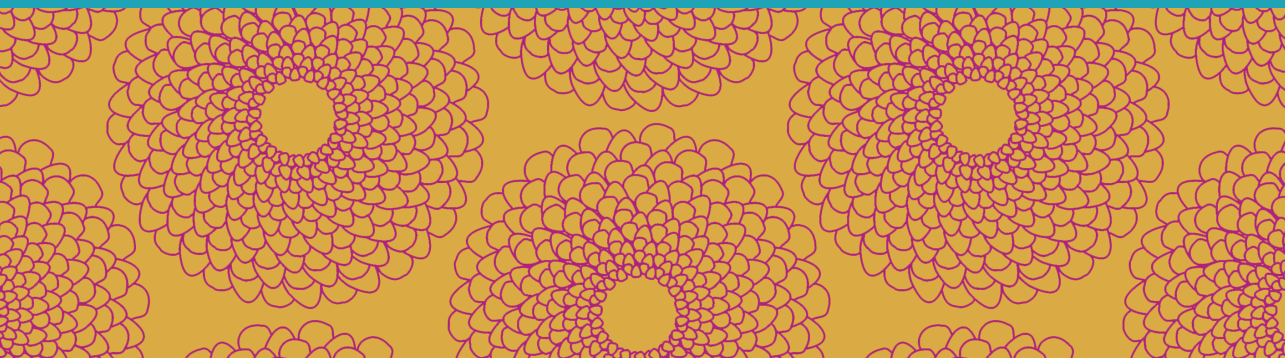


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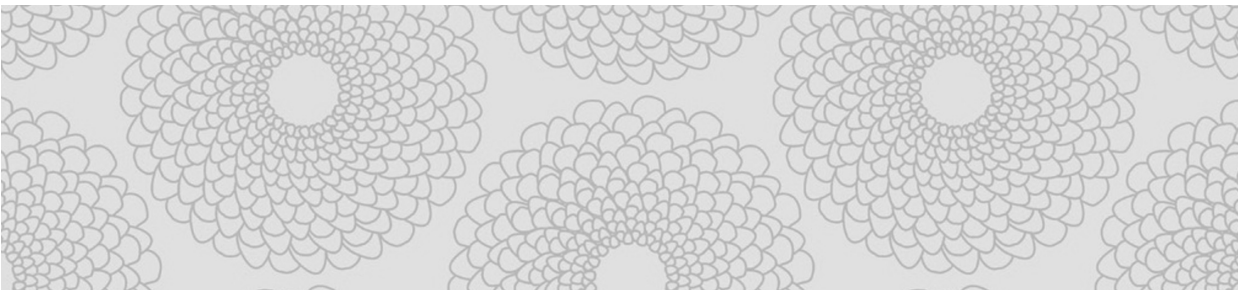


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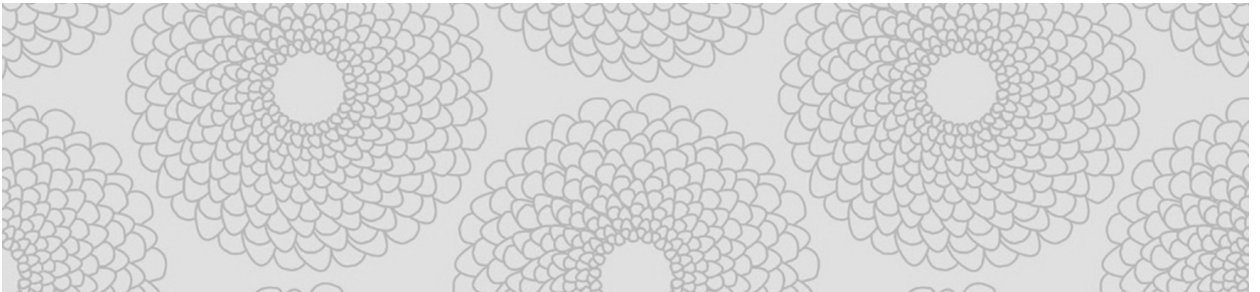
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Health Care Ethics in an Era of Globalisation

Ruth Chadwick, Henk ten Have and Eric M. Meslin

One of the most exciting recent developments in health care ethics is the way that the issues are becoming more international. Discussions about cloning, organ transplantation, reproductive health and health research are now regularly discussed by scholars, governments, advocacy groups, the media and the public in countries around the world. A growing body of research has emerged on comparative international approaches to issues – demonstrating that some of the early foundational work in health care ethics – initially in the U.S.A. and Western Europe, and then expanding to every continent – is now being challenged, amended and applied as countries (and of often different regions within countries) weigh in with different perspectives, strategies, arguments and approaches. International ethics has developed as a field of study in its own right, (Green Donovan and Jauss, 2009; Lavery, Wahl, Grady et al, 2007), suggesting that the implications of the global dimensions of health care ethics, in particular, have been found to merit specific study.

To a significant extent, this phenomenon has informed our choice of topics for inclusion in this *Handbook*. The volume begins with chapters dealing with theoretical perspectives relevant to the field, such as human rights and the ethic of care, and includes a discussion of anti-theory. More traditional areas of bioethics such as reproduction and end of life issues are then discussed. A group of chapters on vulnerable groups considers the principle of vulnerability in addition to specific issues of mental health, children, orphan diseases and poverty. Research ethics is discussed in the international context, and a set of chapters on technologies, including genetics, telemedicine and nanotechnology. The volume concludes with selections that broaden the debate to include environmental health and the pharmaceutical industry's impact on health care. Many anthologies exist covering these topics, of course. No anthology can be fully comprehensive, but we believe that collectively, the selections found in this *Handbook* represent both core and emerging issues in health care ethics in an era of globalization. Therefore, we feel an obligation to explain our rationale.

A WORD ABOUT TERMINOLOGY: MEDICAL ETHICS, BIOETHICS, HEALTH CARE ETHICS

We note that the issues and topics in this volume arose from a much longer tradition in bioethics generally. Indeed, bioethics has been defined in a number of ways. The American cancer specialist Van Rensselaer Potter (1911–2001) is usually credited with coining the term ‘bioethics’, using it for the first time in *Perspectives in Biology and Medicine* in 1970 (Potter, 1970), and repeating a version of it in the first chapter of his *Bioethics, Bridge to the Future*, published in 1971. Potter identified the need for a new discipline combining science and philosophy arguing that we needed to synthesise our biological knowledge of the science of living systems (hence “bio”) and our knowledge of human value systems (hence “ethics”). This synthesis would focus on the basic problems confronting humankind: population (too many people for a sustainable future on earth), peace (the tragedy of war and violence), pollution, poverty, politics (because of its lack of long-term views) and progress (because of the assumption that science and society will always develop in a positive direction). Potter’s called for an interdisciplinary approach was innovative at the time, but it was his global perspective that was especially profound. He argued that we should cross the boundaries between disciplines in order to look for ideas “that are susceptible to objective verification in terms of the future survival of man and improvement in the quality of life for future generations” (Potter 1970, p. 132). In retrospect, as Warren Reich (1994) argued, it is clear that Potter’s ideas about bioethics did not occupy much attention in emerging bioethics literature at the time, and yet the residual impact of Potter’s thinking could be found in many places. The wealth of activities undertaken by scholars promoting an approach to bioethics both as a new ethics of life sciences and health care and as a new focus of applied ethics could be seen in the growth of research centers around the world and through a growing literature.

Bioethics was new, although it emerged from an established history of professional medical ethics. Its topics were broader than those facing clinicians and patients – often associated with the dramatic developments in medical technology and health care, e.g. reproductive medicine, transplantation technology, resuscitation practices and the emergence of intensive care units in hospitals. In this sense, bioethics included a wider and more challenging set of issues than traditional medical ethics.

The precise range of the term ‘bioethics’ today remains a subject of scholarly debate – for some, as in its earliest (Potter) usage, it includes environmental issues, but discussion in bioethics still tend to focus primarily on issues in medicine, the life sciences, and new technologies, including those arising out of the Human Genome Project and its aftermath, which have given rise to an extensive discussion in civil society. It remains wider in scope than but still includes *medical ethics* but the term ‘Medical Ethics’ itself has been challenged in the light of the developing interest in issues related to health care professions other than medicine, in particular nursing.

The development of professional ethics standards in nursing, social work, pharmacy and other allied health sciences and the perception of these professions as accountable in their own right have led to the development of distinct professional ethical standards for each of them. To some extent it is difficult to draw precise boundaries between the different terms, as in common usage they are not infrequently used interchangeably. We have

chosen to use the term ‘health care ethics’ in this volume recognizing that it is not as precise a term as we would like. Below we comment on some of the debates concerning and challenges to bioethics, in so far as they are also relevant to health care ethics.

