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H. Tristram Engelhardt, Jr., *Editor*

Bioethics Critically Reconsidered

Having Second Thoughts

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Having Second Thoughts

Edited by
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Chapter 1
A Skeptical Reassessment of Bioethics

H. Tristram Engelhardt, Jr.

1.1 What Is Bioethics, After All: Claims for Moral Expertise in the Face of Intractable Moral Pluralism

What is bioethics? Who is a bioethicist? Who is a health care ethics consultant or clinical ethics consultant? There are no straightforward answers to such questions. Indeed, the attempt to answer such questions usually engenders controversies. Bioethics is a puzzle. Bioethics is itself a controversy, a theater of dispute. Across the world, there are persons who call themselves bioethicists. But there is no agreement as to what ends they are doing what they do, as to what they should be doing, or even as to what they are doing. In hospitals across the world, there are persons who are paid as clinical ethics consultants (aka health care ethics consultants) and who are often held to be engaged in helping resolve normative questions about health care decisions. But there is no agreement as to what norms they should engage. This is because there is real dispute about the content and character of both morality and bioethics. As a result, there is a puzzle as to how properly to characterize the nature of the normative questions posed to bioethicists, as well as the answers bioethicists give. Bioethicists are asked, for example, about when a particular medical intervention is inappropriate (or futile), about who should make life-or-death decisions, and concerning what information should be provided in order for a patient adequately to consent to treatment. The question is what kinds of norms and which ethics should frame such questions. In answering such questions, what norms and which norms should guide the answers? Are the norms at stake those established at law? Is the ethics about which health care ethics consultants (HCEC) give advice simply an account of relevant law and public policy, as well as of how law and public policy is customarily applied? Or are the norms moral norms? If so, norms of which morality? These puzzles about the nature of bioethics justify second thoughts about the entire endeavor of bioethics.

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If the norms at stake are moral norms, the problems proliferate. In terms of whose morality ought one to pose the questions and/or seek the answers? Do those who present questions to health care ethics consultants often have different genre of norms in mind than do the consultants? If those asking for an ethics consultation do not realize that they may have a different sense of ethics than do health care ethics consultants, what kind of disclosure should the consultants provide concerning the differences (e.g., "Let me make an important disclosure. One might think that my normative advice as a clinical ethicist is grounded in a universal secular ethics, but there is no such ethic. Instead, my ethics advice reflects the moral vision of one group of secular moralists. You, of course, may have quite different and incompatible moral commitments")? When providing ethics guidance, should health care ethics consultants indicate what goods and harms are most important in shaping their answers, as well as what strategies they hold will likely maximize the balance of benefits over harms? For that matter, are consultants, if they are to be moralists, to be consequentialists? And if so, what sort of consequentialists? By appeal to which list of benefits and harms, and in what relative weight or priority are they to give advice? Or should their concern be to indicate how not to violate wrong-making conditions so as to act rightly, so as to be worthy of happiness? That is, should clinical ethicists indicate how to act in deontologically appropriate fashions? Or should they instead offer an integration of concerns about the good and the right? But then how should they balance the good and the right, especially since there is no agreement on these matters in general or regarding matters in moral philosophy in particular? Or yet further, is the cardinal moral goal that of a virtuous life in the context of health care so that clinical ethicists ought to guide those involved to a virtuous life and away from vice? But what then is virtue or vice? About all such normative issues, as well as moral-theoretical and meta-ethical issues, there is dispute, not agreement. Indeed, the history of moral disputes is as old as the project of moral philosophy itself.[1] Or, it may very well be that clinical ethicists rarely give normative advice. In any case, what kind of informed consent and disclosure should be given by clinical ethicists to those seeking an ethics consultation?

One confronts "a field", "a profession", that offers services, but where there is no agreement about the character or substance of the services offered. The chaos in bioethics is analogous to that in European medicine before it acquired a concern to correct for observer bias and achieved a scientific foundation in the contemporary sense of the notion. People may have agreed that patients consulted physicians because they wished to have their illnesses and disabilities cured, as well as their pains ameliorated, but there was great disagreement about the causes of the illnesses, disabilities, and pains, as well as about the nature of illnesses, disabilities, and pains and how to cure them. There was disagreement at both the level of theory and of practice. Bioethics as academic and practical fields are marked by a similar chaos. At both the normative and theoretical levels, there is dispute, not agreement. The level of disagreement may even be greater in bioethics than that which marked traditional Western medicine, because there may be greater unclarity about what the problems are that bioethics should address.

As will be shown by the essays in this volume, clinical ethics is not simply a "field" that engages a multiplicity of disciplines (as would be the case with a

multi-disciplinary field), but it is a number of fields with different disciplines that have successfully coalesced into a marketable service package. As a result, there is no possibility of evidence-based, argument-based assessments of the field that do not beg cardinal questions. This is the case because in the face of moral pluralism there will be different standards of evidence and of sound rational moral argument. What is one to say about all this? Given this disarray, what legitimacy can bioethics, especially clinical ethics consultation, possibly possess? And why? It is the case that, at some level, bioethics seems to function as a publicly recognized social institution and/or cluster of practices. It is the case that bioethics as a "field" has its pundits who can be interviewed for moral, indeed bioethical sound bites. They make assertions such as: "That is morally outrageous!" "I have never heard of someone doing that." "That violates the established consensus." But what is the meaning of such assertions? One might conclude that the outrage expressed and various *obiter dicta* advanced by such pundits are really rhetorical ploys designed to bring others into agreement with the pundit's morality *cum* bioethics, his ideology. Bioethics has become influential, but the source of its influence and legitimacy is far from clear. Bioethics deserves a serious and critical re-assessment. This volume is a step in that direction.

