Theories of Bioethics

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A theory of biomedical ethics I take to be a comprehensive, systematic account of a general approach to addressing ethical questions in the medical or biological sphere. It may be from a religious tradition or a secular world view; it may be articulated by health professionals or by medical lay people. It may be limited to the medical sphere (as the Hippocratic ethic seems to be) or, more plausibly embedded in a more general ethical theory (such as Kantianism, utilitarianism, or Talmudic ethics).

If this is true, then medical or biomedical ethical theories are not limited to those articulated by physicians. Some medical ethical theories may be the exclusive province of physician groups--as the Hippocratic and World Medical Association's are--if one can call these approaches "systematic theories." Others go beyond theories generated by professional physician groups in several ways. First, not all medicine is practiced by physicians. "Medicine," taken in its broad sense, involves other professions--nursing, pharmacy, dentistry, and, especially in some non-Western cultures, shamans, "medicine men," or faith healers. A true biomedical ethic systematically addresses the norms of character and conduct for these other medical professional roles. Beyond that, we must recognize that most medical decisions in any culture are made by lay people: individuals concerned about their own health, lay surrogates, spiritual advisors, and public policy-makers such as judges and legislators.

From this perspective professionally-articulated physician codes are one sub-species of professionally articulated theories of biomedical ethics, which are, in turn, a species of the genus of theories of biomedical ethics. The most powerful and complete biomedical ethical theories have often been lay-articulated, derivative from larger, more coherent systems of ethical thought--religious or secular. Thus, to mention just one example, Roman Catholic moral theology presents a comprehensive ethical system for Catholic lay decision-making as well as health professional behavior articulated by a group of theological professionals who are medical lay persons. They draw on a more comprehensive epistemological and normative framework of Catholicism (1). Likewise, the Caraka Samhita presents the outlines of a comprehensive system grounded in the Vedic belief system and concepts (2).

Secular philosophical systems also have the potential of articulating a bioethical component to their theories. Secular Western liberalism has produced what is probably the most aggressive and successful challenge to Hippocratism as a bioethical theory (3). It includes concepts such as autonomy, equality of human worth, and respect for the individual that are absent from traditional professionally-articulated bioethical theories. Other secular thought systems including Marxism (4), libertarianism (5), and feminist thought (6) also have the potential for generating bioethical theories.

When I published A Theory of Medical Ethics in 1981 (7), I hoped to stimulate a movement among biomedical ethical theorists to articulate descriptions of these comprehensive theories. I admit that one of my chief purposes was to make clear to all--especially to physicians--that the old Pythagorean/Hippocratic ethical theory was only one among many competing theories and that it was, indeed, an anemic, implausible, and even dangerous ethical position, which modern human beings ought to find indefensible and offensive when compared to the richer, more complete, and more sophisticated ethical theories available.

Any general bioethical theory must address five key questions. Therefore, any theorist must speak to

when providing a full and systematic account of a particular theoretical approach to bioethics. Since this paper was first presented as part of a program focusing on the theme "Is Bioethics Love of Life?" I will illustrate how these elements of theory are relevant to the concept of "love" attempting to show how the concept of "love" functions as an ethical category and how it might fit into a general bioethical theory.

Five Central Questions for Bioethical Theories

As long ago as the mid-1970s I suggested that any comprehensive bioethical theory ought to address five critical questions (8). Let me put these forth as a guide for future theorizing. At the same time, I shall comment on what I believe are the prospects for international and cross-cultural agreement on the answers to these questions.

What Is the Metaethic of the Theory?

First, any theory must have a metaethical framework for understanding the meaning of the terms it uses and for explicating how one can have ethical knowledge. Religious bioethical theories have a metaethic that comes pre-formulated. The major world religions provide something of a cosmology, a metaphysics, and a way of knowing. They all provide definitive sacred texts and theories of authority. Protestantism, for example, has a theological framework and, most importantly for modern medical ethics, a doctrine of the "priesthood of all believers" that affirms that every lay person has the capacity to know, understand, and interpret the moral norms without relying on a priestly authority (9). It also hold that the key texts belong in the hands of the lay person. I think it is quite clear that modern Western medical ethics--both religious and secular--is heavily dependent on these metaethical premises. The patient's rights movement is little more than Protestant metaethics secularized and applied to medicine. Other theories incorporate other metaethics: Soviet era medical ethics with its reliance on the authority of the state and Confucianism with its emphasis on the wisdom of the great teachers are other examples (10).