THE MOVE TO INTERNATIONAL ISSUES

We believe that the increased emphasis on the issues that may affect only one country, to those that affect many countries – and indeed the planet—reflects more than just a change in scope and scale. The move from domestic to international concerns may require a serious reconsideration of the way problems are framed, the way theoretical foundations are defended, and finally the way proposed solutions are assessed (Lansang and Dennis 2004). These effects have an impact on the ways in which particular issues are studied – most obviously for the conduct of health research, and for the distribution of limited health care resources – and also, potentially, on the theoretical foundations for the issues themselves. There are several examples of this phenomenon.

The increasing movement towards data sharing between different national biobanking initiatives, for example, has led to challenges for harmonisation not only in standards for data storage but also in relation to the appropriate ethical guidelines (see Chadwick and Strange, 2009). Similarly, health research is increasingly multi-centre and international, with growing numbers of research subjects recruited in economically developing countries, with more money being spent by more sponsors (government, private sector and philanthropies), more prospects of benefit and more challenges for reviewing and approving studies (Hyder, Dawson, Bachiani et al., 2009).

ENDURING ISSUES AND NEW CHALLENGES

As healthcare issues become more global in their reach, the legal and regulatory schemes to provide adequate governance have not always kept pace. In many cases, guidance differs; in other cases guidelines are absent. As the example of reproductive cloning demonstrated, when a new technology has been developed in one country, it is possible to apply the technology everywhere, even if some countries want to ban its use. This has led to concerns about the phenomena of health care and scientific tourism (Cohen and Cohen, 2010; Delmonico 2009; Turner 2010; Shalev 2010). Accepted rules for transplantation and organ donation, for instance, vary among countries and these different approaches have led to abuses such as organ trafficking and commodification of transplantation practices. Furthermore, the burdens and benefits of scientific and technological advancements are unequally distributed. Poorer countries run the risk of being excluded from the benefits of biomedical progress. What follows from this point of view, health care ethics should not only examine the differences among the moral standards in different countries – the values embedded in their cultures and religions – but also what they share in common.

Despite the fact that core issues continue to be important and that new issues are emerging, there have been a number of criticisms of the field as a whole that need to be addressed.

This anthology will not address them all, but we note a few that are discussed. It is sometimes claimed that bioethics will disappear or indeed that it has already had its day. What does this claim mean? It is difficult to believe that the questions covered by the field will disappear. Although it might be tempting to suppose that we will reach a time when they are ‘answered’, this is not normally thought to be in the nature of ethical questions – they are re-asked and re-interpreted along with social change.

Where new technologies are concerned, it might be thought, as has been the case with nanotechnology, that ethical issues associated with them simply represent a revisiting of the issues in other debate (see for example Crowe, 2008). Hence discussions tend to focus on whether there is anything different about them. If there is not, then that might lend credence to the suggestion that bioethics might disappear. In every time and place, however, questions will continue to arise about what we should do and how we should live, whether in relation to new technology or in relation to health care and the life sciences more broadly conceived.

Perhaps the claim, however, is not that the *issues* will cease to arise, but that bioethics may not be the appropriate discipline or approach to answering them. Again it is necessary to ask exactly what is meant by this claim. If the questions *constitute* the domain of bioethics then what can it possibly mean to say that it should not be ‘Bioethics’ that is involved in answering them? One can only give sense to the claim either in terms of bioethics being conceived in terms of one particular disciplinary approach, or in terms of an objection to the notion of some sort of specific expertise that constitutes ‘bioethicists’ as apart from any other disciplinary approach. There seem to be two distinct possibilities here. First, if bioethics is conceived as a branch of an existing discipline, Philosophy is a strong contender, as Ethics is traditionally a branch of Philosophy. Under this interpretation, criticisms of Bioethics as a field are directed against the monopoly of Philosophy in answering ethical questions and against the *way* in which it asks and answers ethical questions in this field (see below). Second, if Bioethics is not a discipline but a multidisciplinary field of study involving ethical, legal, social and philosophical aspects, things look rather different. The inclusion of both ‘ethical’ and ‘philosophical’ aspects here draws attention to the fact that in bioethics some philosophical questions arise that are not ethical e.g. epistemological questions about the limits of knowledge, questions of personal identity and so on.

A potential criticism of this conception is that to constitute such a field *as* a distinct field is a political act. Why should social questions not be addressed by social scientists, legal questions by lawyers, philosophical questions by philosophers? Why is there a need to define bioethics as a distinct field, if not to give a kind of status to those who engage in it? To those who take this view, the attempt to define bioethics by the type of questions covered is insufficient. For some of those who work in the field, however, bioethics is developing as a kind of meta-discipline. It is possible for those who specialise in bioethics to develop different disciplinary approaches to work beyond their home discipline. To engage properly and effectively in bioethics requires the ability to recognise the different and multiple dimensions that ethical questions have, and to be willing to work collaboratively with other disciplinary perspectives and methods.

Misunderstandings are apt to arise concerning the relationship between ‘bioethics’ and ‘bioethicists’. While many people work on ethical aspects of developments in health care and the life sciences (bioethics) then shouldn’t those people be called bioethicists?

Agreement on this has been difficult to achieve particularly when ‘bioethicist’ is taken to mean someone who has privileged expertise on the issues, and excludes others. So let’s be clear.

Under an interpretation of bioethics that construes it largely as a branch of [Applied] Philosophy, there are criticisms of bioethics that could come either from within Philosophy or from without. From within Philosophy, it is important to address Alasdair MacIntyre’s question as to whether applied ethics rests on a mistake (MacIntyre, 1984). If applied ethics is understood as ‘applying’ a set of principles, or a theory, to a practical problem or issue, there is a question as to how that question or issue is conceived, and who construes it as a problem. In the health care field, is it for the health care professionals to define the problem or for the philosophers?

While this is an important question, it will only count as a problem for an account of Bioethics that depends on this model of ‘application’. Critics of bioethics from outside the field of Philosophy may have similar concerns that ‘armchair philosophers’ may be trying to apply theories and principles that have very little relevance to real life practice. It is important to disentangle the particular contribution philosophical ethics has to make to bioethics, and the possibility for productive collaboration with other disciplines. On the other hand the external criticism may be based, not on worries about ‘application’ in general, but on the view that in bioethics particular approaches have been prioritized at the expense of others.

Critics do not always appear to be aware of the diversity of the field. The repertoire of philosophical theoretical approaches is diverse, and yet there is some truth to the idea that there has been a predominantly individualistic focus in bioethics in the first decades of its development. This does not mean, however, that bioethics *itself* is individualistic, and certainly not that it is overwhelmed by an autonomy-based approach. It is possible to find explanations of why bioethics has been primarily (though not exclusively) concerned with the individual to date, and why there is currently a turn to more overtly public health issues. What also has to be borne in mind is that these issues constitute lively debates *within the field*. It would be a mistake to operate with a picture of bioethics as a discrete and unified field being attacked by the critics. As the following quotation shows, there are voices in bioethics who are pointing to two challenges that need to be addressed:

how to shift to locus of bioethical dialogue to bring to the foreground implicit assumptions that frame central issues and determine whose voices are to be heard and how to sharpen the vision of a global bioethics to include the perspectives of the marginalized as well as the privileged (Donchin and Diniz, 2001,iii–iv)

The point about ‘framing’ in the above quotation is important, and leads to discussion of the next criticism, which is that any theoretical approach ‘frames’ the issues in a particular way, drawing attention to what the ‘framer’ considers to be the salient points of a situation. Such approaches, however, can be blind to the concerns that members of different public and community groups have, whether or not they are key stakeholders in some specific issue e.g. by virtue of being a member of a patient advocacy organisation. This is a crucial question for those who use theoretical approaches in bioethics to address, especially where it is claimed that the roots of a given theoretical approach lie in the ‘common morality’. Such concerns have been influential in the ‘empirical turn’ in bioethics, with social science taking an increasingly important role, leading to discussions about the relationship between the disciplines contributing to the field. This criticism, moreover, is not directed

only at academics working in bioethics, but also against members of policy-making committees in the relevant domain, who may, for example, think it adequate to address issues using scientific techniques of risk assessment without having regard to what may be more fundamental social concerns.

Bioethics has increasingly contributed to public policy (Meslin, 2010), yet beyond the discussion of what the role of an ethicist should be in public policy, there has also been criticism of the *performance* of bioethicists in public policy. They are criticised for both trying to ‘stop science’ and, alternately for not wanting to stop anything. Considerations such as these lead to the need to recognise the desirability and urgency of finding a way for bioethics to facilitate good research rather than perceived as burdensome and bureaucratic. It is also important, if it is to acquire and retain legitimacy that it not be conceived of as a tool to support particular political agendas or economic interests (Meslin and Goodman, 2010).

