



In praise of unprincipled ethics

J Harris

J. Med. Ethics 2003;29;303-306
doi:10.1136/jme.29.5.303

Updated information and services can be found at:

<http://jme.bmj.com/cgi/content/full/29/5/303>

These include:

References

This article cites 13 articles, 7 of which can be accessed free at:

<http://jme.bmj.com/cgi/content/full/29/5/303#BIBL>

7 online articles that cite this article can be accessed at:

<http://jme.bmj.com/cgi/content/full/29/5/303#otherarticles>

Rapid responses

You can respond to this article at:

<http://jme.bmj.com/cgi/eletter-submit/29/5/303>

Email alerting service

Receive free email alerts when new articles cite this article - sign up in the box at the top right corner of the article

Notes

To order reprints of this article go to:

<http://journals.bmj.com/cgi/reprintform>

To subscribe to *Journal of Medical Ethics* go to:

<http://journals.bmj.com/subscriptions/>

FESTSCHRIFT

In praise of unprincipled ethics

J Harris

J Med Ethics 2003;29:303–306

In this paper a plea is made for an unprincipled approach to biomedical ethics, unprincipled of course just in the sense that the four principles are neither the start nor the end of the process of ethical reflection. While the four principles constitute a useful “checklist” approach to bioethics for those new to the field, and possibly for ethics committees without substantial ethical expertise approaching new problems, it is an approach which if followed by the bioethics community as a whole would, the author believes, lead to sterility and uniformity of approach of a quite mindbogglingly boring kind. Moreover, much of bioethics is not concerned with identifying the principles or values appropriate to a particular issue, but rather involves analysing the arguments that are so often already in play and which present themselves as offering solutions in one direction or another. Here, as I try to show in discussion of these four scenarios, the principles allow massive scope in interpretation and are, frankly, not wonderful as a means of detecting errors and inconsistencies in argument.

In my response to Raanan’s four scenarios I would like first to record the fact that it was Raanan Gillon who first made me think of myself as a bioethicist.¹ This arose because I had written a paper on withholding and withdrawing treatment which I originally sent to the *Journal of the Royal College of Physicians of London*. The then editor of that journal wrote me a rather disdainful response as if my paper and its accompanying letter had created a rather unusual smell in his office. He told me that my paper seemed to be about medical ethics and that there was a journal for such papers called the *Journal of Medical Ethics* and that I should send my thoughts there. I duly did and received an enthusiastic, indeed thoroughly welcoming, response from Ra which both introduced me to the *Journal of Medical Ethics* and to the idea that I was writing in this distinctive and emerging field. It’s probable that that response of Ra’s and his subsequent encouragement radically altered my career, as I am sure his encouragement and promotion of bioethics has done for many others.

Having recorded this and having failed (here at least) to record many other debts I owe to Ra, I should emphasise that devotion to the four principles is something of which he has entirely failed to persuade me over the many years of our close friendship.

UNPRINCIPLED ETHICS

Here I would like to make a plea for an unprincipled approach to biomedical ethics, unprincipled of course just in the sense that the four principles are neither the start nor the end of the process of ethical reflection. The Beauchamp and Childress, and now one must say Gillon principles, in that they include some of the central ethical principles in all areas of human ethics, are bound to figure in any adequate discussion of the ethics of any issue. My worry is that starting and perhaps ending with just these principles may in many circumstances be inappropriate.

While the four principles constitutes a useful “checklist” approach to bioethics for those new to the field, and possibly for ethics committees without substantial ethical expertise (of which local research ethics committee is this not true?) approaching new problems, it is an approach which if followed by the bioethics community as a whole would, I believe, lead to sterility and uniformity of approach of a quite mind bogglingly boring kind. There are many ways of approaching and solving problems, and while in ethics generally and bioethics in particular, doing good, avoiding harm, protecting justice, and respecting rights and interests are never likely to be far from our minds, they are neither necessarily the best nor the most stimulating way of approaching all bioethical dilemmas.