1.2 Success in the Face of Foundational Disagreement

In the forty years since the term bioethics was first deployed in 1971 to identify a cluster of practices of giving guidance about biomedical morality and since the Center for Bioethics of the Kennedy Institute of Ethics of Georgetown University was brought into existence, bioethics has become widely accepted across the world. The growth has been dramatic. How ought one to understand this phenomenal development, especially in light of the circumstance that many of the crucial founding assumptions have simply proven false. How could bioethics have emerged and grown so quickly despite disputes about what bioethics actually is? In Beauchamp and Childress's account in *The Principles of Biomedical Ethics* (1979), a common human morality is presupposed, and therefore a common bioethics. Yet clearly there is no such common morality, or for that matter a common bioethics. Humans have fundamental disagreements regarding the content of morality and of bioethics. All human societies are marked by moral controversies that are reflected in political disagreements. Given the strident moral disputes within societies across the world and over history, the incredible claim that humans share a common morality is perhaps best understood as a special pleading on behalf of a particular morality. In any event, humans disagree as to when it is forbidden, obligatory, or merely licit to have sex, reproduce, transfer private property from unconsenting owners, and kill their fellow humans. There are disagreements as to when it is good or evil to tell the truth or to lie, whether homosexual acts are immoral, or whether capital punishment is to be celebrated or prohibited. Moral and bioethical pluralism reigns in the face of Beauchamp and Childress's claims on behalf of a common morality and a common bioethics. How, then, given that it is so unclear what morality and bioethics are, could bioethics have experienced the success it now enjoys?

Many appear simply to deny the problems confronting bioethics and are impressed by its seeming success. They have always hoped for a common morality, and they are committed to act in accord with their hope, facts of the matter to the contrary notwithstanding. Thus, in the face of deep moral disagreements, many bioethicists nevertheless talk about a moral consensus regarding cardinal moral and bioethical issues. The romance with consensus persists, often passionately, although there is likely no moral or bioethical issue regarding which all agree. Moreover, this lack of agreement is implicitly taken for granted in many countries, such as in the United States, where one has experienced the phenomenon of different presidents appointing different bioethics advisory groups with different understandings of what the canonical moral content of bioethics should be. For example, the moral commitments of President Bill Clinton's National Bioethics Advisory Commission were different from those embraced by President George W. Bush's President's Council on Bioethics. The connection between bioethics and politics became especially salient, when during the administration of President George W. Bush the President's Council on Bioethics and its chairman Leon Kass were the focus of criticism by those of different bioethical, political, and/or ideological persuasions. As in all policy issues with a heavy political and moral overlay, each seeks to choose the experts who will favor his approach to legal and political policy agendas. It is also clear why governments would want the blessing of a bioethics committee for the law and public policy they wish to establish. The governmental engagement of bioethics functions to convey a "moral" *imprimatur* for particular agendas in law and public policy. It is in addition clear why bioethicists would speak of consensus in the face of strong disagreement, for appeals to moral consensus can function as a camouflaged appeal for supporters to rally around a political agenda. There is a quite understandable aspiration to have the right bioethics so as to "bless" the right politics. Governments choose the morality and bioethics that will support their desired public policy. Does this mean that bioethics is primarily an element of biopolitics?

Bioethics has been engaged to support social movements. As Laurence McCullough notes, bioethics emerged inter alia as part of a social crusade on behalf of a particular understanding of autonomy and against a particular practice of medical paternalism. As McCullough also shows, although the medical paternalism decried may not have been frequent, it became a focus of major concern, which is to recognize that bioethics emerged as one of the many "rights" movements of the 1960s and 1970s. In this way, at the macro-level bioethics became, at least in part, biopolitics. At the micro-level bioethics became a resource engaged within hospitals and elsewhere to protect the alleged rights of patients despite secular "moral" disagreement regarding such rights. Of course, in doing so bioethics reflected a particular "moral" and a particular socio-political agenda directed against medical paternalism. In all of this, the question is whether bioethics as it took shape as a social movement was in the main a response to changes in the law bearing on consent to medical treatment that took place in the 1970s and 1980s. Or is bioethics best understood as having primarily arisen around a cluster of very particular moral and socio-political agendas that engaged bioethics to change law and public policy?

For example, did those with particular political commitments such as the Kennedy family engender bioethics in order to support their larger political goals?