CAN GLOBAL HEALTH CARE ETHICS RESPOND TO THESE CHALLENGES?

What is distinctive and helpful about taking a global approach to health care ethics? Under one interpretation, it is simply that the issues addressed are global in scope. Health inequalities exist both within societies and between societies: a global ethic will be particularly concerned with the latter. The ways in which, for example, genetic information will be interpreted is closely linked with social conditions: for example, whereas in western countries there has been a considerable discussion about the insurance implications of predictive genetic information; in some countries prospects of stigmatisation may be much more immediate a concern, and may be highly influenced by gender. Discussions of the implementation of ‘personalised’ genomic medicine look rather different in varying social contexts. Take the issue of food, for example. The problems literally span the spectrum: food security, malnutrition, poverty, food safety are not limited to the impoverished economically developing world of lower and middle income countries. Similarly a poor diet leading to unhealthy lifestyles, obesity and an increase in diabetes are not limited to the economically developed countries of higher income. Worries about food security look different in different countries, although issues of malnourishment can apply in situations of both plenty and scarcity.

However, these examples arguably display a framing that is still *local* in scope – it is just that it shows awareness of differences across the globe which need to be taken into account. To be truly global in scope, the focus should perhaps be on global challenges requiring global *solutions*. Examples of such problems might be global pandemics, such as SARS or H1N1 (“swine”) influenza were feared to be. This leads to the suggestion that what distinguishes a global from a non-global ethic is that it applies a global *frame*. Whereas, as Heather Widdows points out, all applied ethics *can* be global (as is shown by the work of prominent philosophers who have contributed to the field, such as Peter Singer and Onora O’Neill), global ethics *must* be global (Widdows, forthcoming, 2012). Global ethics is not concerned with the interests of particular professional groups, it is concerned more with institutional and political factors, which other branches of applied ethics,

including bioethics, perhaps take insufficiently into account. Widdows makes the point that global ethicists are more likely to be found in political science departments than are applied ethicists of other varieties, and the priority moral/political concept is likely to be *justice* rather than, for example, autonomy, which has been so predominant in bioethics and health care ethics, at least for a major part of the second half of the twentieth century.

There is a question, then, about the extent to which there are particular theoretical approaches that are relevant in a global context. There have been debates, for example, about whether the 'four principles' of biomedical ethics can be transferred without difficulty from one culture to another (e.g. Holm, 1995). The challenges identified by Donchin and Diniz in the quotation above come from a feminist bioethics perspective, and it might be argued that such a perspective is particularly appropriate for some of the issues of global health ethics. We need, however, to examine the relevance to the present work of the phenomenon of the development of global ethics as a distinct field. Global bioethics poses specific theoretical and practical challenges related to the interaction between globalization and localization. If ethical principles are identified that are valid for all human beings regardless of gender, religion, nationality, race and bodily and mental constitution, how can at the same time the cultural diversity of humankind be taken into account?

The 1990s and 2000s saw considerable discussion about the possibility of a global bioethics, and the extent to which it is possible for principles to have global applicability. Again, however, there are different possibilities to be considered. One is the transferability of a set of ethical principles already alluded to above, and this is what has been at issue in, for example, discussions as to whether the four principles could form the basis of a global bioethic. Another is the question whether a different approach is appropriate. The principle of cosmopolitanism, for example, has been prominent in global ethics *per se*, but has not figured large in bioethics. It may be, however, that global bioethics requires, if not different principles, different priorities.

INTERNATIONAL ORGANIZATIONS

The globalisation of ethical problems and challenges is also reflected in the growing activity of international organizations in the field of bioethics. Nowadays, many of them have programmes and advisory bodies in the area of bioethics. Examples are the European Commission, the Council of Europe and the Arab League. UNESCO started its ethics program in 1993 with the establishment of the International Bioethics Committee (IBC), the first and until now only bioethics committee with a global scope and membership. Its Members States have adopted, unanimously and by acclamation on 19 October 2005, the *Universal Declaration on Bioethics and Human Rights*, affirming the commitment of the international community to respect a set of principles for humanity in the development and application of biomedical science and technology. With this new Declaration, for the first time a political commitment was made towards a set of *universal* principles in bioethics that could and should apply in all countries, regardless of culture, religion and tradition. The Universal Declaration also underscored the requirement to respond to the particular

needs of economically developing countries, indigenous communities and vulnerable groups or persons, reminding the international community of its duty of solidarity towards all countries.

What has changed in the last few years is that on the one hand a broader range of relevant ethical principles have been identified and adopted, and on the other hand a wide range of new issues and problems has emerged. The adoption of the UNESCO Declaration marks the evolution of a global perspective in the field of bioethics, since it underlines a broader set of ethical *principles*. The focus is not only on individually orientated principles such as respect for autonomy and human dignity, but also on principles that relate to the social and cultural context, such as the principles of solidarity and social responsibility, and even to the global context, such as the principles of benefit-sharing and protecting future generations. Instead of the critique that ethical principles usually reflect a particular cultural setting (traditionally the western one), there is now emerging agreement on ethical principles that take into account a really global perspective (Ten Have and Jean, 2009).

At the same time, new *problems* are on the agenda of bioethics discourse; – problems that previously were either non-existent or neglected. One example is ‘conflict of interest’, a concern that existed already but that has been exacerbated enormously due to the neoliberal intertwinement of industry and science. For many developing countries, topics as migration, organ trade, access to health care and medication, clean water and poverty are more pressing, daily problems. Another example is ‘dual use’, a new issue that has emerged recently as a result of bio-terrorism and security concerns.

Against this background of a broader set of ethical principles and a wider range of issues and topics for analysis and critical consideration, bioethics is in the process of being redefined as global bioethics. Curiously enough, some of the initial ideas of Potter are recurring in this new approach and conception of global bioethics. Potter’s emphasis that we need to bridge the present and the future is reiterated in the view of bioethics as a new interdisciplinary approach with a focus on long-term interests and goals that safeguard the survival of humanity. Potter’s argument that we also need to bridge nature and culture as well as human beings and nature invites us to regard bioethics as responsibility for the future and as a new ethics that takes into account the science of ecology and regards human beings as interrelated with their environment. Social, cultural and ecological problems are now definitely within the remit of global health care ethics.

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REFERENCES

- Chadwick, R. and Strange, H. (2009) ‘Harmonisation and standardisation in ethics and governance: conceptual and practical challenges’ in H. Widdows and C. Mullen (eds) *the Governance of Genetic Information: Who Decides?* 201–13 Cambridge: University Press.

- Cohen, C.B. and Cohen, P.J. (2010) International stem cell tourism and the need for effective regulation. Part I: Stem cell tourism in Russia and India: clinical research, innovative treatment, or unproven hype? *Kennedy Inst Ethics J.* 20(1): 27–49.
- Crowe, S. (2008) Understanding the ethical implications of nanotechnology. Highlights of a limited inquiry by the President's Council on Bioethics. Staff paper. http://bioethics.georgetown.edu/pcbe/background/nanotechnology_implications.html (accessed October 26, 2010).
- Delmonico, F.L. (2009) The implications of Istanbul Declaration on organ trafficking and transplant tourism. *Curr Opin Organ Transplant.* 14(2): 116–9.
- Donchin, A. and Diniz, D. (2001) 'Guest editors' note'. *Bioethics* 15 (3): iii–v.
- Gilligan, C. (1982) *In a Different Voice: psychological theory and women's development* Cambridge, Mass.: Harvard University Press.
- Green, R.M., Aine D., and Steven A.J. (eds.) (2009) *Global Bioethics: Issues of Conscience for the Twenty-first Century.* Oxford University Press.
- Grimshaw, J. (1986) *Feminist Philosophers: women's perspectives on philosophical traditions* Brighton: Wheatsheaf Books.
- Holm, S. (1995) 'Not just autonomy – the principles of American biomedical ethics' *J Med Ethics* 21: 332–338.
- Hyder, A., Dawson, L., Bachani, A., & Lavery, J. (2009). Moving from research ethics review to research ethics systems in low-income and middle-income countries. *The Lancet* 373(9666): 862–865.
- Knoppers, B.M. and Chadwick, R. (2005) 'Human genetic research: emerging trends in ethics' *Nature Reviews Genetics* 6: 75–79.
- Lansang, M., & Dennis, R. (2004) Building capacity in health research in the developing world. *Bulletin of the World Health Organization* 82, 764–770.
- Lavery, J.V., Wahl, E., Grady, C. and Emanuel, E.J. (eds) (2007) *Ethical Issues in International Biomedical Research: A Case Book.* New York: Oxford University Press.
- MacIntyre, A. (1984) Does Applied Ethics Rest on a Mistake? *The Monist* 67(4): 498–513.
- Meslin, E.M. (2010) 'Can National Bioethics Commissions Be Progressive? Should They?' In: Moreno, J. and Berger, S. (eds.) *Progress in Bioethics: Science, Policy and Politics* Cambridge MA: MIT Press: 143–160.
- Meslin, E.M. and Goodman, K.G. (2010) An Ethics and Policy Agenda for Biobanks and Electronic Health Science Progress <http://www.scienceprogress.org/2010/02/bank-on-it/>
- Potter, V.R. (1970) Bioethics, the science of survival. *Perspectives in Biology and Medicine* 14: 127–153.
- Potter, V.R. (1971) *Bioethics. Bridge to the future.* Prentice-Hall, Englewood Cliffs, New Jersey.
- Reich, W.T. (1994) The word 'bioethics': its birth and the legacies of those who shaped it. *Kennedy Institute of Ethics Journal* 4(4): 319–335.
- Shalev, C. (2010) Stem cell tourism – a challenge for trans-national governance. *Am J Bioeth* 10(5): 40–2.
- Sherwin, S. (1992) *No Longer Patient: feminist ethics and health care.* Philadelphia: Temple University Press.
- Singer, P. and Kuhse, H. (2009) *A Companion to Bioethics.* (2nd ed.), Oxford: Blackwell.
- Ten Have, H. and Jean, M. (eds.) (2009) *The UNESCO Universal Declaration on Bioethics and Human Rights. Background, principles and application.* UNESCO Publishing, Paris.
- Turner, L. (2010) "Medical tourism" and the global market place in health services. U.S. patients, international hospitals, and the search for affordable healthcare. *Int J Health Serv.* 40(3): 443–67.
- Widdows, H. (forthcoming, 2012) 'Global ethics: overview'. In: Chadwick, R. (ed.) *Encyclopedia of Applied Ethics*, 2nd edn. Oxford: Elsevier.