Moreover, much of bioethics is not concerned with identifying the principles or values appropriate to a particular issue, but rather involves analysing the arguments that are so often already in play and which present themselves as offering solutions in one direction or another. Here, as discussion of these four scenarios will doubtless show, the principles allow massive scope in interpretation and are, frankly, not wonderful as a means of detecting errors and inconsistencies in argument. One is reminded of the Russian proverb immortalised for philosophy by Isaiah Berlin “the fox knows many things, but the hedgehog knows one big thing”. For the purposes of bioethics Ra acts as if he knows four big things (plus scope). Of course he knows much more than this and his writing would not be as lively and as stimulating as it is if he didn’t constantly improvise way beyond the four part harmony he advocates.

CASE I: COMMERCE IN TRANSPLANTATION

Let’s look then at the first of the two cases I wish to consider, which is selling kidneys for transplantation. The festspiel scenario summarising how Ra would analyse this says:

Correspondence to:
John Harris, Institute of
Medicine, Law and
Bioethics, School of Law,
University of Manchester,
Manchester M13 9PL, UK;
john.m.harris@man.ac.uk

Accepted for publication
20 June 2003

None the less overall the likely dangers of financial exploitation and of postoperative harm to predominantly poor donors/sellers, the likely increased risks to recipients of HIV and other infections, and the likely reduction in volunteer donors, will probably result in sufficient excess overall of harm over benefit for him [Gillon] to conclude that a legal ban would be justified.¹

This is a very interesting example of the four principles being rather unhelpful, since they do not enable Raanan to think more widely about the circumstances in which all of his objections based on the four principles might in fact be met. What we have here is a bioethicist moving from examination of the problem in the light of a set of principles to a conclusion, but without a mechanism for seeing that all of the principled objections that he finds to the sale of donor organs might be met by the employment of a regulatory framework to meet the principled objections and to put the appropriate safeguards in place. It is just this sort of checklist guarantee against overlooking possible important features of a case that the four principles are supposed to provide. As it happens, in conjunction with my colleague Charles Erin, I have proposed just such a regulatory mechanism.²

I have also proposed a different and perhaps even more radical solution to the problem of the shortage of donor organs. This solution was arrived at also without four principled benefit, and perhaps could not have benefited from those principles as we shall see. But first we need to remind ourselves of the motive for proposing such measures.

The shortage of donor organs and tissue for transplantation constitutes an acute emergency which demands radical rethinking of our policies and radical measures. While estimates vary and are difficult to arrive at there is no doubt that the donor organ shortage costs literally hundreds of thousands of lives every year. "In the world as a whole there are an estimated 700 000 patients on dialysis . . . In India alone 100 000 new patients present with kidney failure each year" (few if any of whom are on dialysis and only 3000 of whom will receive transplants). Almost "three million Americans suffer from congestive heart failure . . . deaths related to this condition are estimated at 250 000 each year . . . 27 000 patients die annually from liver disease . . . In Western Europe as a whole 40 000 patients await a kidney but only . . . 10 000 kidneys" become available. Nobody knows how many people fail to make it onto the waiting lists and fail to register in the statistics. Facts like these make strong measures imperative. If reflection on the four principles prevents us from seeing ethical solutions with adequate policy safeguards then the four principles are doing humanity a disservice.

First I will give my own solution and then a solution I worked on with my colleague Charles Erin. Here first is my solution—principled to be sure but not four principled.

