients, more so than if they accepted treatment willingly. Nevertheless, as Gross points out, '[the] indignity wrought by forced treatment is only one sort of indignity and does not entail a sweeping disrespect for dignity in general... the coerced patient is otherwise treated in a dignified manner by

the medical staff⁸⁵ (that Gross uses the language of ‘dignity’ rather than ‘nonmaleficence’ may be seen as contributing to his inability to develop this point further). It may be significant that Hurwitz suggests he may have had a different subsequent view of his own decision had Mrs. Thomas resisted being taken into hospital (‘[to] my relief, when the ambulance arrived she did not resist this course of action [my emphasis]’)⁸⁶.

If we consider each of the five cases described in the course of Gross, Glick and Hurwitz’ articles in terms of balancing concerns of autonomy, nonmaleficence and beneficence rather than as conflicts between autonomy and beneficence it is noticeable that in what seem to be the least problematic coercions not only is the patient’s ability to make an autonomous refusal either questionable or compromised, but the potential level of harm seems much lower. In Mrs. Thomas’ case, for example, not only was a cure virtually certain (and not noticeably more unpleasant than the infections to her ulcerated tumour), Hurwitz also considers the possibility that the patient’s ‘child-like’ attitude to medicine, hospitals and doctors may have *necessitated* her needing to be under ‘doctor’s orders’ to fully comprehend the nature of her treatment⁸⁷. In both of Glick’s examples, not only do the patients fail to understand the nature of the proposed treatment, but at least a significant proportion of the harm is transitory: the treatment is a temporary measure and the patient will not always require medical assistance to breathe (and in the second example, that the doctors waited for the patient to fall unconscious also avoided the patient suffering the indignity of forced sedation or causing physical harm to himself or others whilst resisting treatment). As we have already noted, Gross’ second example is very similar (again, the patient does not – indeed refuses to – understand the suggested treatment, which is intended to have the opposite effect from the one he fears). Notably, however, in the most problematic case (Gross’ first example) the patient appears to be acting with close to full autonomy (allowing, of course, for the emotional distress occasioned by her diagnosis) and, if treated, would not only be subjected to the harms associated with forced sedation and treatment, but to *irreversible* negative effects of this treatment: the patient would have to endure the reduced quality of life that she finds unacceptable for the rest of her days.

That the above examples suggest that a more nuanced reading of the way that principles interact in different situations may endorse some forms of coercive treatment does not necessarily mean that the provisions of the IPRA should necessarily be accepted. Its inability, as written, to effectively distinguish between disputes of fact and disputes of value is, as Gross suggests, one major drawback. The other is that, without explicitly incorporating the arguments described above it can be seen as a more straightforward endorsement of the idea that the state has a ‘duty to protect life at the *expense* of liberty and dignity [my emphasis]’ and thus of practices such as the force-feeding of prisoners and the application of what is (rather euphemistically) referred to as “moderate physical pressure” to ‘criminals (specifically, suspected terrorists)... during interrogation’⁸⁸. Moreover, any impact of the Act on the public perception of medicine, doctors and the state that could, conceivably, be harmful (with fear of unwanted treatment, for example, causing patients to hold back from consulting doctors or driving them into the ever-welcoming arms of quacks and charlatans) will (as with the ODWDA) need to be investigated and continually monitored. Nevertheless, as Gross suggests, despite these reservations the IPRA may at least offer an example of how these difficult decisions may be ‘[eased]... through a deliberative forum and thereby serve as a model for similar forums in other nations’⁸⁹.

This last point brings out one final, and very important element of such cases that is perhaps best expressed through Hurwitz’ account of his treatment of Mrs. Thomas. Glick is most likely correct that Hurwitz should be congratulated for his actions in this case; however, we may have some reservations over his apparent belief that the latter’s description of the case constitutes something like an apology. First of all, it is reasonably clear that the question ‘Did I apply undue pressure upon Mrs Thomas?’ is a good deal more rhetorical than Glick seems to realise: as noted above, Hurwitz does not always seem sure that he *did* meaningfully infringe Mrs. Thomas’ autonomy. More importantly, however, Hurwitz account shows the importance of conscientiously engaging with principles rather than simply applying them. First of all, in Beauchamp and Childress’ terms, he affirms their *prima facie* nature in accounting for an apparent breach of autonomy by both questioning its specification in the particular context, and by balancing it against the requirements of nonmaleficence (the low likelihood of Mrs. Thomas resisting being taken in the

ambulance), beneficence (the virtual certainty of curing her condition, the positive impact on her son's life) and (in his 'responsibility towards the community nursing staff and other patients... not to allow scarce and valued resources to be consumed by... futile and irrational treatment') justice⁹⁰. Moreover, in publicly discussing the case he both subjects his analysis to the judgement of others, and enables his own conclusions to be used in the discussion of other cases. It may, therefore, be the second element for which Hurwitz' receives Glick's congratulations, namely his 'raising the issue publicly'⁹¹, that is most significant: conscientiousness is not merely deliberative; it is also (perhaps necessarily) collaborative.