Methodology

Vittorio Hösle

INTRODUCTION

Ethics cannot, and does not want to, replace moral life. It is both logically and nomologically possible to be a moral individual without engaging in ethics; and it is also possible to be both a good ethicist and a vicious person at the same time. For ethics is nothing other than the theoretical analysis of the nature of morality: of the values and goods that are to be considered moral; of acts aiming at implementing these values; and of the habits (called virtues) from which such moral acts flow. It is the nature of ethics, as a practical discipline, however, to demand that its insights be acted upon. While engaging in a theoretical discipline like theology or mathematics is an end in itself; the whole end of ethics is to ask for acts in accordance with it. The vicious person who refuses to act according to valid ethical insights is no doubt a possibility and even a reality. But his behavior is condemned by his own insights.

On the other hand, the desire to act morally leads almost inevitably to ethical reflections. In times of rapid social change and institutionalized intercultural encounters, at least, what is morally demanded loses the obviousness that it enjoys in traditional societies. The desire to act morally entails the desire to know what is moral. But, for example in the aforementioned circumstances, such a knowledge cannot be gotten from one's own traditions alone, since their claim to teach what is moral no longer enjoys unquestioned plausibility, challenged as it is by new sets of norms and alternative traditions.

Thus, in both the ancient and modern world, philosophers like Socrates and Kant – who are clearly driven by a desire to act with integrity – engage in ethical research because they regard it as their moral duty to do so. Certainly, ethical and meta-ethical theories can also contradict each other, and this has led anti-theorists to ask for a return to traditional ethics. But this appeal does not solve the original contradiction between the various traditions. The only answer can be to work out an all-encompassing ethical theory that tries to make sense of as many moral traditions as possible. The moral sphere is founded in reason, not

in social facts; but social facts have to be interpreted as approximations to the demands of the moral sphere (see Hösle, 2004).

CONSISTENCY IN ETHICS

In some respects, the methods of ethics can be compared to those of jurisprudence. Jurisprudence logically presupposes, and ethics genetically starts from, a set of norms that are accepted by a society (legal norms having the additional property of being enforceable). Since these sets of norms have evolved over time and originate in different sources, they are not always consistent.

One of the first tasks of ethics is thus to eliminate contradictions between concrete applications of what have been called *prima facie* norms – contradictions at which already the historical Socrates seems to have pointed (at least both Plato and Xenophon ascribe to Socrates' such reflections). Examples of *prima facie* norms are: 'Do not lie', and 'Do not abet the killing of an innocent'. It is not difficult to find a situation in which both norms contradict each other in application: an innocent person has taken refuge in one's house from murderers who pursue him, and the murderers come to the house asking whether he is hiding in it. Let us assume that one has no chance to ward off the murderers (they may be a group of police agents of a totalitarian state) and that the refusal to answer would be interpreted as a positive answer. What is one supposed to do? Kant's (1797) famous answer is that one is not allowed to lie, since the duty not to lie is a so-called perfect duty, which does not bear exceptions and to which the duty to help other people is subordinated. Whatever one thinks of Kant's answer, the case discussed by him is a typical example of a moral dilemma, where different *prima facie* norms (or the different goods that are the basis of these norms, namely, human life and truth) seem to lead to contradictory norms for this concrete case: 'You ought to lie' – 'You must not lie'.

The use of terms like 'ought to' and 'must not' is typical of ethics. Even if it is controversial whether norms are originary, as Kant teaches, or themselves founded in values and goods, as the Aristotelean tradition assumed, it cannot be denied that an ethical theory needs deontic operators. Their use characterizes deontic logic, which outlines hypothetical rational commitments with regard to norms – if one accepts the validity of certain norms, then one is obliged to accept the validity of other norms. As Leibniz already understood, the three basic modal operators 'It is necessary', 'It is possible', 'It is impossible' are structurally analogous to the three deontic operators 'It is obligatory', 'It is permissible', 'It is forbidden'.

The system of modal logic that can be given a deontic interpretation is called D (on its logical peculiarities, see Hughes and Cresswell, 1996: 43 ff.). Ethics must not only avoid contradictions (as every rational theory must), for if they are allowed, in classical logic at least, anything can be proven; but, besides logical inconsistencies (A. \sim A), ethics must avoid also deontic inconsistencies like O (A). O (\sim A), i.e. cases in which both A and its negation are obligatory (see Kutschera, 1973: 29 f.). However, the two demands are equivalent, since logical inconsistencies, entailing everything, entail also deontic inconsistencies, and deontic inconsistencies immediately entail logical inconsistencies: If A is

obligatory, A is also permissible; and if $\sim A$ is obligatory, A is not permissible. Obviously, deontic logic presupposes that statements about norms can have different truth values. This does not preclude ethical statements from also expressing or exciting feelings; but this does not entail, as Ayer (1936) maintains, that ethical propositions have no factual (normative) meaning.

EMPIRICAL KNOWLEDGE IN ETHICS

The elimination of inconsistencies is of course only a necessary, not a sufficient, condition for the rationality of an ethical theory. A popular methodology for science has added empirical knowledge to logic. Would it not be sufficient to do the same for ethics? No doubt the empirical insight that something is a means to an end is of importance for ethics. If certain medical treatments save human lives and have no negative side effects, it is morally justified to engage in them. But of course the latter judgment can be regarded as the conclusion of a syllogism only if a normative or evaluative premise like 'You ought to save human lives' or 'Human life is a value' is added to the descriptive premise 'Certain medical treatments save human lives'. A normative conclusion can never be derived from a set of exclusively descriptive premises; at least one of the premises must be normative or evaluative in order to have a valid normative conclusion.

It is this combination that constitutes a so-called mixed syllogism. It is the merit particularly of George Edward Moore (1903) to have drawn attention to the epistemic difference between statements which claim that something is a means to an end or that something is a consequence of an act (assertions that are open to empirical validation) and statements claiming that something has intrinsic value (which cannot be verified or falsified by experiments). According to Moore, and similarly Max Scheler (1913/16), intrinsic values can only be grasped by a non-discursive value intuition. The main problem of intuitionism is that there is hardly a way in which people with different value intuitions can be brought to an agreement; they will probably end only by reproaching the other with value blindness. Furthermore, the canon of values developed (e.g. by Moore) smacks of the specific limits of his time. Even if, according to Moore, there are no reasons for such intuitions, it is not difficult to find causes why a man linked to the later founders of the Bloomsbury Group defended the values that he set forth in his ethical works.

But could one not try to reduce statements about something being intrinsically valuable to empirical statements, e.g. by claiming that something has an intrinsic value if it enhances the happiness of the person who accepts that value? Before Kant severed the link between ethics and happiness, the millennial eudaimonistic tradition of occidental ethics had usually argued this way and thus avoided some of the typically modern epistemological difficulties. However, that link could be read in two different ways: either as the statement that acting in the morally right way would cause happiness, or as the naturalistic definition of the good as that which is conducive to personal happiness. The ethical tradition before Kant often oscillated between the two positions, and while the first reading made better ethical sense, the second solved the problem of the foundation of ethics by transforming ethics into the empirical discipline of a prudential quest for personal happiness.