This solution concerns the automatic availability of all cadaver organs—a measure, which I first advocated publicly in 1983.^{4,5} Since then I have made a number of other radical proposals.² Here I have followed the explanation of these ideas given in my paper, Organ procurement—dead interests, living needs.⁶

The automatic availability of donor organs

We need to begin by being clear about just what it is I propose and why. At the moment in the United Kingdom we have an "opting in" system (donor cards) and there has been some pressure for us to move to an "opting out" system which is sometimes called "presumed consent". In this latter case organs would be available for transplantation unless the potential donor had registered his or her objections to donation prior to death. Both of these systems give central place to the individual's right to determine what happens to his or her body after death. I challenge this assumption. I suggest that consent is inappropriate as a "gatekeeper" for cadaver donations.⁷

All the moral concern of our society has so far been focused on the dead and their friends and relatives. But there are two separate sets of individuals who have moral claims upon us, not just one. There is the deceased individual and her friends and relatives on the one hand, and the potential organ or tissue recipient and her friends and relatives on the other. Both have claims upon us, the claims of neither have obvious priority. If we weigh the damage to the interests of the deceased, and her friends and relatives if their wishes are overridden against the damage done to would be recipients and their friends and relatives if they fail to get the organs they need to keep them alive, where should the balance of our moral concern lie?

If we address this question seriously we must think what each group stands to lose. She is dead and past being harmed, except in the relatively trivial sense in which people possess interests that persist beyond their death and which can in some sense be harmed.^{8,9}

We must remember that while the organ donor may have a posthumous preference frustrated, or a posthumous interest ignored, and her friends and relatives may be distressed and upset, the potential organ recipient stands to lose her very life and her friends and relatives will have grief to add to their distress.

The four principles do not tell us how those interests that have been variously called "posthumous" or "persisting" or "critical" interests are to count when compared with the interests of existing individuals. These are the interests an individual has which can be said to survive their deaths and which might therefore be thought to have weight when considering what those whose interests they are claimed to be have at stake. This can be important.

It is tempting to think of the sorts of interests I have termed "critical" or "persisting" as contrasted with so called "experiential" interests—interests that we are aware of and aware of being either served or not served by what happens. Ronald Dworkin highlights this particular contrast, defining experiential interests as things we have an interest in because we like the experience of doing them. Critical interests on the other hand are those "interests that it does make . . . life genuinely better to satisfy" (p 201 ff).⁹

Although the question of whether such interests are to count and how much they count obviously falls under the dimension of the "scope" of the four principles, such principles do not help us in deciding questions of scope. To understand the scope of the principles we have to think about the question of whether morality is essentially "person affecting" and how this idea is to be understood.

Interests are "person affecting" when their satisfaction or frustration would be good or bad for the person whose interests they are. It is widely accepted in contemporary ethics that as Derek Parfit states, following Jan Narveson, the person affecting restriction can be defined thus:

This part of morality, the part concerned with human wellbeing, should be explained entirely in terms of what would be good or bad for those people whom our acts affect.¹⁰

So although what happens to my children, or my body after my death, can involve my critical interests in the sense that it contributes both to the success or failure of my life as a whole and to whether or not it has achieved the meaning with which I had hoped to endow it, such things are not person affecting, they are not good or bad *for me*, they do not affect my wellbeing because "I" no longer exist. I am simply not there to be affected one way or the other; my wellbeing cannot be affected because I am no longer "a being". In short, though in a sense my *interests* persist, "I" do not.

Cadaver organs should be automatically available

If, as I suggest, it was judged ethical for cadaver organs to be automatically available, (of course only as a result of democratic acceptance of the idea) neither relatives nor the former “owners” of the cadavers need be consulted about their disposal. This would remove the necessity for asking permission at a sensitive moment and hence the moral objections to so doing. People would, I believe, soon get used to the idea, particularly if there were to be a concerted campaign of education and argument.

Indeed it seems clear that the benefits from cadaver transplants are so great, and the harms done in going against the wishes of those who object, so comparatively small, that we should remove altogether the habit of seeking the consent of either the deceased or relatives. This would be another example of a small but significant class of public goods, participation in which is mandatory.

