

- Kelsey, Sheryl F. et al., and Investigators from the National Heart, Lung, and Blood Institute Percutaneous Transluminal Coronary Angioplasty Registry. 1993. "Results of Percutaneous Transluminal Coronary Angioplasty in Women: 1985–1986 National Heart, Lung, and Blood Institutes Coronary Angioplasty Registry." *Circulation* 87(3): 720–727.
- Kuhn, Thomas S. 1970. *The Structure of Scientific Revolutions*. 2nd edition. Chicago: University of Chicago Press.
- Longino, Helen. 1990. *Science as Social Knowledge: Values and Objectivity in Scientific Inquiry*. Princeton, NJ: Princeton University Press.
- Manley, Audrey; Lin-Fu, Jane S.; Miranda, Magdalena; et al. 1985. "Special Health Concerns of Ethnic Minority Women." In vol. 2 of *Women's Health: Report of the Public Health Service Task Force on Women's Health Issues*, pp. 37–47, ed. Ruth L. Kirschstein and Doris H. Merritt. Washington, D.C.: U.S. Dept. of Health and Human Services.
- Money, John, and Erhardt, Anke. 1972. *Man and Woman, Boy and Girl: The Differentiation and Dimorphism of Gender and Identity from Conception to Maturity*. Baltimore: Johns Hopkins University Press.
- Multiple Risk Factor Intervention Trial Research Group. 1990. "Mortality Rates after 10.5 Years for Participants in the Multiple Risk Factor Intervention Trial: Findings Related to A Priori Hypotheses of the Trial." *Journal of the American Medical Association* 263(13): 1795–1801.
- Oakley, Ann. 1981. "Interviewing Women: A Contradiction in Terms." In *Doing Feminist Research*, pp. 30–61, ed. Helen Roberts. London: Routledge & Kegan Paul.
- Pattrow, Lynn M. 1990. "When Becoming Pregnant Is a Crime." *Criminal Justice Ethics*, (Winter/Spring): 41–47.
- Rose, Hilary, and Rose, Stephen. 1980. "The Myth of the Neutrality of Science." In *Science and Liberation*, pp. 17–32, ed. Rita Arditti, Pat Brennan, and Steve Cavrak. Boston: South End Press.
- Rosser, Sue V. 1994. *Women's Health: Missing from U.S. Medicine*. Bloomington, IN: Indiana University Press.
- Rosser, Sue V. 2000. *Women, Science, and Society: The Crucial Union*. New York: Teachers College Press.
- Steering Committee of the Physicians' Health Study Group. 1989. "Final Report on the Aspirin Component of the Ongoing Physicians' Health Study." *New England Journal of Medicine* 321: 129–135.
- Steingart, Richard M.; Packer, Milton; Hamm, Peggy; et al. 1991. "Sex Differences in the Management of Coronary Artery Disease." *New England Journal of Medicine* 325(4): 226–230.
- Washburn, Jennifer. 1996. "The Misuses of Norplant: Who Gets Stuck?" *Ms.* 7(3): 232–236.
- Webster, Douglas, and Webster, Molly. 1974. *Comparative Vertebrate Morphology*. New York: Academic Press.
- Wenger, N. K.; Speroff, L.; and Packard, B. 1993. "Cardiovascular Health and Disease in Women." *New England Journal of Medicine* 329: 247.

- Zimmerman, B., et al. 1990. "People's Science." In *Science and Liberation*, pp. 299–319, ed. Rita Arditti, Pat Brennan, and Steve Cavrak. Boston: South End Press.

BIOETHICS

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"There is," says the biblical book of Ecclesiastes, "no new thing under the sun." Those words are worth pondering in light of the emergence of the field of bioethics since the 1950s and 1960s. From one perspective it is a wholly modern field, a child of the remarkable advances in the biomedical, environmental, and social sciences. Those advances have brought a new world of expanded scientific understanding and technological innovation, seeming to alter forever what can be done about the vulnerabilities of nature and of the human body and mind, and about saving, improving, and extending human lives. Yet from another perspective, the kinds of questions raised by these advances are among the oldest that human beings have asked themselves. They turn on the meaning of life and death, the bearing of pain and suffering, the right and power to control one's life, and our common duties to each other and to nature in the face of grave threats to our health and well-being. Bioethics represents a radical transformation of the older, more traditional domain of medical ethics; yet it is also true that, since the dawn of history, healers have been forced to wrestle with the human fear of illness and death, and with the limits imposed by human finitude.

It is wholly fitting that an encyclopedia of bioethics devote some of its space to defining and understanding the field that it would examine in both breadth and depth. Yet that is not an easy task with a field that is still evolving and whose borders are hazy. The word *bioethics*, of recent vintage, has come to denote not just a particular field of human inquiry—the intersection of ethics and the life sciences but also an academic discipline; a political force in medicine, biology, and environmental studies; and a cultural perspective of some consequence. Understood narrowly, bioethics is simply one more new field that has emerged in the face of great scientific and technological changes. Understood more broadly, however, it is a field that has spread into, and in many places has changed, other far older fields. It has reached into law and public policy; into literary, cultural, and historical studies; into the popular media; into the disciplines of philosophy, religion, and literature; and

into the scientific fields of medicine, biology, ecology and environment, demography, and the social sciences.