But the price is far too high – the latter eudaimonistic conception simply misses the peculiar nature of the ethical demand. There may be an excuse if someone acts against a duty because this would have involved too much of a sacrifice of his/her personal happiness, but this does not entail that the corresponding duty does not exist. One has therefore to pay the price of greater epistemological complexity and recognize that ethics cannot be based solely upon hypothetical imperatives that tell us which means are necessary in order to achieve certain ends, even if the end is as universally shared as personal happiness.

Ethics essentially needs a categorical imperative – so much must be granted to Kant, even if one does not share either the concrete content of his imperative or the formalist nature of his ethics.

LIMITS OF EMPIRICISM IN ETHICS

How does one arrive at basic ethical principles? They cannot be deduced from other principles, since they are the starting points of any ethical deduction; nor can they be gotten from experience; and the mere appeal to intuition is equally unsatisfying. Let us look at the previous example concerning contradictions between the application of *prima facie* norms. First, it is obvious that there are various, equally consistent ways of eliminating the contradiction; but hardly all are equally acceptable. Kant's solution to the above-mentioned dilemma is consistent; but it would also be consistent to aver that the protection of an innocent life is of a higher value than sincerity toward criminals to whom we do not owe it. In order to justify one type of solution against another, it is, second, helpful if one can appeal to a principle of higher generality, as e.g. a doctrine about the relation between omissions and actions or a rank order of values. While in our development we start from convictions about the moral nature of certain individual acts and slowly develop more general principles, it would be a misrepresentation of the nature of ethical reasoning if we assumed that such general principles are inductively acquired from a set of original convictions regarding concrete cases. It cannot be discussed here whether the natural sciences are based on induction or not; for the sake of the argument, some form of falsificationism may be granted. But even according to the latter, it remains true that a scientific theory must render justice to each and every relevant fact; a single counterexample destroys the claim that there is a valid law of nature. (I abstract here from the fact that experiments falsify always only a conjunction of hypotheses, never a single hypothesis.)

In ethics, however, an analogous principle does not hold. The normative nature of the discipline entails that ethical claims are not refuted by the fact that the norms they defend are often violated in reality. Even more: not only the wide diffusion of a certain behavior, but also the wide diffusion of the conviction that this behavior is moral is not sufficient to warrant the legitimacy of this belief. This means that, in principle, an ethical theory has the right to be taken seriously even if it violates widespread moral intuitions. (This is one way of interpreting Hume's famous law; see 1739/40: 177 f.) Indeed, as we have seen, moral intuitions have changed – suffice it to mention the attitude regarding slavery or women's political rights.

Thus, an 'inductive' approach to ethical principles from concrete judgments on single cases may render justice to the ontogenetical and phylogenetical moral evolution, but it

does not solve the question of the validity of moral principles. Rawls' concept of 'reflective equilibrium' (1971: 46 ff.) rightly insists on the reciprocal adjustment of concrete judgments and general principles, but it does not say enough about the intrinsic criteria that justify general principles. (Rawls himself is seduced by the prospect of inventing a fictitious situation in which rational egoism may be brought to accept principles of justice that he himself regards as valid.) No doubt, an ideal ethical theory will try to satisfy two different criteria: it will not give up widespread moral intuitions without good arguments, but it will be willing to reformulate our moral convictions if this is entailed by principles that are simpler and better connected with general features of our rationality than their alternatives.

THE PRINCIPLE OF UNIVERSALIZABILITY

One such principle is the principle of universalizability: something is obligatory, permissible, or forbidden for a person if and only if, *ceteris paribus*, it is obligatory, permissible, or forbidden for all other persons. The '*ceteris paribus*' is an important limitation, since, of course, every reasonable person recognizes that in a complex society different persons must have different rights. In particular, medical ethics cannot abstract from those asymmetric features of the physician–patient relation that are grounded in the superior knowledge of the physician and constitute a form of vertical responsibility. But in a universalistic ethics the burden of proof is always with those who claim there is a legitimate exception to the principle of equality and symmetry, e.g. because it is in the interest of the patients not to enjoy the same rights that are granted to the physicians.

Limited to all persons within certain groups characterized by the same gender, age, and rank, the principle of equal rights is a basic human principle of justice. But in its universal formulation, this principle is a result of modern Enlightenment. One cannot understand the enormous changes in the legal and political systems brought about in the last three centuries (on these, see Israel, 2001) if one does not interpret them as consequences of this moral principle. Kant has been seduced by the importance of the principle of universalizability to try to reduce ethics to it. But utilitarianism also, the other main modern ethical theory, is committed to it, since in its normative preference relation the utility of each person receives the same weight. The principle is not based on formal logic, since it would not be contradictory to ascribe certain rights only to oneself. But it remains true that a theory is more rational if it is free of indicators like 'me'. It is also true, as discourse ethics has stated, that a universalistic theory can be communicated more widely than a particularistic ethical theory, not to speak of a theory that denies the existence of moral obligations.

Thus it smacks of a performative contradiction to publicly proclaim that nobody has duties toward others, since it cannot be in the interest of the rational egoist to transform people who still accept obligations toward him/her into rational egoists – it is only a sense for universalistic justice that drives him to teach such a doctrine. The idea that any ethical theory that claims to be true must in principle be universally communicable and open to criticism by everyone has been articulated with particular force by Karl-Otto Apel (1973) and Wolfgang Kuhlmann (1985). This, they argue, is the only way to give the principle of

universalizability a transcendental foundation. Such a transcendental justification must not be confused with a deduction from axioms.

But even if under conditions of modernity only ethical theories committed to the principle of universalizability can be taken seriously, this does not mean that the principle is a sufficient condition for an ethical theory. It inevitably favors symmetric relations, but does not exclude symmetric brutality. Kant, however, claims in the *Grundlegung zur Metaphysik der Sitten* (1785) that the categorical principle can be formulated in three different, but (as he erroneously thinks) logically equivalent versions. One of these consists in the injunction to treat humanity – whether in one's own person or in the person of any other – never simply as a means, but always at the same time as an end. Now, a symmetrical instrumentalization is not logically incompatible with the first formulation of the categorical principle.

But Kant seems to believe that the categorical nature of the moral imperative, which is not a means to achieve anything else, is communicated to those who are able to act according to the categorical imperative, i.e. persons. They must therefore be regarded as beings with intrinsic value. This conclusion should be also accepted by those who do not share Kant's conviction that persons (whether human or not) are the only beings with intrinsic value. For the latter conviction entails that, e.g. plants, animals, ecosystems, can only have an instrumental value for humans.

MATERIAL GOODS; DECISION THEORY IN ETHICS; INTENTIONALISM

Kant's recognition of the intrinsic value of persons is an important step beyond pure formalism. But it seems necessary to add a list of goods to a concrete ethical theory. However, such an ethics of goods should not be conceived as an alternative to a universalistic ethics: whoever wants to avoid the possible return of a justification of slavery is well advised not to idealize Aristotle, but to integrate the insights of ethical theories based on goods into a universalistic framework. (While Kant rejects the priority of the concept of the good in favor of the concept of duty, he has an elaborate doctrine of virtue. Therefore, an interest in the concept of virtue does not at all recommend a rejection of the Kantian approach.) Some of the basic goods of ethics can be justified with transcendental arguments. Freedom of action and truthfulness, for example, seem indeed to be transcendental presuppositions of any argument (see Gewirth, 1978; Illies, 2003).

One of the major problems of an ethics that recognizes a plurality of goods is how to put them in a plausible hierarchy. The development of comparative concepts is for ethics no less important than the development of classificatory concepts. One basic argument in this context is that a good is more important if it is a necessary presupposition of another good. To give one example: life is more fundamental than property, since property cannot be enjoyed without life. Thus many legal systems do not criminalize the violation of another's property if the violation is necessary to save a human life. It is one of the merits of utilitarianism (compared with Kantianism) that it offers a plausible account of legitimate violations of *prima facie* norms. But the problem of hedonistic utilitarianism is that it usually assumes that all goods must be reduced to a basic unity, which may be called 'pleasure'. Thus, even if the life of an innocent person is a higher good than, e.g. sexual pleasure, as

long as we accept the Archimedean axiom (for all $m < n$, there is an a such that $(a \cdot m) > n$), that life will be a lesser good than the appropriate multiplication of that pleasure. In order to avoid this consequence, the introduction of non-Archimedean goods is required.