Mandatory and voluntary participation in public goods

It is widely recognised that there is clearly sometimes an obligation to make sacrifices for the community or an entitlement of the community to go so far as to deny autonomy and even violate bodily integrity in the public interest and this obligation is recognised in a number of ways.¹¹

All British citizens between 18 and 70 are liable for jury service, (although those over 65 may be excused if they wish). They may be called, and unless excused by the court, must serve. This may involve days, but sometimes months of daily confinement in a jury box or room, whether they consent or not. Although all are liable for service, only some, however, are actually called. If someone is called and fails to appear they may be fined. Most people will never be called but some must be if the system of justice is not to break down. Participation in or facilitation of this public good is mandatory.

There are many senses in which automatic cadaver donation involves features relevantly analogous, in particular to jury service. But the clearest case is that of postmortem examination. The courts can order examinations without any consents being required and despite the fact that these involve interference with the dignity of a dead body and the removal of organs. Of course postmortem examinations are not usually ordered out of simple curiosity, there are public safety and public policy considerations. It is important that the cause of death be known in case the same cause represents a further danger to the community whether that danger be in the form of a disease or contagion, or in the form of a possible murderer at large. I have recently discussed the ethics of postmortem examinations and of retained organs and tissue at some length. In the same place I elaborate the, of necessity rather brief, discussion here of posthumous interests and consent from dead people.⁷ But again related but more powerful considerations weigh in favour of mandatory cadaver transplants.

It therefore seems appropriate to consider mandatory availability of cadaver organs. The public interest in saving the lives of fellow citizens at risk is at least as urgent and as important as the public interest which justifies court ordered postmortem examinations. Moreover it is, I suggest, less damaging to civil liberties and less compromising of individual autonomy than—for example, compulsory jury service. I say nothing of compulsory military service, which is widely accepted in many countries. For although both jury service and postmortem examinations have justifications in terms of protection of the lives and liberties of citizens, so of course does the automatic availability of cadaver organs.

We can now turn to the second proposed solution to the shortage of donor organs which Raanan’s four principled approach rejects because it has paid insufficient attention to the way considerations of regulation and control affect ethics.

An ethical organ market

At its annual meeting in 2002, the American Medical Association voted to encourage studies to determine whether finan-

cial incentives could increase the supply of organs from cadavers.¹² In 1998, the International Forum for Transplant Ethics concluded that trade in organs should be regulated rather than banned.¹³ In 1994, with Charles Erin I proposed possibly the only circumstances in which a market in donor organs could be achieved ethically, and in a way that minimises the dangers normally envisaged for such a scheme.² See also our paper in the *BMJ* in 2002.¹⁴

To meet legitimate ethical and regulatory concerns, any commercial scheme must have built into it safeguards against wrongful exploitation and show concern for the vulnerable, as well as taking into account considerations of justice and equity.

The ethics of buying and selling organs and indeed other body products and services, surrogacy and gametes, for example, are bedevilled by hypocrisy. Objections to “commercialisation” and advocacy of “altruism”, in effect usually involve a highly artificial “enforced altruism” according to which everyone is paid and no one required to be altruistic but the donor. The surgeons and medical team are paid, the transplant coordinator does not go unremunerated, and the recipient receives an important benefit in kind. Only the unfortunate and heroic donor is supposed to put up with the insult of no reward, to add to the injury of the operation.

With a strictly regulated and highly ethical market in live donor organs and tissue, however, I believe all the moral dangers of a market can be satisfactorily addressed. We should note that the risks of live donation are relatively low: “The approximate risks to the donor . . . are a short term morbidity of 20% and mortality, of 0.03% The long term risks of developing renal failure are less well documented but appear to be no greater than for the normal population.”¹⁵ See also—for example, the paper by Bay and Herbert.¹⁶ In a study by Spital it was reported that in a sample of American life insurance companies, all would insure a transplant donor who was otherwise healthy, and only 6% of companies would load the premium.¹⁷ (I am indebted to Søren Holm for pointing me to these latter two sources.) And recent evidence suggests that living donor organ transplantation has an excellent prognosis, better than cadaver organ transplantation.¹⁸ See also the paper by Gjertson *et al.*¹⁹ and that by Terasaki *et al.*¹⁹ (I am indebted to Aaron Spital for pointing me to these three papers.)