The focus here will be on the broader meaning, place, and significance of bioethics. The aim will be to determine not only what the field means for specific ethical problems in the life sciences, but also what it has to say about the interaction of ethics and human life, and of science and human values. Bioethics is a field that ranges from the anguished private and individual dilemmas faced by physicians or other healthcare workers at the bedside of a dying patient, to the terrible public and societal choices faced by citizens and legislators as they try to devise equitable health or environmental policies. Its problems can be highly individual and personal—what should I do here and now?—and highly communal and political—what should we together do as citizens and fellow human beings?

While the primary focus of this entry will be on medicine and healthcare, the scope of bioethics—as the encyclopedia as a whole makes clear—has come to encompass a number of fields and disciplines broadly grouped under the rubric *the life sciences*. They encompass all those perspectives that seek to understand human nature and behavior, characteristically the domain of the social sciences, and the natural world that provides the habitat of human and animal life, primarily the population and environmental sciences. Yet it is the medical and biological sciences in which bioethics found its initial impetus, and in which it has seen the most intense activity. It thus seems appropriate to make that activity the center of attention here.

Historical Background

An understanding of the emergence of bioethics will help to capture the panoramic breadth and complexity of the field. The 1960s is a pertinent point of departure, even though there were portents of the new field and issues in earlier decades. That decade brought into confluence two important developments, one scientific and the other cultural. In biomedicine, the 1960s was an era of extraordinary technological progress. It saw the advent of kidney dialysis, organ transplantation, medically safe abortions, the contraceptive pill, prenatal diagnosis, the widespread use of intensive-care units and artificial respirators, a dramatic shift from death at home to death in hospitals or other institutions, and the first glimmerings of genetic engineering. Here was a truly remarkable array of technological developments, the palpable outcome of the great surge in basic biomedical research and application that followed World War II. At the same time, stimulated by Rachel Carson's book *Silent Spring*, there was a gradual awakening to the environmental hazards posed by

the human appetite for economic progress and the domination of nature. Taken together, these developments posed a staggering range of difficult, and seemingly new, moral problems.

Bioethics as a field might not have emerged so strongly or insistently had it not been for parallel cultural developments. The decade was the spawning ground for a dazzling array of social and cultural reform efforts. It saw a rebirth, within the discipline of moral philosophy, of an interest in normative and applied ethics, both out of a dissatisfaction with the prevailing academic emphasis on theoretical issues and in response to cultural upheavals. It was the era of the civil-rights movement, which gave African Americans and other people of color new rights and possibilities. It was the era that saw the rebirth of feminism as a potent social movement, and the extension to women of rights often previously denied them. It was the era that saw a fresh surge of individualism—a by-product in many ways of postwar affluence and mobility—and the transformation of many traditional institutions, including the family, the churches, and the schools. It was an era that came to see the enormous possibilities the life sciences offer to combat disease, illness, and death—and no less to see science's possibilities for changing the way human beings could live their lives.

Some of these possibilities had been foreseen in the important book *Medicine and Morals*, written by Joseph Fletcher, an Episcopal theologian who eventually came to reject religious beliefs. He celebrated the power of modern medicine to liberate human beings from the iron grip of nature, putting instead in their hands the power to shape lives of their own choosing. This vision began to be lived out in the 1960s. That decade brought together the medical advances that seemed to foreshadow the eventual conquest of nature and the cultural changes that would empower newly liberated individuals to assume full control of their own destinies. There was in this development both great hope and ambition, and perhaps great hubris, the prideful belief that humans could radically transcend their natural condition.

The advances of the biomedical sciences and their technological application had three great outcomes that came clearly into full view by the 1960s. They transformed first many traditional ideas about the nature and domain of medicine, then the scope and meaning of human health, and, finally, cultural and societal views of what it means to live a human life. Medicine was transformed from a diagnostic and palliative discipline into a potent agent able to cure disease and effectively forestall death. Human "health" more and more encompassed the 1947 World Health Organization definition with its broad emphasis on health as "a state of complete physical, mental, and social well-being and not

merely the absence of disease or infirmity.” Traditional notions of the living of a life were changed by longer life expectancies, the control of procreation, and powerful pharmacological agents able to modify mood and thought.

The advent of bioethics can be seen as the principal social response to these great changes. If there was any single, overarching question, it might have been this: How were human beings wisely to confront the moral puzzles, perplexities, and challenges posed by the confluence of the great scientific and cultural changes? But this large question concealed an intimidating range of more specific issues. Who should have control over the newly emergent technologies? Who should have the right or privilege to make the crucial moral decisions? How could individuals be assisted in taking advantage of the new medical possibilities or, if need be, protected from being harmed by them? How could the fruits of the medical advances be most fairly distributed? What kind of character or human virtues would be most conducive to a wise use of the new technologies? What kind of institutions, or laws, or regulations would be needed to manage the coming changes in a moral fashion?