Conclusions

The two case studies above demonstrate, as we have suggested, the value of Beauchamp and Childress' approach (both in general terms, and with regards to the choice of principles) to particular problematic situations in medical ethics. In the first case, the principles suggest both specific actions (for example, considering the social status of the patient and their relationship with others in terms of recognising how best to respect their autonomy) and general concerns (for example, addressing the public perception of what medicine is able to do, and encouraging recognition of non-medical elements of health such as the importance of diet and exercise). Moreover, when compared to narrow, 'top-down' applications of traditional moral theories, this kind of approach may be seen to offer a fuller picture of the richness and complexity of our moral lives. In the second case, application of the principles not only ensures that our attention is drawn to the problematic elements of what may be morally necessary decisions (for example, the harm caused even by justifiable cases of coercion), but emphasises the need for open discussion of difficult cases and, perhaps, revisions to laws, rules and guidelines surrounding certain kinds of treatment. Furthermore, in helping to unravel the substantive questions surrounding such intervention, it reveals how the language of, and distinction between, beneficence and nonmaleficence may be more useful than a single principle of either beneficence or dignity.

In the case described by Westin and Nilstun, the analysis of the type we (and, it seems without realising, *they*) have carried out can reveal apparent conflicts to be, if not

illusory, then amenable to resolution through further reflection and specification. For similar examples, we may recall Daniels' hope that certain differences between contractarians and utilitarians could be resolved by negotiating around differences in underlying theories of the person, or Hoffmaster's that differences between doctors and nurses in a neonatal ICU could be resolved by negotiating around differences in underlying conceptions of medicine, as discussed in Chapter 9 (so, in this case, the dispute between autonomy and beneficence that Westin and Nilstun encounter might, as we have seen, be resolved by negotiating what both terms mean in this particular context). In the cases encountered in our discussion of the IPRA, however, further reflection and specification does not make the conflicts go away. Even allowing for Gross' (sensible and valuable) differentiation of disputes of fact from disputes of judgement, it may not be possible to reconcile the differing requirements of autonomy, nonmaleficence and beneficence, *however* complex our specifications of them are. Nevertheless, the kind of conscientious, discerning reflection required in specifying the principles is still likely to furnish us with a better understanding of the decisions we are making; in some we may find that even unimpaired autonomy does not override other elements (to return to *The Pot of Caviare*, the professor cannot ask the others if they wish to commit suicide since he knows that many of them will feel morally obliged to refuse⁹²; we may wonder if the Krakow doctor mentioned by Beauchamp and Childress faced a similar dilemma). In others, for example in Gross' second example, it may mean proportionally more (and could possibly continue to do so even in cases where the benefits were much greater and harms much smaller).

The value of this approach outside of the sphere of medical ethics remains to be seen. Certainly, it is highly questionable whether the norms, virtues and principles that are especially relevant to medical ethics will all be present, or of equal importance, in other sub-fields of applied ethics (business ethics, for example) or in discussions of ethics as a whole. Nevertheless, an account of the principles that incorporates these elements as part of a web of ideas seems to offer intriguing possibilities for the way in which philosophy may approach moral problems of other kinds, and to itself pose questions about both moral reflection (philosophical and otherwise) itself and our responsibilities in the social, historical and political contexts in which it takes place, and which it (and we) help to shape. Our account of the historical development of this approach seems to suggest that the process of moral reflection is unlikely ever to

reach a settled conclusion: the quest for Winkler's 'Holy Grail' may be, as Murdoch seems to suggest, of primarily symbolic value. Nevertheless, whilst not without dangers, it is very far from being a fool's errand. There remains, and is likely to remain, much difficult work to be done. Nevertheless, we have grounds to hope that it will be important and rewarding, and very unlikely to ever be 'dull'.

¹ Westin, L. and Nilstun, T. 'Principles Help to Analyse But Often Give No Solution – Secondary Prevention after a Cardiac Event' in *Health Care Analysis* 2006; 14 (2) 111-117 p.111

² Ibid. p.112

³ Ibid. p.111

⁴ Ibid. p.111

⁵ Ibid. p.113

⁶ Ibid. p.113

⁷ Ibid. p.114

⁸ Ibid. p.114

⁹ Ibid. p.113

¹⁰ Ibid. p.114

¹¹ Ibid. p.114

¹² Ibid. p.114

¹³ Ibid. p.114

¹⁴ Ibid. p.114

¹⁵ Ibid. p.115

¹⁶ Ibid. p.115

¹⁷ Ibid. p.115

¹⁸ Ibid. p.115

¹⁹ Ibid. p.115

²⁰ Waltho, S. 'Response to Westin and Nilstun' pp.119-20

²¹ Westin, L. and Nilstun, T. 'Principlism Revisited: Response to Simon Waltho' in *Health Care Analysis* 2006; 14 (4) 247-248 p.247

²² Westin, L. and Nilstun, T. 'Principles Help to Analyse But Often Give No Solution' p.113