Many secular philosophical theories also provide metaethical systems that can be appropriated for a medical ethic: Kantianism's reliance on reason and the British empiricist tradition reliance on experience are two examples. Stoicism's turn to natural law theory is another. Even Hippocratism has its own metaethic. It traditionally has considered only the professional group to be capable of understanding and articulating the norms for physician conduct, a view compatible with the Hippocratic tradition's Pythagorean origins, but incomprehensible either by modern democratic theories of knowledge or by religious authoritarian epistemologies (11). Hippocratism is also characterized by the view that only medical professionals are capable of adjudicating disputes about physician conduct--what most of us would see as naive at best and simple in-group self-serving protection, at worst.

These metaethical, metaphysical, and epistemological disputes have existed throughout history. I see no real hope that these questions will be resolved soon. Fortunately, it appears that it may be possible to reach convergence on the some other four great questions in ethical theory even if the metaethical issues are intractable.

Normative Theory I: What Is the Axiology (Theory of Value)?

Next come three core questions of any systematic bioethical theory--all at the level of normative ethics. These three questions spell out the content of the character and conduct that the theory requires. The first two may be as intractable as the metaethics. The third may turn out to be our best hope for cross-cultural agreement.

The first of the normative questions has to do with what is considered intrinsically valuable. It is the question of axiology. Almost all normative theories pay at least some attention to striving to produce good outcomes (12). Utilitarianism, for example, strives to maximize the aggregate net good; Thomistic Catholicism seeks to do good and avoid evil. Hippocratism commits the physician to maximizing the patient's welfare. This radical limitation of the good to that of the individual patient is unique in Hippocratic theory and extraordinarily controversial, especially in these days of managed care and health resource rationing. It would not only permit the individual physician to "game" the system by lying to an insurer, it would make such lying morally required (if it were necessary to benefit the patient). It would ban all systematic research conducted for the good of society. It would even proscribe public health efforts, especially those that came at the expense of a physician's patient--such as reporting a positive HIV diagnosis.

Whatever version of the pursuit of the good that a theory commits to, it must have a notion of what counts as the good. It must incorporate a version of a desire satisfaction view, a preference theory, or perhaps, as most traditional religions do, an objective theory of the good.

One of the great contributions of the modern period was the realization of how difficult it is for someone, especially a specialized professional, to know what will produce overall maximization of the good. Some Hippocratists short-circuit this problem by limiting the physician's attention to the "medical good." That, however, overlooks the fact that rational people are not interested in maximizing their medical good, at least when doing so comes at the expense of their overall good. All rational people will trade off some medical well-being for well-being in other spheres of life. Even more critically, even medical well-being is a complex concept. It includes prolongation of life, cure of disease, relief of suffering, and promotion of health in some mysterious combination. The important cases are those in which maximizing one dimension of medical well-being comes at the expense of another dimension, when relieving suffering comes at the expense of prolonging life, for example. No rational person would maximize any one of these dimensions of medical well-being in all imaginable circumstances.

One of the great contributions of medical ethical theory of the past twenty years has been the convincing demonstration that there is no way that the typical physician in the typical patient-physician relation can be expected to know what will best serve the interest of his or her patient. Thus even if it is morally correct for the physician to hold such a goal, it will be impossible to accomplish in the typical case. There is as little reason to expect international cross- cultural convergence on the theory of the good as there is on the metaethical questions. For those who remain committed to the idea that the physician's moral task is to maximize some entity's welfare, either the patient's or society's, this is a serious problem. For those more committed to patient autonomy and societal democratic decision-making, this may be of more marginal significance. They will see the health professional's moral duty to be the fulfilling of promises, the telling of the truth, or the following of just policy democratically determined rather than pursuing the good.

Normative Theory II: What Counts as Virtue?

The second major question in theory at the normative level is what should be considered praiseworthy character trait? This is often referred to as the theory of virtue (13). Regardless of what counts as good outcomes and what counts as right behavior, we often want to know what traits of character a theory affirms. For Plato the praiseworthy traits were wisdom, temperance, courage, and justice; for the Christian, Paul, they were faith, hope, and love or charity. But for other ethical systems other character traits predominate. For the "Islamic Code of Medical Professional Ethics," (14) there are seven virtues including kindness, mercy, patience, and tolerance.. For Homer the virtues included proper hatred of the enemy, the opposite of Christian ethics. They also included for women, proper subservience to husbands (15).

There is more divergence in bioethical theory regarding the virtues than any other question. There seems to be little hope of resolving the controversy. Fortunately, for much of what an ethical theory is supposed to do--guide proper conduct--agreement on the virtues may be unnecessary. Within close-knit communities--the family, the religious group, or the small town--we rightly worry a great deal about manifesting the proper virtues. We want our children, clergymen, and neighbors to act from praiseworthy motivation, not merely to engage in the right action. However, much of ethics, especially at the cross-cultural level, pertains to conduct among strangers. At this level, we are usually much more worried about what the stranger does rather than the disposition from which it is done. At most instilling a virtue becomes a cause to hope that right conduct will come more reliably. Given the enormous diversity over what constitutes the proper virtues from one culture to another, it may be hopeless to strive for international cross-cultural agreement. But it may not matter all that much anyway.