However, even if one grants that, in principle, a ranking of different goods is possible, every realistic ethicist will grant that tragic conflicts cannot be excluded. There are at least three different reasons for their emergence. First, there may be a conflict between goods of similar rank. Or one can think of situations in which one has, due to a personal commitment, a stricter duty to preserve a lower good than one has the duty to care for a higher good. In fact, universalism need not deny that there are specific duties toward some people (e.g. the members of one's family) that take precedence, as long as one recognizes that every person is in the same predicament with regard to the members of one's family. The third type of a tragic conflict is given when the expected moral value of two possible actions may be very similar, since the action that is intrinsically better may be turned by a probable event into a calamity.

The term 'expected value' stems from decision theory and game theory, which are powerful tools of ethical analysis, even if they are amoral theories. But they are amoral, not immoral; they do not exclude moral preferences and can thus teach a moral agent what action under conditions of risk or uncertainty is the most rational. In the case of decisions under uncertainty, i.e. when no probabilities can be ascribed to the possible events that will determine the different outcomes, there are good moral reasons for exercising the maximin principle, i.e. for choosing the action with the least negative outcome, particularly if the negative consequences threaten people who would not benefit from the advantages in the case of the positive outcome. It is furthermore hard to deny that acts of omission are not on par with other possible actions, insofar as people are less responsible for them than they are for actions. At least this is so in the case where one has not undertaken a concrete responsibility. For example a physician who intentionally omits to save his patient becomes almost as guilty as if he had killed him; but a bystander does not have an analogous responsibility, because he never accepted a concrete obligation as did the physician.

The development of ethical theory in history is not only characterized by an increased awareness of the universalistic nature of any acceptable set of norms. Another dimension of ethical theory that has developed throughout the Middle Ages and modernity is the insistence that the proper subject of moral predicates is the intention of the agent. A physician may cause the death of a person; if his intention was to cure the patient and he could in no way have foreseen that his therapy could possibly cause the death, he is not to be blamed, not even for negligence. But even more: the last source of morality is not to be found in the intention either, but in the motive on the basis of which someone forms his intention. Thus we have to ask: Does someone help another for egoistic reasons, or because he thinks that this is the right thing to do, independently of any advantage for him? As plausible as this point of view is, it seems to have seduced Kant to believe that only acts of the will can be morally evaluated. However, an act of the will is subjectively moral if it aims at something that is objectively right, and if the person competently uses the means that are generally believed to effectively bring about what is objectively right. A comprehensive ethical theory has to recognize a large variety of ethically relevant goods: one of the varieties of goodness, e.g. is medical goodness (see von Wright, 1963: 51 ff.). Furthermore, the general defense of intentionalism should not prevent a person from

supporting what is objectively right, even if other people do it for the wrong reasons. In relation to oneself, one has to work on one's motives; but if one can achieve a higher level of public health only by appealing to the egoistic motives of society at large, it would be irresponsible to forego appealing to them.

ABORTION AS AN EXAMPLE

The rejection of the naturalistic fallacy entails only that it is wrong to think that something ought to be only because it exists. It does not at all entail a lack of intrinsic value in something, only because it exists. On the contrary, the evaluative or normative qualities of something supervene on its descriptive qualities (see Hare, 1952: 80 ff.), and one cannot be obliged to aim at the impossible. This has the important consequence that, in order to justify the different moral statuses of two things, morally relevant differences on the descriptive level have to be shown. What 'morally relevant' means is not easy to determine; but this qualification of the differences cannot be renounced, since otherwise the principle of universalizability could easily be circumvented. The racist, for example, would simply say that political rights can only be granted to a person of a certain race. However, it is easy to object that this difference is morally irrelevant.

On the other hand, one may reasonably argue that convicted criminals should be deprived (at least as long as they are in prison) of their political rights, since they have forfeited them through their crimes. The main – purely ethical, not at all religious – issue at stake with regard to the question of the moral legitimacy of abortion is whether one can find a characteristic that applies to human embryos (or even fetuses), but not to human infants. The trait 'not yet being born' seems arbitrary, particularly since it depends on contingent facts of whether someone is born after six or nine months. Moreover, arguments that point to the fact that the embryo could not survive outside of the womb can easily be countered by the claim that infants are equally unable to survive without the help of adults. Even insisting on the fact that consciousness begins only after the first trimester seems unsatisfying, since the conscious life of the fetus, but also the infant, is hardly more complex than that of an adult ape. If one points to the potential development of the infant, this argument applies to the embryo as well. And indeed, the potential development distinguishes the embryo significantly from the patient with irreversible brain death.

The abortion issue, however, is more complex, since the proper ethical issue must be distinguished from the question of what a moral legal system should determine. I do not have in mind the factual legal systems of the various countries, but the philosophical question of how a just legal system should be structured. The tradition has used the term 'natural law' to name such a just legal system, and it is obvious that many questions of medical ethics involve a concept of natural law. For they do not simply ask what the physician – as a benevolent private individual – should do, but also what a reasonable system of public health should enforce by appropriate legal means.

Now, it is clear that not all moral norms can, nor should, be enforced by the state. Thus, the sphere of inner convictions and actions that express it (i.e. religious duties) must not be enforced by the state. Furthermore, since legal enforcement is costly, and the state has

a duty to be as parsimonious as possible in using citizens' taxes, the state will have to limit its enforcement actions. Criteria for economic rationality are always appropriate when dealing with scarce resources – and legal enforcement is indeed a scarce resource. Even if someone believes that abortion is morally wrong, and that the state has a duty to protect human life in its early forms, he/she may still hold that, in an age when people can easily go abroad, the possibility of the state to protect the embryo's life against the mother's will is extremely limited and that criminal prosecution is not the most efficient way to achieve this end. (I am speaking of the first trimester when the pregnancy is not yet visible.) In any case, the difference in perspective between ethics and natural law is one of the issues that makes the methods of ethics as complicated as they are. This is unfortunate for the person who desires a quick decision, but fortunate for the professional ethicist trying to draw subtle conceptual distinctions that map the intricacies of the moral world.

SUMMARY

Ethics is a rational discipline. Its first task is to eliminate inconsistencies between the various norms and evaluations one can find in any given culture. This, however, is only a necessary, not a sufficient, condition for the rationality of an ethical theory. How can its norms be positively justified? Within a mixed syllogism, some ethical norms can be deduced from a set of premises including descriptive ones (if the set also includes at least one normative, or evaluative, premise). The most general normative premises are either unjustifiable, or they can be grounded only by transcendental arguments. Such a foundation has been proposed for the principle of universalizability in particular. Clearly, the latter principle is central for any acceptable ethical theory. But theories about material goods, the role of decision and game theory in ethical reasoning, and the difference between the objectively right and the subjectively moral have to be added to a universalistic ethics in order to make it applicable to concrete cases.

REFERENCES

- Apel, K.O. (1973) *Transformation der Philosophie*, 2 vols. Frankfurt: Suhrkamp.
- Ayer, A.J. (1936) *Language, Truth and Logic*. London: Gollancz.
- Gewirth, A. (1978) *Reason and Morality*. Chicago/London: University of Chicago Press.
- Hare, R.M. (1952) *The Language of Morals*. Oxford: Clarendon Press.
- Höslé, V. (2004) *Morals and Politics*. Notre Dame, IN: University of Notre Dame Press.
- Hughes, G.E. and Cresswell, M.J. (1996) *A New Introduction to Modal Logic*. London/New York: Routledge.
- Hume, D. (1739/40) *A Treatise of Human Nature*. London: John Noon.
- Illies, C. (2003) *The Grounds of Ethical Judgement*. Oxford: Clarendon Press.
- Israel, J. (2001) *Radical Enlightenment*. Oxford: Oxford University Press.
- Kant, I. (1785) 'Grundlegung zur Metaphysik der Sitten', in Wilhelm Weischedel (ed.), *Werke in zwölf Bänden*, vol. 7. Frankfurt: Suhrkamp.
- Kant, I. (1797) 'Über ein vermeintes Recht, aus Menschenliebe zu lügen', in Wilhelm Weischedel (ed.), *Werke in zwölf Bänden*, vol. 8. Frankfurt: Suhrkamp.
- Kuhlmann, W. (1985) *Reflexive Letztbegründung*. Freiburg/München: Alber.

- Kutschera, Franz von (1973) *Einführung in die Logik der Normen, Werte und Entscheidungen*. Freiburg/München: Alber.
- Moore, George E. (1903) *Principia Ethica*. Cambridge: Cambridge University Press.
- Rawls, J. (1971) *A Theory of Justice*. Cambridge, MA: Belknap Press of Harvard University Press.
- Scheler, M. (1913/16) *Der Formalismus in der Ethik und die materiale Wertethik*. Halle an der Saale: Max Niemeyer.
- Von, W. and Georg, H. (1963) *The Varieties of Goodness*. London/New York: Routledge/Humanities Press.