Facts and Values

It soon became evident that such questions required more than a casual response. Two important tasks emerged. One of them, logically the first, was to distinguish the domain of science from that of ethics and values. As a consequence of the triumphalist positivism that during the late nineteenth and the first half of the twentieth century had come to dominate the general understanding of science, matters of ethics and values had been all but banished from serious intellectual discussion. A sharp line could be drawn, it was widely believed, between scientific facts and moral values (MacIntyre, 1981b). The former were solid, authoritative, impersonally true, while the latter were understood to be “soft,” relativistic, and highly, even idiosyncratically, personal. Moreover, doctors should make the moral decisions no less than the medical decisions; indeed, a good medical decision was tantamount to a good moral decision. The first task of bioethics, then, was to erase the supposedly clear line that could be drawn between facts and values, and then to challenge the belief that those well trained in science and medicine were as capable of making the moral decisions as the medical decisions.

The second important task was to find or develop the methodologies necessary to come to grips with the new moral problems. If there is no sharp line between facts and values, how should their relationship be understood? If there is a significant difference between making a medical (or scientific) decision and making a moral decision, how are

those decisions different and what kinds of skills are needed to make the one or the other? Who has a right to make the different kinds of decisions? If it is neither sensible nor fair to think of moral and value matters as soft and capriciously personal, hardly more than a matter of taste, then how can rigor and objectivity be brought to bear on them?

As the scope and complexity of these two large tasks became more obvious, the field of bioethics began to emerge. From the first, there was a widespread recognition that the moral problems would have to be approached in an interdisciplinary way (Callahan, 1973). Philosophy and religion, long the characteristic arenas for moral insight, analysis, and traditions, should have an important place, as should the historical moral traditions and practices of medicine and biology. Ample room would also have to be made for the law and for the social and policy sciences. Moral problems have important legal, social, political, and policy implications; and moral choices would often be expressed through court decisions, legislative mandates, and assorted regulatory devices. Hardly less important was the problem of which moral decisions should be left to private choice and which required some public standards. While there was a strong trend to remove procreational choices from public scrutiny, and thus to move toward the legal use of contraception and abortion, environmental choices were being moved from private choice to governmental regulation. Debates of this kind require the participation of many disciplines.

While the importance of an interdisciplinary approach was early recognized, three other matters were more troublesome. First, what should be the scope of the field? The term *bioethics*, as it was first used by the biologist Van Rensselaer Potter, referred to a new field devoted to human survival and an improved quality of life, not necessarily or particularly medical in character. The term soon was used differently, however, particularly to distinguish it from the much older field of medical ethics. The latter had traditionally been marked by a heavy, almost exclusive emphasis on the moral obligations of physicians and on the doctor–patient relationship. Yet that emphasis, while still important, was not capacious enough to embrace the huge range of emerging issues and perspectives. *Bioethics* came to refer to the broad terrain of the moral problems of the life sciences, ordinarily taken to encompass medicine, biology, and some important aspects of the environmental, population, and social sciences. The traditional domain of medical ethics would be included within this array, accompanied now by many other topics and problems.

Second, if the new bioethics was to be interdisciplinary, how would it relate to the long-standing disciplines of moral theology and moral philosophy? While those disciplines are

able to encompass some interdisciplinary perspectives, they also have their own methodologies, developed over the years to be tight and rigorous. For the most part, moreover, their methodologies are broad, aimed at moral problems in general, not just at biomedical issues. Can they, in their broad, abstract generality, do justice to the particularities of medical or environmental issues?

Another problem becomes apparent. An interdisciplinary field is not necessarily well served by a tight, narrow methodology. Its very purpose is to be open to different perspectives and the different methodologies of different disciplines. Does this mean, then, that although parts of bioethics might be rigorous—the philosophical parts taken by themselves or the legal parts—the field as a whole may be doomed to a pervasive vagueness, never as strong as a whole as its individual parts? This is a charge sometimes leveled against the field, and it has not been easy for its practitioners to find the right balance of breadth, complexity, and analytical rigor.

Varieties of Bioethics

As the field has developed, it has become clear that because of the range of diversity of bioethics issues, more than one methodology is needed; by the same token, no single discipline can claim a commanding role. At least four general areas of inquiry can be distinguished, even though in practice they often overlap and cannot clearly be separated.

THEORETICAL BIOETHICS. Theoretical bioethics deals with the intellectual foundations of the field. What are its moral roots and what ethical warrant can be found for the moral judgments made in the name of bioethics? Part of the debate turns on whether its foundations should be looked for within the practices and traditions of the life sciences, or whether they have philosophical or theological starting points. Philosophers and theologians have a central place in this enterprise, but draw strongly upon the history and practices of the life sciences to grasp the aims and developments of these fields.