An ethical market would look like this: the market would be confined to a self governing geopolitical area such as a nation state or indeed the European Union. Only citizens resident within the union or state could sell into the system and they and their families would be equally eligible to receive organs. Thus organ vendors would know they were contributing to a system which would benefit them and their families and friends since their chances of receiving an organ in case of need would be increased by the existence of the market. (If this were not the case the main justification for the market would be defeated.) There would be only one purchaser, an agency such as the National Health Service in the UK, which would buy all organs and distribute according to some fair conception of medical priority. There would be no direct sales or purchases, no exploitation of low income countries and their populations (no buying in Turkey or India to sell in Harley Street). The organs would be tested for HIV, etc, their provenance known, and there would be strict controls and penalties to prevent abuse.

Prices would have to be high enough to attract people into the marketplace but dialysis and other alternative care does not come cheap. Sellers of organs would know they had saved a life and would be reasonably compensated for their risk, time, and altruism, which would be undiminished by sale. We do not after all regard medicine as any the less a caring profession because doctors are paid. So long as thousands continue to die for want of donor organs we must urgently consider and implement ways of increasing the supply. A market of the sort outlined above is surely one method worthy of active and urgent consideration.

Neither of these proposals are obviously inconsistent with the four principles, but I am far from convinced that had I started with those principles, taken them, as Raanan urges, as my point of departure, these solutions would ever have emerged. The four principles impose a sort of straitjacket on thinking about ethical issues and encourage a one dimensional approach and the belief that this approach is all that ethical thinking requires.

CASE II: GERMLINE TRANSMISSIBLE GENETIC ENHANCEMENT

The second case I would like to discuss, is that of genetic manipulation to produce germline transmissible genetic enhancement. Ra considers the case of a germline therapy that might be successful in conferring resistance to HIV/AIDS¹. Here:

using the four principles approach [Raanan Gillon argues] that the technique should be accepted for clinical testing by willing and informed volunteers, even though it would involve both genetic enhancement and germline transmissibility

and he points out that

As with other examples ... by giving a different “weighting” to the conflicting principles, it is possible to come to different conclusions, despite accepting the same prima facie principles.

I have always been perplexed as to why it is an advantage that by fiddling the weightings of the principles one can come to radically different conclusions. It is almost an invitation to cynically shift priorities. It seems to me, however, that the four principles approach to the problem of genetic enhancements and germline gene therapy misses the main point. It is significant that Gillon says that we might find germline gene therapy to confer resistance to AIDS acceptable “[e]ven though it would involve genetic enhancement and germline transmissibility”. But why the “even though”? Ra has assumed the main point to be established, namely the prima facie undesirability of germline manipulation. I argued against any such prima facie rejection of germline manipulation in my *Wonderwoman and Superman*.⁸

Surely the main issue is: what are the ethical objections to either enhancing human capacities or to germline transmissibility. It seems to me that these are best discovered not by applying the four principles to the case but by reflection on what the “good” to be delivered by the health care system is,^{21 22} by analysis of the idea of enhancement, and by noting the continuum between removing or curing dysfunction and enhancing function. Here it seems to me that we also need to consider the consequences of our failure to enhance and our responsibility for those consequences. Here we need not the four principles, but an understanding of the lack of difference between acts and omissions and a theory of causal and moral responsibility. I have discussed virtually this example and came to the same conclusions as Ra, namely the acceptability of both enhancement and germline therapy but by a very different route.⁸ It seems to me that the crucial issue is our responsibility for what happens in the world. Crucially, where

we can make things better, where we can create a better world either by repairing or curing dysfunction (the business of the health care system) or by enhancing function, as in Gillon’s example, by conferring genetic resistance to HIV/AIDS, we should certainly do so.