Foundationalism and Principles

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INTRODUCTION

One of the interesting aspects of bioethics today is that it is becoming more and more international. Many clinical trials nowadays are executed in developing countries. When some countries take legal measures against organ trade, the trafficking is displaced to other countries without regulations. Fringe scientists announcing that they have produced the first human clone always do that in areas of the world where it is not explicitly prohibited. Many countries do not have an adequate infrastructure to deal with bioethical issues. They lack expertise, ethics committees, ethics teaching programs, and ethics-related regulations and legislation. Because they are not the drivers of scientific and technological development, they fear to be excluded from the benefits of biomedical progress. At the same time there is the risk of double, or at least different, moral standards being applied in different regions of the world.

It was in this context that in October 2003, based on preliminary feasibility studies of the International Bioethics Committee, UNESCO was mandated by its 191 member states to draw up a declaration setting out fundamental principles in the field of bioethics. Especially the developing countries requested that the organization make normative standards with a truly universal scope. After two years of intense work, the member states adopted, unanimously and by acclamation on 19 October 2005, the Universal Declaration on Bioethics and Human Rights, thus solemnly affirming the commitment of the international community to respect a certain number of universal principles for humanity in the development and application of biomedical science and technology. With this new declaration, UNESCO strives to respond in particular to the needs of developing countries, indigenous communities, and vulnerable groups or persons. The declaration reminds the international community of its duty of solidarity toward all countries.

Unlike the Oviedo Convention adopted by the Council of Europe, the Universal Declaration of UNESCO does not constitute a binding normative instrument in

international law. However, the unanimous adoption by the member states is not merely symbolic but gives the declaration moral authority and creates a moral commitment. For the first time in the history of bioethics, all states of the international community are committed to respect and implement the basic principles of bioethics, set forth within a single text. The innovative dimension of the declaration is that it constitutes a commitment of governments to a set of bioethical principles. Previous international declarations, although sometimes very influential (such as the Declaration of Helsinki) have been adopted by professional organizations (such as the World Medical Association). The adoption of the declaration also illustrates that there is now agreement about principles that form the basis of international, multicultural bioethics, itself firmly founded on international human rights (Thomasma, 1997a).

After several decades, bioethics has developed into an established and recognized discipline. During this process of maturation, consensus on fundamental principles has gradually emerged. It is important to note that the rather limited core of four principles that are always recited (the so called ‘Georgetown mantra’) is now evolving into a coherent set of 15 principles, taking into account not only individual and interpersonal perspectives but also community, social, and even global perspectives. This new constellation of fundamental principles is not only the outcome of a process of internationalization of bioethics, taking into account a wider range of ethical principles that goes beyond the perspective of particular cultures and specific societies. It is also the starting point for a true globalization of bioethics – a global bioethics that cares about issues and problems in all areas of the world and that responds to the needs and concerns of all human beings on this planet. This globalization has reactivated the older debate on the role of principles in bioethics, as well as their foundation.

BIOETHICS AS APPLIED ETHICS

During the last 40 years, a popular and unique view of bioethics as a new discipline has emerged. The growing appeal of this new discipline among public and scientific circles of opinion leaders can be attributed to the empowering combination of two traditional notions from the history of moral philosophy: ‘application’ and ‘principle’.

The dominant conception of bioethics reflected in the mainstream of scholarly literature is that of applied ethics. In Beauchamp and Childress’s well known textbook, biomedical ethics is defined as ‘the application of general ethical theories, principles and rules to problems of therapeutic practice, health care delivery, and medical and biological research’ (Beauchamp and Childress, 1983: ix-x). Instead of the theoretical abstractions of traditional moral philosophy, applied ethics can contribute to analyze dilemmas, resolve complex cases, and clarify practical problems arising in the healthcare setting. The practical usefulness of applied ethics not only manifests itself in biomedicine, but it has a wider scope. In the *Encyclopedia of Applied Ethics*, the following definition is presented:

Applied ethics is a general field of study that includes all systematic efforts to understand and to resolve moral problems that arise in some domains of practical life, as with medicine, journalism, or business, or in connection with some general issue of social concern, such as employment, equity or capital punishment (Winkler, 1998: 192).

A distinction is made between three major areas of applied ethics: biomedical ethics, business and professional ethics, and environmental ethics. However, the table of contents of the four encyclopedia volumes show a wide range of topics covered, such as archaeological ethics, censorship, divorce, electronic surveillance, gun control, nuclear power, vegetarianism, and wildlife conservation. Applied ethics can extend to almost any area of life where ethical issues arise. 'Application' here has a double connotation: it indicates that ethics is available for what we usually do, it applies to our daily problems; but it is also helpful, practical, in the sense that ethics is something to do; it works to resolve our problems.

The second characteristic of the dominant conception of bioethics is the focus on principles. If ethics is conceived as applied ethics, then subsequent reflection is needed on what is being applied. The emerging consensus that principles should provide the answer to this quest is coherent with the moralities of obligation that have dominated modern ethical discourse, especially since Kant. Behavior in accord with moral obligations is considered morally right. The morality of behavior is a morality of duty. Morality is understood as a system of precepts or rules people are obliged to follow. Particularly in the early days of bioethics, when medical power was strongly criticized, and the rights of patients were vehemently emphasized as requiring respect, the moralities of obligation presented themselves as a common set of normative principles and rules that we are obliged to follow in practice. As Diego Gracia (1999) pointed out, the Belmont Report in 1978 was influential because it was the first official document to identify three basic ethical principles: autonomy, beneficence, and justice. A basic principle was defined as a general judgment serving as a basic justification for particular prescriptions and evaluations of human actions. From these principles, ethical guidelines can be derived that could be applied to the biomedical area. About the same time, Beauchamp and Childress, in the first edition of their book, introduced the four-principles approach, adding 'nonmaleficence' to the above three principles. In their view, principles are normative generalizations that guide actions. However, as general guides they leave considerable room for judgment in specific cases. Various types of rules are needed to specify the principles into precise action guides.

Although Beauchamp and Childress have considerably elaborated and adapted their theoretical framework in later editions, their work has contributed to the conception of bioethics that has long dominated the practical context in ethics committees, clinical case-discussions, ethics courses, and compendia and syllabi. This conception is sometimes called 'principlism': the focus is on the use of moral principles to address ethical issues and to resolve conflicts at the bedside (DuBose et al., 1994). Belief in the power of principlism is sometimes proselytizing. Raanan Gillon, for example argues that the advantage of the four principles not only is that they are defensible from a variety of theoretical moral perspectives, but also that 'they can help us bring more order, consistency, and understanding to our medico-moral judgments' (Gillon, 1986: viii).

Later, Gillon used the principles-approach to develop a major scholarly project, the voluminous textbook *Principles of Health Care Ethics* (Gillon, 1994). Over 100 authors discuss in 90 chapters all possible ethical dilemmas in modern health care, employing the analytical framework of the four principles. In his Preface, Gillon confesses that he is inclined to believe that the four principles approach can encompass all moral issues, not only those arising in health care. Principlism apparently is a universal tool; it provides a

method to resolve all moral issues in all areas of daily life, whatever the personal philosophies, politics, religions, cultural traditions, and moral theories of the persons involved.

FOUNDATIONALISM

The emergence of principlism as the dominant approach in bioethics has led to intensive debates on the foundations of moral thought. How can bioethical views be justified, and how can bioethical dilemmas be resolved in a pluralistic and multicultural modern society? Ethical foundationalism is the view that bioethics can identify and produce valid principles because it has a clear theoretical rock bottom. At least some bioethical principles can be based on noninferentially justified beliefs. Such principles can be rationally defended and they apply to all human beings (Thomasma, 1997b). A comprehensive philosophical theory, such as utilitarianism, Kantian deontology, or libertarianism should provide the bedrock for bioethics. Bioethical judgments can only be justified on the basis of an ethical theory that is rational and universal at the same time.

Principlism is criticized because it does not provide such a fundamental theoretical framework. In daily practice, bioethics focuses on mid-level principles – respect for autonomy, beneficence, nonmaleficence, and justice. These principles are applied to dilemmas, cases, and problems encountered in the practice of health care. From a specific principle, guidelines or recommendations can be derived in order to resolve various problematic situations. Yet there is no single rational criterion on the basis of which to decide which principle is overriding; there is no definitive scheme for ordering principles and for choosing between them (Clouser and Gert, 1990). The problem is that as long as the principles of applied ethics are not integrated into some broader theoretical framework they tend to lead to conflicting judgments about which actions and social policies one ought to carry out (Brody, 1988). The lack of agreement on which moral theory to apply on concrete medical cases could make applied ethics counterproductive. Confronting physicians and medical students with a variety of conflicting but plausible theories, applied medical ethics may be seen to give no moral guidance but to reinforce the belief that whatever is done in problematic situations, some moral theory will condone, another will condemn it (Baier, 1985). Because mainstream bioethics focuses on the application of principles and is rather loosely embedded in philosophy providing a clear foundation for moral judgments, it can easily result in a chaos of conflicting moral judgments.