CLINICAL ETHICS. Clinical ethics refers to the day-to-day moral decision making of those caring for patients. Because of that context, it typically focuses on the individual case, seeking to determine what is to be done here and now with a patient. Should a respirator be turned off? Is this patient competent to make a decision? Should the full truth be disclosed to a fearful cancer patient? Individual cases often give rise to great medical and moral uncertainty, and they evoke powerful emotions among those with a role in the

decisions. Decision-making procedures, as well as the melding of theory and practice—what Aristotle called “practical reason”—come sharply into play. It is the concreteness of the judgment that is central here: What is to be done for this patient at this time? The experience of practicing physicians, other healthcare workers, and patients themselves takes a prominent place, yet on occasion can require a collaborative interplay with those trained more specifically in ethics.

REGULATORY AND POLICY BIOETHICS. The aim of regulatory and policy bioethics is to fashion legal or clinical rules and procedures designed to apply to types of cases or general practices; this area of bioethics does not focus on individual cases. The effort in the early 1970s to fashion a new legal definition of clinical death (from a heart-lung to a brain-death definition), the development of guidelines for the use of human subjects in medical research, and hospital rules for do-not-resuscitate (DNR) orders are examples of regulatory ethics. It can also encompass policies designed to allocate scarce healthcare resources or to protect the environment. Regulatory ethics ordinarily seeks laws, rules, policies, and regulations that will command a wide consensus, and its aim is practical rather than theoretical. The law and the policy sciences are highly important in this kind of bioethics work; but it also requires a rich, ongoing dialogue among those concerned with theoretical bioethics, on the one hand, and clinical ethics and political realities, on the other. Regulatory bioethics seeks legal and policy solutions to pressing societal problems that are ethically defensible and clinically sensible and feasible.

CULTURAL BIOETHICS. Cultural bioethics refers to the effort systematically to relate bioethics to the historical, ideological, cultural, and social context in which it is expressed. How do the trends within bioethics reflect the larger culture of which they are a part? What ideological leanings do the moral theories undergirding bioethics openly or implicitly manifest? A heavy emphasis on the moral principle of autonomy or self-determination can, for example, be said to display the political and ideological bias of culturally individualistic societies, notably the United States. Other nations—those in central and eastern Europe, for instance—give societal rather than individual concerns a more pronounced priority (Fox). Solidarity rather than autonomy would be their highest value.

The social sciences, as well as history and the humanities, have a central place in this interpretive effort (Marshall). If done well, the insights and analysis they provide can help everyone to a better understanding of the larger cultural and social dynamic that underlies the ethical problems. Those problems will usually have a social history that reflects the

influence of the culture of which they are a part. Even the definition of what constitutes an ethical “problem” will show the force of cultural differences. Countries with strong paternalistic traditions may not consider it necessary to consult with patients about some kinds of decisions; they will not see the issue of patient choice or informed consent as a moral issue at all—yet they may have a far livelier dedication to equality of access to healthcare.

General Questions of Bioethics

While bioethics as a field may be understood in different ways and be enriched by different perspectives, at its heart lie some basic human questions. Three of them are paramount. What kind of a person ought I to be in order to live a moral life and to make good ethical decisions? What are my duties and obligations to other individuals whose life and well-being may be affected by my actions? What do I owe to the common good, or the public interest, in my life as a member of society? The first question bears on what is often called an ethic of virtue, whose focus is that of personal character and the shaping of those values and goals necessary to be a good and decent person. The second question recognizes that what we do can affect, for good or ill, the lives of others, and tries to understand how we should see our individual human relationships—what we ought to do for others and what we have a right to expect from them. The third question takes our social relationships a step further, recognizing that we are citizens of a nation and members of larger social and political communities. We are citizens and neighbors, sometimes acquaintances, and often people who will and must live together in relatively impersonal, but mutually interdependent, ways.

These are general questions of ethics that can be posed independently of the making of biomedical decisions. They can be asked of people in almost any moral situation or context. Here we encounter an important debate within bioethics. If one asks the general question “What kind of person ought I to be in order to make good moral decisions?” is this different from asking the same question with one change—that of making “good moral decisions in medicine”? One common view holds that a moral decision in medicine ought to be understood as the application of good moral thinking in general to the specific domain of medicine (Clouser). The fact that the decision has a medical component, it is argued, does not make it a different kind of moral problem altogether, but an application of more general moral values or principles. A dutiful doctor is simply a dutiful person who has refined his or her personal character to respond to and care for the sick. He or she is empathic to

suffering, steadfast in devotion to patients, and zealous in seeking their welfare.

Another, somewhat older, more traditional view within medicine is that an ethical decision in medicine is different, precisely because the domain of medicine is different from other areas of human life and because medicine has its own, historically developed, moral approaches and traditions. At the least, it is argued, making a decision within medicine requires a detailed and sensitive appreciation of the characteristic practices of medicine and of the art of medicine, and of the unique features of sick and dying persons. Even more, it requires a recognition of some moral principles, such as *primum non nocere* (first, do no harm) and beneficence, that have a special salience in the doctor–patient relationship (Pellegrino and Thomasma). The argument is not that the ethical principles and virtues of medical practice find no counterpart elsewhere, or do not draw upon more general principles; it is their combination and context that give them their special bite.