²³ Westin, L. and Nilstun, T. 'Principlism Revisited' p.248

²⁴ Waltho, S. 'Response to Westin and Nilstun' p.120

²⁵ Westin, L. and Nilstun, T. 'Principles Help to Analyse But Often Give No Solution' p.113

²⁶ Westin, L. and Nilstun, T. 'Principlism Revisited' p.248

²⁷ Ibid. p.248

²⁸ Beauchamp, T.L and Childress, J.F *Principles of Biomedical Ethics (6th Edition)* p.388

²⁹ Westin, L. and Nilstun, T. 'Principles Help to Analyse But Often Give No Solution' p.116

³⁰ Westin, L. and Nilstun, T. 'Principlism Revisited' p.248

³¹ Waltho, S. 'Response to Westin and Nilstun' p.121

³² Westin, L. and Nilstun, T. 'Principlism Revisited' p.248

³³ Waltho, S. 'Response to Westin and Nilstun' p.122

³⁴ Westin, L. and Nilstun, T. 'Principles Help to Analyse But Often Give No Solution' p.116

³⁵ Westin, L. and Nilstun, T. 'Principlism Revisited' p.248

³⁶ Ibid. p.247

³⁷ Westin, L. and Nilstun, T. 'Principles Help to Analyse But Often Give No Solution'

³⁸ Westin, L. and Nilstun, T. 'Principlism Revisited' p.116

³⁹ Ibid. p.121

⁴⁰ Waltho, S. 'Response to Westin and Nilstun' p.122

⁴¹ Gross, M.L. 'Treating Competent Patients by Force: the Limits and Lessons of Israel's Patient's Rights Act' in *Journal of Medical Ethics* 2005; 31 (1) 29-24 p.29

⁴² Ibid. p.29

⁴³ Ibid. p.29

⁴⁴ Ibid. p.30

⁴⁵ Ibid. p.30

⁴⁶ Ibid. p.31

⁴⁷ Ibid. p.31

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- ⁴⁸ Ibid. p.32
- ⁴⁹ Hemingway, E. *The Sun Also Rises* (London: Arrow, 1993) p.29
- ⁵⁰ Gross, M.L. 'Treating Competent Patients by Force' p.30
- ⁵¹ Glick, S.M. 'The Morality of Coercion' in *Journal of Medical Ethics* 2000; 26 (5) 393-395 p.393
- ⁵² Ibid. p.393
- ⁵³ Glick, S.M. 'The Morality of Coercion' p.393
- ⁵⁴ Hurwitz, B. 'Pressuring Mrs Thomas to Accept Treatment: A Case History' in *Journal of Medical Ethics* 1998; 24 (5) 320-321 p.320
- ⁵⁵ Ibid. p.320
- ⁵⁶ Ibid. p.320
- ⁵⁷ Ibid. p.320
- ⁵⁸ Ibid. pp.320-1
- ⁵⁹ Ibid. p.320
- ⁶⁰ Ibid. p.320
- ⁶¹ Glick, S.M. 'The Morality of Coercion' p.394
- ⁶² Ibid. p.394
- ⁶³ Ibid. p.393
- ⁶⁴ Ibid. p.394
- ⁶⁵ Ibid. p.393
- ⁶⁶ Ibid. p.395
- ⁶⁷ Ibid. p.393
- ⁶⁸ Ibid. p.394
- ⁶⁹ Ibid. p.394
- ⁷⁰ Ibid. p.394
- ⁷¹ Ibid. p.395
- ⁷² Gross, M.L. 'Treating Competent Patients by Force' p.30
- ⁷³ Ibid. p.30
- ⁷⁴ Gillon, R. 'Refusal of Potentially Life-Saving Blood Transfusions by Jehovah's Witnesses: Should Doctors Explain that Not All Jehovah's Witnesses Think it's Religiously Required?' in *Journal of Medical Ethics* 2000; 26 (5) 299-301 p.301
- ⁷⁵ Gross, M.L. 'Treating Competent Patients by Force' pp.30-1
- ⁷⁶ Ibid. p.33
- ⁷⁷ Ibid. p.33
- ⁷⁸ Ibid. p.33
- ⁷⁹ Ibid. p.33
- ⁸⁰ Ibid. p.33
- ⁸¹ Ibid. p.31
- ⁸² Ibid. p.33
- ⁸³ Ibid. p.33
- ⁸⁴ Ibid. p.31
- ⁸⁵ Ibid. p.31
- ⁸⁶ Hurwitz, B. 'Pressuring Mrs Thomas' p.320
- ⁸⁷ Ibid. pp.320-1
- ⁸⁸ Gross, M.L. 'Treating Competent Patients by Force' p.30
- ⁸⁹ Ibid. pp.33-34
- ⁹⁰ Hurwitz, B. 'Pressuring Mrs Thomas' p.320
- ⁹¹ Glick, S.M. 'The Morality of Coercion' p.395
- ⁹² Conan Doyle, A. *The Pot of Caviare* p.4