In any event, at the macro-level bioethics has supported particular goals for governance. At the micro-level, one can say that as a fact of the matter, as a strategy for social cooperation, clinical bioethics has served as an instrument for conflict and risk management in hospitals. Given its apparent success in these areas, bioethics has become widely accepted as useful. Yet, at both the macro- and micro-levels, it is unclear as to what bioethics actually does or should do. These cardinal and unanswered questions return one to the issue of what patients, their families, physicians, and other health professionals should be told as a disclosure regarding the ethics that clinical ethicists advance. Before patients, their families, and/or health care providers consent to receive a clinical ethics consultation, what sort of information should they be given so that they will not be deceived regarding what bioethics in general and bioethics consultations in particular can offer? What sort of disclosure ought health care ethics consultants to make about bioethics in general and about the special commitments of the consultants in particular in order not to engender false expectations?

The problems with bioethics lie not just with false claims and false expectations about the character of morality and bioethics (e.g., "there is a common morality and bioethics and I am its spokesman"), as well as with one-sided accounts of the history of physician-patient relationships. The problems are far more fundamental. They involve questions about the nature of normative concerns themselves. The nature of secular morality and secular bioethics deserves a skeptical reappraisal because the very project of secular morality is itself questionable, or at least may not at all be what many thought it to be, or at least hoped that it would be. Many who were once religious may falsely presume that with regard to secular morality they can continue with business as usual even when a God's-eye perspective is denied or simply not recognized. They may expect direction in bioethics from a quasi-God's-eye perspective about what they ought to do. But "after God", no such perspective is available. The point is that reality and morality appear quite different without a final point of orientation and meaning.[2] It is not just that the project of morality has failed to establish a canonical morality or to vindicate a general theory of what a morality should be (i.e., to establish what morality is about), but that once morality is rendered secular, it does not have the force that was generally expected from morality in Western culture when morality was recognized as anchored in and enforced by God. Absent God, the appreciation of morality and metaphysical meaning, the phenomenological experience of reality and of morality, changes.[3] As Kant, likely an atheist,[4] recognized: without embracing the existence of God and immortality as postulates of practical reason, morality fragments and there are also no longer compelling grounds for moral obligations always trumping prudential considerations (Engelhardt, 2010c). If one embraces an atheistic methodological postulate so that all is viewed as coming from nowhere, going nowhere, and for no ultimate purpose,[5] then it also follows that morality and bioethics are multiple and ultimately meaningless.[6] Morality and bioethics cannot speak to humans generally as theologians might speak to members of a particular religion.

This leads to the question of reassessing the status of morality after God and after metaphysics. We have just begun to think through what bioethics can be "after God" (Engelhardt, 2010d), as well as what political authority means apart from reference to God. That is, we have just begun to ask what it means to talk of moral and political obligations if one acts as if everything, including morality, were ultimately meaningless. It would appear, for example, that the more-than-minimal state becomes simply a *modus vivendi* absent a God's-eye perspective. The state no longer functions with moral authority because there can in principle be no general agreement concerning which morality should frame its structure or give moral authority to the state. The more-than-minimal state becomes merely a political structure which one should out of concerns for prudence usually obey, but which possesses no general secular moral standing or authority (Engelhardt, 2010a, 2010b). Christians had accepted the authority of the state as a matter of divinely established obligation (see esp. Romans 13:1–4). But in a cosmos without final significance and in the face of moral pluralism, and given a state that acts in conflict with one's own moral and bioethical commitments, why morally ought one to obey the state, especially the more-than-minimal state, which acts without the consent of all its participants? The minimal state can at least indicate that all that support it consent to the state in the sense of agreeing to act together with the consent of all participants. That is, the minimum state is grounded in never using any citizen without his permission. But no state in the contemporary world is a minimal state, and the more-than-minimal state has no canonical secular moral justification because there is no canonical secular morality available to convey authority. Moreover, the claims of a social contract, if this means the authorization of its citizens, is at best specious once the state is a more-than-minimal state, a state through which certain groups (even if they are the majority) impose their will, even if it is through voting (should there be such), on all its citizens (while not responding to the pleas of citizens: "Love me, State, or leave me alone"). "After God," the significance of morality and political authority change radically.

As Vattimo wryly remarks regarding the wide-ranging implications of atheism, and indeed even of agnosticism, "God is dead, but man isn't doing so well himself" (Vattimo, 1991, p. 31). Which is to say that "the death of God, which is at once the culmination and conclusion of metaphysics, is also the crisis of humanism" (Vattimo, 1991, pp. 32–33). Without a God's-eye perspective, there is no longer a unitary meaning or significance to being human. Instead, there are multiple socio-historically-conditioned constructions of morality and of the significance of morality. Morality within the horizon of the finite and the immanent is both irresolvably multifocal and deflated in its meaning (e.g., it is unclear why moral concerns should always trump concerns for one's own self-interest). So, too, the significance of being human is also deflated with wide-ranging implications for claims of human dignity and human rights. The universality and strong normative force of claims of human rights and human dignity shipwreck on moral pluralism, as well as on the lack of any anchorage in being. It is for this reason that, as Vattimo acknowledges, atheism appears "as another catastrophic Tower of Babel" (Vattimo, 1991, p. 31). If there is no longer any final perspective in terms of which there could be