The Foundations of Bioethics

There may not be a definitive resolution to the puzzle of whether bioethics should find its animating moral foundations within or outside medicine and biology. In any case, with time these two sources become mixed, and it seems clear that both can make valuable contributions (Brody, 1987). Perhaps more important is the problem of which moral theories or perspectives offer the most help in responding to moral issues and dilemmas.

Does an ethic of virtue or an ethic of duty offer the best point of departure? In approaching moral decisions, is it more important to have a certain kind of character, disposed to act in certain virtuous ways, or to have at hand moral principles that facilitate making wise or correct choices? The traditions of medicine, emphasizing the complexity and individuality of particular moral decisions at the bedside, have been prone to emphasize those virtues thought to be most important in physicians. They include dedication to the welfare of the patient and empathy for those in pain. Some philosophical traditions, by contrast, have placed the emphasis on *principlism*—the value of particular moral principles that help in the actual making of decisions (Childress; Beauchamp and Childress). These include the principle of respect for persons, and most notably respect for the autonomy of patients; the principle of beneficence, which emphasizes the pursuit of the good and the welfare of the patient; the principle of nonmaleficence, which looks to the avoidance of harm to the patient; and the principle of justice, which stresses treating persons fairly and equitably.

The advantage of principles of this kind is that, in varying ways and to different degrees, they can be used to protect patients against being harmed by medical practitioners and to identify the good of patients that decent medical and healthcare should serve. Yet how are such principles to be grounded, and how are we to determine which of the principles is more or less important when they conflict? Moral principles have typically been grounded in broad theories of ethics—utilitarianism, for example, which justifies acts as moral on the basis of the consequences of those acts (sometimes called consequentialism). Utilitarian approaches ask which consequences of a choice or an action or a policy would promote the best possible outcome. That outcome might be understood as maximizing the widest range of individual preferences, or promoting the greatest predominance of good over evil, or the greatest good of the greatest number. Just what one should judge as a “good” outcome is a source of debate within utilitarian theory, and a source of criticism of that theory. Such an approach to healthcare rationing, for instance, would look for the collective social benefit rather than advantages to individuals.

A competing theory, deontology, focuses on determining which choices most respect the worth and value of the individual, and particularly the fundamental rights of individuals. The question of our basic obligations to other individuals is central. From a deontological perspective, good consequences may on occasion have to be set aside to respect inalienable human rights. It would be wrong, for instance, to subject a human being to dangerous medical research without the person’s consent even if the consequences of doing so might be to save the lives of many others. Our transcendent obligation is toward the potential research subject.

Not all debates about moral theory come down to struggles between utilitarianism and deontology, though that struggle has been central to much of the moral philosophy that influenced bioethics in its first decades. Other moral theories, such as that of Aristotle, stress neither principles nor consequences but see a combination of virtuous character and seasoned practical reason as the most likely source of good moral judgment. For that matter, a morality centering on principles raises the problems of the kind of theory necessary to ground those principles, and of how a determination of priorities is to be made when the principles conflict (Clouser and Gert). A respect for patient autonomy, stressing the right of competent patients to make their own choices, can conflict with the principle of beneficence if the choice to be made by the patient may actually be harmful. And autonomy can also conflict with the principle of nonmaleficence if the patient’s choice would seem to require

that the physician be the person who directly brings harm to the patient.

Another classical struggle turns on the dilemma that arises when respect for individual freedom of choice poses a threat to justice, particularly when an equitable distribution of resources requires limiting individual choice. Autonomy and justice are brought into direct conflict. Recent debates on healthcare rationing, or setting priorities, have made that tension prominent.

Even if principles—like autonomy and justice—are themselves helpful, their value declines sharply when they are pitted against each other. What are we supposed to do when one important moral principle conflicts with another? The approach to ethics through moral principles—often called *applied ethics*—has emphasized drawing those principles from still broader ethical theory, whose role it is to ground the principles. Moral analysis, then, works from the top down, from theory to principles to case application. An alternative way to understand the relationship between principles and their application, far more dialectical in its approach, is the method of *wide reflective equilibrium*. It espouses a constant movement back and forth between principles and human experience, letting each correct and tutor the other (Daniels).

Still another approach is that of casuistry, drawn from methods commonly used in the Middle Ages. In contrast with principlism, it works from the bottom up, focusing on the practical solving of moral problems by a careful analysis of individual cases (Jonsen and Toulmin). A casuistical strategy does not reject the use of principles but sees them as emerging over time, much like the common law that has emerged in the Anglo-American legal tradition. Moral principles derive from actual practices, refined by reflection and experience. Those principles are always open to further revision and reinterpretation in light of new cases. At the same time, a casuistical analysis makes prominent use of analogies, employing older cases to help solve newer ones. If, for instance, general agreement has been reached that it is morally acceptable to turn off the respirator of a dying patient, does this provide a good precedent for withdrawing artificially provided hydration and nutrition? Is the latter form of care morally equivalent to the former, so that the precedent of the former can serve to legitimate the latter? Those are the kinds of questions that a casuistical analysis would ask. At the same time, a casuistical analysis runs the risk of being too bound to past cases and precedents. It can seem to lack the capacity to signal the need for a change of moral direction (Arras).