Our obligations to do this are part of our responsibility to create the best possible world. Now it is true of course that this is also part of our responsibility to promote beneficence and to avoid maleficence, two of the famous principles, and the consistent application of those principles leads to the same result. Whether there is much to choose between the two so called methodologies in arriving at sound defensible and workable conclusions is doubtful.

Perhaps this is just a natural inclination on my part to “do it my way” and there is no doubting that Ra has made a major and a powerful contribution to the development of medical ethics, both through his own scholarship and his selfless encouragement and promotion of the work of others. But my own view for what it’s worth, is that this immense contribution is due more to a combination of his powerful intellect, his charm, and above all his good nature, tolerance, and generosity, than to his adherence to a particular methodology, which on his own admission, is compatible with a large number of incompatible conclusions.

REFERENCES

- 1 Gillon R. Four scenarios. *J Med Ethics* 2003;**29**:267–8.
- 2 Erin CA, Harris J. A monopsonistic market—or how to buy and sell human organs, tissues and cells ethically. In: Robinson I, ed. *The social consequences of life and death under high technology medicine*. Manchester: Manchester University Press in association with the Fulbright Commission, London, 1994:134–57.
- 3 Cooper dKC, Lanza RP. *Xeno*. Oxford: Oxford University Press, 2000: 7–17.
- 4 Harris J. In vitro fertilisation: the ethical issues. *Philos Q* 1983;**33**:217–38.
- 5 Harris J. *The value of life*. London: Routledge and Kegan Paul, 1985:ch 6.
- 6 Harris J. Organ procurement—dead interests, living needs. *J Med Ethics* 2003;**29**:130–5.
- 7 Harris J. Law and regulation of retained organs: the ethical issues. *Legal Studies* 2002;**4**:527–49.
- 8 Harris J. *Wonderwoman and Superman*. Oxford: Oxford University Press, 1992:ch 5.
- 9 Dworkin R. *Life’s dominion*. London: Harper Collins, 1993:ch 7.
- 10 Parfit D. *Reasons and persons*. Oxford: Clarendon Press, 1984:394.
- 11 Harris J. Ethical issues in geriatric medicine. In: Tallis RC, Brocklehurst JC, Fillett H, eds. *Textbook of geriatric medicine and gerontology* [5th ed]. London: Churchill Livingstone, 1998.
- 12 Josefson D. AMA considers whether to pay for donation of organs. *BMJ* 2002;**324**:1541.
- 13 Radcliffe-Richards J, Daar AS, Guttman RD, et al. International Forum for Transplant Ethics. The case for allowing kidney sales. *Lancet* 1998;**351**:1950–2.
- 14 Harris J, Erin CA. An ethically defensible market in organs. *BMJ* 2002;**325**:114–15.
- 15 Allen RDM, Lynch SV, Strong RW. The living organ donor. In: Chapman JR, Wight C, eds. *Organs and tissue donation for transplantation*. London: Arnold, 1997:165.
- 16 Bay WH, Herbert LA. The living donor kidney transplantation. *Ann Intern Med* 1987;**106**:719–27.
- 17 Spital A. Life insurance for kidney donors—an update. *Transplantation* 1988;**45**:819–20.
- 18 Hariharan S, Johnson CP, Bresnahan BA, et al. Improved graft survival after renal transplantation in the United States, 1988 to 1996. *N Engl J Med* 2000;**342**:605–12.
- 19 Gjertson DW, Cecka MJ. Living unrelated kidney transplantation. *Kidney Int* 2000;**58**:491–9.
- 20 Terasaki PI, Cecka JM, Gjertson DW, et al. High survival rates of kidney transplants from spousal and living unrelated donors. *N Engl J Med* 1995;**333**:333–6.
- 21 Harris J. What is the good of health care. *Bioethics* 1996;**10**:269–92.
- 22 Brazier M, Harris J. Public health and private lives. *Med Law Rev* 1996;**4**:171–92.