For Beauchamp and Childress this criticism is not relevant. For them, principlism is non-foundationalist. In the earlier editions of their work, theoretical encompassing frameworks are not lacking but they are multiple. The authors can be relatively indifferent to the question of ethical foundations since they argue that the focus should be on mid-level principles. Agreement on such principles can be reached from the point of view of radically different moral theories, like in their own case, utilitarian and deontological theories. Even champions of diverging moral theories can reach convergence on principles. What is sufficient for bioethics is an integrated framework of principles through which to handle diverse moral problems (Beauchamp and Childress, 1983).

In later editions they are more critical about foundational theories because these are one-sided and insufficiently rich to understand the complexities and uncertainties of bioethical

dilemmas and cases. The four principles approach is more subtle. It is not a simple deduction of moral judgments from rules and principles but a dialectic process of interpretation, specification, and balancing. The authors reiterate that the justification of moral judgments is provided through an appeal to principles. But there is no single unifying principle or encompassing theory to justify the principles. The framework of principles they present is the theory (Beauchamp and Childress, 1994).

ANTIFOUNDATIONALISM

Antifoundationalism is the view that there are no ethical principles that are certain and universally valid, so that all moral judgment can be firmly grounded on them. In response to the universal claims of principlism, two types of criticism have been advanced.

First, mainstream bioethics has developed within a particular cultural and social context. The fundamental ethos of applied ethics, its analytical framework, methodology, and language, its concerns and emphases, and its very institutionalization have been shaped by beliefs, values, and modes of thinking grounded in specific social and cultural traditions (i.e. primarily Western ones). Nowadays, the bioethics literature serves as one of the most powerful means by which to express and articulate these traditions. However, the literature only rarely attends to or reflects upon the sociocultural value system within and through which it operates. Scholars usually assume that its principles, theories, and moral views are transcultural. Bioethics is a common neutral language, a secular moral grammar, guaranteeing a peaceable society (Engelhardt, 1986). But how neutral is the common neutral language? Is this moral language itself not the expression of a commitment to a certain 'hypergood' (Taylor, 1989), in particular the good of universal and equal respect and self-determining freedom – primal values in the liberal tradition? Such questions assume that the values of mutual respect and individual freedom are not de-contextualized, universal standards but themselves expressions of community-bound agreements.

The second criticism of principlism is focused on its inattention to the particularities of the practical setting. Moral theories and principles are necessarily abstract and therefore not immediately relevant to the particular circumstances of actual cases, the concrete reality of clinical work, and the specific responsibilities of health care professionals. By appealing to basic principles bioethics may fail to realize the importance of concretely lived experiences of health care professionals, as well as patients. The moral agent is taken to have an abstract existence. This point is critically elaborated by contemporary philosophers. Ethics, according to Williams (1988), does not respect the concrete moral subject with his personal integrity. It requires that the subject gives up his personal point of view and exchanges it for a universal and impartial point of view. This is, Williams argues, an absurd requirement, because the moral subject is requested to give up what is constitutive for his or her personal identity and integrity. The idea that knowledge of normative theories and principles can be applied to medical practice simply ignores the fact that moral concerns tend to emerge from experiences in medical settings themselves. A similar issue is raised by Taylor (1989), arguing that morality and identity are two sides of the same coin. To know who we are is to know to which moral sources we should appeal. The community, the particular social group to which we belong, is usually at the center of our moral experience. Even the use of ethical

language depends on a shared form of life. The Wittgensteinian notion that our understanding of language is a matter of picking up practices and being inducted into a particular form of life is germane here. Bioethicists should therefore become more appreciative of the actual experiences of practitioners and more attentive to the context in which physicians, nurses, patients, and others experience their moral lives, e.g. the roles they play, the relationships in which they participate, the expectations they have, and the values they cherish (Zaner, 1988). The physician–patient relationship is neither ahistorical, acultural, nor an abstract rational notion; persons are always persons-in-relation, are always members of communities, are immersed in a tradition, and are participants in a particular culture.

In response to these types of criticism new approaches to bioethics have emerged in the 1980s and 1990s: phenomenological ethics (Zaner, 1988); hermeneutic ethics (Carson, 1990; Leder, 1994); narrative ethics (Brody, 1987; Newton, 1995); and care ethics (Tronto, 1993). Furthermore, traditional conceptions have been revitalized, notably the new casuistry (drawing from the classical casuistic mode of moral reasoning) (Jonsen and Toulmin, 1988); and the virtue approach, emphasizing qualities of character in both individuals and communities (Drane, 1988; Pellegrino and Thomasma, 1993).

COMMON MORALITY

Having expressed their skepticism about foundationalism, Beauchamp and Childress have since 1989 been locating the source of bioethical principles in what they call ‘common morality’. This is the morality shared in common by all persons in all places. It is the starting point of moral reasoning. Principles have their origin in the common morality. This is not a unified foundation for ethics from which moral judgments can be deduced. Although we are all embedded in common morality, a continuous work of analysis, clarification, interpretation, specification, and balancing is required in order to make a moral judgment on a specific case or problem.

At the same time, Beauchamp and Childress want also to avoid an antifoundationalist point of view. In later editions of their book, they critically discuss all current types of ethical theory, not only utilitarianism and Kantian deontology, but also theories of virtue, rights, community, care, and casuistry. These theories rightly point out that we need to be sensitive to context and community and to individual differences. But they are often too contextual, do not provide certitude, and do not guide conduct. Common morality on the other hand provides a basis for the evaluation and criticism of actions, because it transcends merely local customs and attitudes; in other words ‘the principles of the common morality are universal standards’ (Beauchamp and Childress, 1994: 101).

Evidently, rejecting foundationalism, Beauchamp and Childress do not want to join antifoundationalism either. Otherwise, the universality of bioethical judgments would be lost, principles would no longer work as action-guides, and actions could not be morally justified. Although the principles embedded in common morality are abstract and general, simple deductivism is impossible. A specific moral problem cannot be solved by simple application of the four principles. However, they are universal principles. Common morality in fact is the guiding meta-principle of principlism (Gordon et al., 2009).

Nowadays, common morality has become an important topic of debate (Veatch, 2003). The notion, as explained by Beauchamp and Childress and recently introduced in the bioethics debate, is associated with older ideas from interpretive bioethics. As a particular domain of philosophy, ethics proceeds from empirical knowledge, viz. moral experience. The moral dimension of the world is first and foremost experienced. Moral experience is humanity's way of understanding itself in moral terms (van Tongeren, 1988). Ethics is therefore the interpretation and explanation of this primordial understanding. Before acting morally we must already know, at least to some extent, what is morally desirable or right. Otherwise, we would not recognize what is appealing in a moral sense. On the one hand, moral normativity is pre-given and common to all human beings. The precepts of common morality are universally binding but at the same time historical; they have emerged in the history of humanity because they promote human flourishing. On the other hand, what we recognize in our experience is typically unclear and in need of further elucidation and interpretation. Normativity in bioethics in particular requires continuous specification of principles and balancing against other principles in a specific situation. But in the end, the moral judgment in this situation will be justified by the principles of the common morality. According to some critiques, the four-principle approach of Beauchamp and Childress is therefore foundationalist (Arras, 2009). At least common morality presents a substitute foundation enabling us to make universal and rational moral judgments.

In the debate, many scholars question whether there is a common morality. It is argued that common morality as a universal framework does not exist, that there is no evidence that all cultures and religions have accepted the same common morality. The claim of a universal, cross-cultural common morality is dismissed on empirical grounds (Turner, 2003). Societies differ in the moral norms and values they regard as basic, certainly if we examine them from a historical perspective. Beauchamp (2003) agrees that a distinction should be made between particular moralities and the common morality. The first differ according to history and culture; they express norms unique to particular cultures, groups, and individuals. But there is also a small set of commonly shared principles and norms related to the objectives of morality (i.e. promoting human flourishing). Common morality is not simply a morality among many others; its principles represent at an abstract level the human experience that following them will ameliorate the human condition. Therefore, more important than consensus is justification of principles (relating to the achievement of the objectives of morality). Whether or not there is universal agreement on some principles (which is a matter of empirical study), the question how principles of common morality can be justified, however, is crucial (which is a matter of normative analysis).

CHANGING COMMON MORALITY?

Beauchamp's distinction between common morality and particular moralities locates universality in the first one. Particular moralities present concrete and specific nonuniversal norms that arise from religious traditions, cultural contexts, and professional practices. It is clear that these moralities do develop and change over time. What about the common