Still another principle-oriented approach proposes a new social contract between medicine and society (Veatch).

Such a contract would be threefold. It comprises basic ethical principles for society as a whole, a contract between society and the medical profession about the latter's social role, and a contract between professionals and laypersons that spells out the rights and prerogatives of each. This strategy is designed both to place the ethics of medicine squarely within the ethical values of the larger society and to make sure that laypeople have sufficient choice and power to determine the kind of care they, and not paternalistic physicians, choose. Still another approach, more skeptical about finding any strong consensus on ethical foundations, stresses an ethic of secular pluralism and social peace, devising a minimal ethic for the community as a whole but allowing great play to the values and choices of different religious and value subcommunities (Engelhardt).

Contemporary feminist approaches to bioethics, like casuistry, reject the top-down rationalistic and deductivist model of an ethic of principles (Baier; Sherwin). They reject even more adamantly what is seen as the tendency of an ethic of principles to universalize and rationalize. Feminist ethics lays a far heavier emphasis on the context of moral decisions, on the human relationships of those caught in the web of moral problems, and on the importance of feeling and emotion in the making of moral decisions. Feminist approaches, rooted in ways of thinking about morality that long predate the feminist movement of recent decades, also reflect a communitarian bias, reacting against the individualism that has been associated with a principle-oriented approach. Feminist thinkers commonly argue that those who lack power and status in society are often well placed to see the biases even of those societies that pride themselves on equality. While feminism has gained considerable prominence in recent years, it is only one of a number of efforts to find fresh methods and strategies for ethical analysis and understanding. These include phenomenological analyses, narrative-based strategies, and hermeneutical, interpretive perspectives (Zaner; Brody, 1987).

How Important is Moral Theory?

There can be little doubt that the quest for the foundations of bioethics can be difficult and frustrating, no less so than the broader quest for the foundations of ethics in general (MacIntyre, 1981a). Yet how important for bioethics are moral theory and the quest for a grounding and comprehensive theory? Even the answers to that question are disputed. At one extreme are those who believe that bioethics as a discipline cannot expect intellectual respect, much less legitimately affect moral behavior, unless it can show itself to be grounded in solid theory justifying its proposed virtues,

principles, and rules. At the other extreme are those who contend that—even if there is no consensus on theory—social, political, and legal agreement of a kind sufficient to allow reasonable moral decisions to be made and policy to be set can be achieved. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research of the early 1980s, and the National Commission for the Protection of Human Subjects in the mid-1970s, were able to achieve considerable agreement and gain general public and professional respect even though individual members disagreed profoundly on the underlying principles of the consensus. There is of course nothing new in that experience. The American tradition of freedom of religion, for instance, has been justified for very different reasons, both theological and secular—reasons that in principle are in fundamental conflict with each other, yet are serviceable for making policy acceptable to believers and nonbelievers alike.

What kind of authority can a field so full of theoretical and practical disputes have? Why should anyone take it seriously? All important fields, whether scientific or humanistic, argue about their foundations and their findings. Bioethics is hardly unique in that respect. In all fields, moreover, agreement can be achieved on many important practical points and principles even without theoretical consensus. Bridges can be built well even if theoretical physicists disagree about the ultimate nature of matter. But perhaps most important, one way or another, moral decisions will have to be made, and they will have to be made whether they are well grounded in theory or not. People must do the best they can with the material at hand. Even in the absence of a full theory, better and worse choices can be made, and more or less adequate justification can be offered. As the field progresses, even the debates on theory can be refined, offering greater insight and guidance even if the theories are still disputable.

Where, then, lies the expertise and authority of bioethics (Noble)? It lies, in the end, in the plausible insight and persuasive rationality of those who can reflect thoughtfully and carefully on moral problems. The first task of bioethics—whether the issues are clinical, touching on the decisions that must be made by individuals, or policy-oriented, touching on the collective decisions of citizens, legislators, or administrators—is to help clarify what should be argued about. A closely related task will be to suggest how these issues should be argued so that sensible, moral decisions can be made. Finally, there will be the more advanced, difficult business of finding and justifying the deepest theories and principles. There can, and will, be contention and argument at each of these stages, and it well may appear at first that no resolution

or agreement can be found. Endless, unresolved disagreement in fact rarely occurs in practice, and that is why, if one looks at bioethics over a period of decades, achieved agreement and greater depth can be found, signs of progress in the field. The almost complete acceptance of such concepts as *patient rights*, *informed consent*, and *brain death*, for instance—all at one time heatedly disputed concepts—shows clearly enough how progress in bioethics is and can be made.