Normative Theory III: What are the Principles of Right Conduct?

The third question at the normative level of theory is in many ways the most critical. We would like to have some general norms for right conduct, norms that govern individual actions or rules that in turn govern actions. These norms are often called principles. When used in this technical way, a principle is not a value and it is not a virtue. It is a norm of right action, not an intrinsic good or a praiseworthy trait of character. Contrary to what some believe, there is no rule that there must be four principles. I favor seven in my theory (16); others support one (17), two (18), three (19), or five (20).

It is at this point that bioethical theory comes much closer to convergence at the international level. Almost all medical ethical theories make room some place for doing good for patients and preventing harm to them (what in the jargon are called the principles of beneficence and nonmaleficence). Most theories also make room for some non-consequence-maximizing principles such as veracity, fidelity to promises, and avoidance of killing of humans. Theories as diverse as the Islamic Code, Buddhist ethics, Talmudic law, and Engelhardtian libertarianism all make room for veracity or truth-telling. Most modern theories also include the principle of respect for autonomy. Different theories may get these principles into their system using different mechanisms. Some utilitarians, for example, do so through the use of rule-utilitarianism-a device that generates consequence-based rules regarding truth-telling, promise-keeping, and the like. Kantians may group several of these principles under the heading of respect for persons. Most theories also have some account of the way goods and harms should be distributed. This will appear under the rubric of the principle of justice.

There is room for considerable disagreement at the cross-cultural level in exactly how these variables enter a normative theory of right action. Utilitarians may find most of them derivative from the principle of utility; the Dartmouth theorists derive them from nonmaleficence--the "do-no-harm-without-good-reason" principle." Some, express these in the language of human rights rather than as principles. One way or another, however, the content at the level of norms for right action is remarkably similar from one medical ethical system to another.

Of course, there will continue to be differences at the margin, even some very important margins. Whether to make an exception to the avoidance of killing norm when the patient is suffering and voluntarily asks to be put out of his misery is one current controversy. What constitutes the proper pattern of distribution of the good in a theory of justice is another. However, we at least seem to have enough of a common vocabulary and an agreement on norms to be able to talk to one another and identify those marginal areas where we continue to disagree. The task seems much less formidable than trying to agree on the theory of the good or the theory of the virtues.

To the extent that love is a virtue rather than an action norm, this will have important implications its place in theories of bioethics.

What Is the Relation Between Principles and Cases?

The fifth and final critical question in a bioethical theory is how the principles, the norms for right conduct, relate to individual instances of behavior. Here we are at the level of casuistry (21). One very popular view among physicians and undergraduate college students is that the principles, as abstract general action guides, must be brought to bear on each moral situation making a bold, independent judgment about what is the right action without having the principles mediated through rules that are binding at the level of individual instances of action. This view, sometimes called situationalism, evolved as a backlash to what many perceived as an excessively rigid conversion of the principles into rules of conduct. This is a device for handling potential conflict among duties, for example, when one has promised to tell a lie or when knows that speaking the truth will result in a killing. A variant of this approach is seen among some principlists including my colleagues at the Kennedy Institute, Tom Beauchamp and Jim Childress, who hold that when the principles conflict, there must be a balancing of the weightiness of the competing claims (22). The result may be an act-utilitarianism or act-deontology.

Some who balance competing claims nevertheless give rules more status than mere guidelines. It can lead to a rule-utilitarianism or rule-deontology. Still others claim that these balancing approaches, even the approach that generates rules for a specific domain--sometimes called specification (23) --still permits too much bending of morality to the whim of the powerful. They claim that it would permit terribly offensive research using human subjects and grossly inequitable allocation of health resources, for example, if only the consequences to the society as a whole were good enough.

A full theory of bioethics will have to provide an account of how to move from principles to cases (or perhaps from cases to principles and back again). On this final question, once again we have nothing like agreement internationally. We do not even have agreement domestically. There was a time when liberals supported more situational approaches as a hedge against legalistic application of moral rules. More recently, the critics of establishment medicine from the radical left have turned hostile to act-utilitarian and act-deontological theories and specificationism, in favor of more old-fashioned rigid rule following, perhaps dressed in the respectable garb of the name given by philosopher John Rawls--the rules-of-practice view (24). They fear that situationalism opens the door too wide for those in authority--such as physicians--to impose their tailor-made judgments on the powerless and weak to use them as research subjects, withhold the truth from them, and divert resources rightfully theirs to others of higher status who treatment can be deemed more useful to society. The case can be made that more rigorous commitment to the rules is really the more radical view. Only recently have we seen another potential reversal in this oscillation between the rule-followers and the case-by-case decision-makers as the contemporary feminist bioethicists have moved once-again for a more "relationship-oriented" derivation of what counts as morally right conduct.