Making Good Moral Decisions

Good individual decision making encompasses three elements: self-knowledge, knowledge of moral theories and traditions, and cultural perception. Self-knowledge is fundamental because feelings, motives, inclinations, and interests both enlighten and obscure moral understanding. In the end, individual selves, alone with their thoughts and private lives, must wrestle with moral problems. This sort of struggle often forces one to confront the kind of person one is, to face one's character and integrity and one's ability to transcend narrow self-interest to make good moral decisions. And once a decision is made, it must be acted upon. A decision of conscience blends moral judgment and the will to act upon that judgment (Callahan, 1991). A complementary kind of knowledge, not easy to achieve, is also needed. Even as individuals we are social creatures, reflecting the times in which we live, embodied in a particular society at a particular time. Our social embeddedness will shape the way we understand ourselves, the moral problems we encounter, and what we take to be plausible and feasible responses to them. Moral theory by itself is hardly likely to be able to give us all the ingredients needed for an informed, thoughtful moral judgment. Only if it is complemented by self-understanding and reflectiveness about the societal and cultural context of our decisions can moral theory be fleshed out sufficiently to be helpful and illuminating. Good moral judgment requires us to move back and forth among the necessary elements: the reflective self, the interpreted culture, and the contributions of moral theory. No one element is privileged; each has an indispensable part to play.

Yet something else is needed as well: a vision of the human good, both individual and collective. The biomedical, social, and environmental sciences produce apparently endless volumes of new knowledge about human nature and its social and natural setting. However, for that knowledge to be useful or meaningful, it must be seen in light of some notions of what constitutes the good of human life. What should human beings seek in their lives? What constitute good and worthy human ends? Proponents of the technological advances that emerge from the life sciences claim they

can enhance human happiness and welfare. But that is likely to be possible only to the extent we have some decent idea of just what we need to bring us happiness and an enhanced welfare.

Bioethics must pay sustained attention to such issues. It cannot long and successfully attend only to questions of procedure, or legal rules and regulations, without asking as well about the ends and goals of human life and activity. Ethical principles, rules, and virtues are in part a function of different notions of what enhances human life. Implicitly or explicitly, a picture of human life provides the frame for different theories and moral strategies of bioethics. This picture should animate living a life of our own, in which we develop our own understanding of how we want to live our individual lives, given the vast array of medical and biological possibilities; living our life with other human beings, which calls up ideas of rights and obligations, bonds of interdependency, and the creation of a life in common; and living our life with the rest of nature, which has its own dynamics and ends but provides us with the nurturing and natural context of our human lives.

Is there such a thing as the human good, either individually or collectively? Is there something we can, in an environmental context, call the good of nature? There is no agreement on the answer to those questions; on the contrary, there is fundamental disagreement. Some would argue that ethics can proceed with a relatively thin notion of the human good, placing the emphasis on developing those moral perspectives that would make it most possible to live with our differences about the meaning and ends of life. Others stress the importance of the substantive issues and reflect some basic doubt about whether ethics can proceed very far, or have sufficient substance, without trying to gain some insight into, and agreement upon, those basic matters (Kass; Callahan, 1993). Those debates must continue.

The greatest power of the biomedical, social, and environmental sciences is their capacity to shape the way we as human beings understand ourselves and the world in which we live. At one level—the most apparent—they give us new choices and thus new moral dilemmas. At another level, however, they force us to confront established views of our human nature, and thus to ask what we should be seeking: What kind of people do we want to be? A choice about artificial reproduction, say surrogate motherhood, is surely a moral choice. But it is also a way into the question of how we should understand the place of procreation in our private lives and in society. To see that is to appreciate profound challenges to our understanding of sexual and familial roles and purposes. The boundaries of bioethics cannot readily be constrained. The expanding boundaries

force us to take up larger and deeper problems, much as a small stone tossed into the water creates larger and larger ripples.

Summary

In its early days, contemporary bioethics was generally seen as an activity on the fringes of research and practice in the life sciences; it had no place within environmental analysis. The dominant view was that the life sciences were a strictly scientific endeavor, with questions of morality and values arising only now and then in the interstices. That view has gradually changed. The life sciences are increasingly understood as, at their core, no less a moral endeavor than a scientific one. Ethics lies at the very heart of the enterprise, if only because facts and values can no longer be clearly separated—any more than the ends of the life sciences can be separated from the means chosen to pursue them.

No less important, questions of the moral means and ends of the life sciences cannot be long distinguished from the moral means and ends of the cultures and societies that pursue and deploy them. Here, fundamental questions must be asked. First, what kind of medicine and healthcare, what kind of stance toward nature and our environment, do we need for the kind of society we want? Such a question presupposes that we have some end in view for our society, though that may not be all that clear. What is clear, however, is that it is almost impossible to think for long about bioethics without being forced to think even more broadly about the society in which it will exist and whose ends—for better or worse—it will serve.

The second question reverses the first: What kind of a society ought we to want in order that the life sciences will be encouraged and helped to make their best contribution to human welfare? The contribution bioethics makes will in great part be a function of the goals sought by the life sciences, and those in turn will be stimulated or formed by society's goals. The life sciences shape the way we think about our lives, and thus they increasingly provide some key ingredients in society's vision of itself and in the lives of the citizens who comprise society.