The Place of Love In Bioethical Theory

I shall close with some final comments on how the concept of love fits into bioethics at the theoretical level. It is hard to imagine how love would play a role in any of the metaethical issues. Love does not tell us anything about the source or grounding of ethics. Nor does it provide an epistemology. Likewise, only by a stretch is love relevant to understanding the relation of principles to cases. Joseph Fletcher the one-time Anglican ethicist who developed a 1960s version of situationalism claimed that love could guide an individual to move directly from the principle of beneficence to the right action in the individual case (25). He led the charge against rule-based ethics. He seemed never to grasp that love could also push people to inappropriate, irrational action. The real issue is where love might fit among the three central questions of normative ethics. Does it have a role in value theory, virtue theory, or the theory of right action?

Love is an ambiguous term. People can show love of things. They can love a food, a painting, or knowledge. Among the intrinsic values are pleasure, beauty, and knowledge. Here love seems to function merely as a synonym for "value" or "desire." When love is applied to a thing, it means nothing more than one places very high value on the thing. It is part of value theory. I think this applies to the idea of "love or life." (26)

Love also relates to the way an individual interacts with another human. It describes a disposition, a character trait. We have already seen that one interpretation of it (the Greek agape) functions in Christian ethics as a virtue, indeed the most important virtue. The issue, however, is whether it plays a similar role in the virtue theory of other ethics. We have seen it was not on Plato's list of virtues. It is not a key virtue in the code of the International Organization of Islamic Medicine (27) and is not even mentioned in the Oath of the Islamic Medical Association of the USA and Canada (28). It is not in Confucian ethics; that tradition generally mentions humaneness, compassion, and sometimes filial piety (29). Buddhist or Hindu ethics do not include it either. It is not mentioned in any physician-generated medical ethic. The Hippocratic Oath mentions purity and holiness; The Percivalian Code, tenderness, steadiness, condescension, and authority; the World Medical Association, "conscience and dignity" (whatever those might mean). The Nazi physicians went so far as to berate Christian ethics, claiming that love of the genetically afflicted would contaminate the gene pool by preserving the lives of the unfit.

New, feminist bioethical theory often emphasizes the virtue of "care." (30) A first question for us to address is whether the Christian virtue of love can be related to this virtue of care or to various other virtues such as compassion, benevolence, or humaneness. I do not see how these terms can be considered complete synonyms. If love has meaning for ethical systems other than the Christian ethic, we need to clarify what it could be and why these other virtue terms prevail.

More critically, if love is merely a virtue, it should only tell us what disposition or character trait of an actor is praiseworthy, not what behaviors are morally right or wrong. When Fletcher treated love and utility as synonyms, he was surely incorrect. Producing good outcomes-what is called for by the ethical principle of beneficence or utility-cannot be equated with acting lovingly. We know that because we know that someone can act so as to produce good outcomes in an unloving way. They may do so malevolently or merely because it promotes their own self-interest. They may even produce good outcomes by accident while trying to hurt someone. One may produce good results with evil intention or act in a loving way that results in nothing but harmful outcomes.

Beneficence is a principle of right action, as are justice and the other principles. Love is virtue describing the character of the actor. They are logically independent, even if one who is loving may tend to be more inclined to engage in right action. Moreover, to the extent that the physician is a stranger to the patient (and perhaps the patient's culture), merely being loving may leave one without any guide for action because one may not know either what is utility maximizing or how the principle of utility relates to other ethical principles in the ethical system of the patient or the patient's culture. Love may be crucial in certain special medical relations within a Gemeinschaft, a small, closed community. Love in a medical setting among strangers may turn out to leave both physician and patient without action guides. Worse than that, if it gives the actors a sense that moral self-confidence, it could be dangerous. It could leave the actors feeling they need pay less attention to moral principles, rules, and codes, because if they have love, they have everything.

Love, then, is an ethical concept closely related to only one of the five questions that any ethical theory must address. It is a candidate for the list of virtues. It is one possible answer to the question of what are

morally praiseworthy traits or character or virtues? It seems to have little to do with the other four critical question s in bioethical theory. It does not tell us much about the meaning and grounding of ethical claims or how ethical truths can be known (metaethics). It is not an intrinsic good the way knowledge, beauty, holiness, or health might be. It is not a norm for right action. It describes not characteristics of actions that are morally right-making, but rather a trait of human character that, according to some ethical theories, is praiseworthy.

Other concepts and terms in the language of ethics deserve similar analysis to see which of the five questions in ethical theory they address. Anyone who attempts to build or describe a theory in bioethics must examine each of these five questions.

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