Understood in terms of these two broad questions, bioethics takes its place at the heart of the enterprise of the life sciences. Only a part of its work will bear on dealing with the daily moral dilemmas and ethical puzzles that are part of contemporary healthcare and environmental protection. A no less substantial part will be to help shape the social context in which those dilemmas and puzzles play themselves out. At its best, bioethics will move back and forth between the concreteness of necessary individual and policy

decisions and the broad notions and dynamic of the human situation. It is still a new field, seeking to better define itself and to refine its methods. It has made a start in shaping its direction and possible contribution, but only a start.

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SEE ALSO: *Abortion; Animal Welfare and Rights; Bioethics Education; Clinical Ethics; Death, Definition and Determination of; Environmental Ethics; Ethics; Eugenics and Religious Law; Fertility Control; Genetic Testing and Screening; Health and Disease; Healthcare Resources; Informed Consent; Life, Quality of; Life Sustaining Treatment and Euthanasia; Medical Ethics, History of; Mental Health; Population Ethics; Reproductive Technologies*

BIBLIOGRAPHY

- Arras, John D. 1991. "Getting Down to Cases: The Revival of Casuistry in Bioethics." *Journal of Medicine and Philosophy* 16(1): 29–51.
- Baier, Annette C. 1992. "Alternative Offerings to Asclepius?" *Medical Humanities Review* 6(1): 9–19.
- Beauchamp, Tom L., and Childress, James F. 1989. *Principles of Biomedical Ethics*. 3rd edition. New York: Oxford University Press.
- Brody, Baruch A. 1988. *Life and Death Decision Making*. New York: Oxford University Press.
- Brody, Howard. 1987. *Stories of Sickness*. New Haven, CT: Yale University Press.
- Callahan, Daniel. 1973. "Bioethics as a Discipline." *Hastings Center Studies* 1(1): 66–73.
- Callahan, Daniel. 1993. *The Troubled Dream of Life: Living with Mortality*. New York: Simon and Schuster.
- Callahan, Sidney Cornelia. 1991. *In Good Conscience: Reason and Emotion in Moral Decision Making*. San Francisco: HarperSanFrancisco.
- Carson, Rachel. 1962. *Silent Spring*. Boston: Houghton Mifflin.
- Childress, James F. 1989. "The Normative Principles of Medical Ethics." In *Medical Ethics*, pp. 27–48, ed. Robert M. Veatch. Boston: Jones and Bartlett.
- Clouser, K. Danner. 1978. "Bioethics." In vol. 1 of *Encyclopedia of Bioethics*, pp. 115–127, ed. Warren T. Reich. New York: Free Press.
- Clouser, K. Danner, and Gert, Bernard. 1990. "A Critique of Principlism." *Journal of Medicine and Philosophy* 15(2): 219–236.
- Daniels, Norman. 1979. "Wide Reflective Equilibrium and Theory Acceptance in Ethics." *Journal of Philosophy* 76(5): 256–282.
- Engelhardt, H. Tristram, Jr. 1986. *The Foundations of Bioethics*. New York: Oxford University Press.

- Fletcher, Joseph F. 1954. *Morals and Medicine: The Moral Problems of: The Patient's Right to Know the Truth, Contraception, Artificial Insemination, Sterilization, Euthanasia*. Boston: Beacon.
- Fox, Renée C. 1990. "The Evolution of American Bioethics: A Sociological Perspective." In *Social Science Perspectives on Medical Ethics*, pp. 201–217, ed. George Weisz. Philadelphia: University of Pennsylvania Press.
- Hoffmaster, Barry. 1991. "The Theory and Practice of Applied Ethics." *Dialogue* 30(2): 213–234.
- Jonsen, Albert R., and Toulmin, Stephen E. 1988. *The Abuse of Casuistry: A History of Moral Reasoning*. Berkeley: University of California Press.
- Kass, Leon R. 1985. *Toward a More Natural Science: Biology and Human Affairs*. New York: Free Press.
- MacIntyre, Alasdair. 1981a. "A Crisis in Moral Philosophy: Why Is the Search for the Foundations of Ethics So Frustrating?" In *The Roots of Ethics: Science, Religion, and Values*, pp. 3–20, ed. Daniel Callahan and H. Tristram Engelhardt, Jr. New York: Plenum.
- MacIntyre, Alasdair. 1981b. *After Virtue*. Notre Dame, IN: University of Notre Dame Press.
- Marshall, Patricia A. 1992. "Anthropology and Bioethics." *Medical Anthropology Quarterly* 6(1): 49–73.
- Noble, Cheryl N. 1982. "Ethics and Experts." *Hastings Center Report* 12(3): 7–9.
- Pellegrino, Edmund D., and Thomasma, David C. 1981. *A Philosophical Basis of Medical Practice: Toward a Philosophy and Ethic of the Healing Professions*. New York: Oxford University Press.
- Potter, Van Rensselaer. 1971. *Bioethics: Bridge to the Future*. Englewood Cliffs, NJ: Prentice-Hall.
- Sherwin, Susan. 1992. *No Longer Patient: Feminist Ethics and Health Care*. Philadelphia: Temple University Press.
- Toulmin, Stephen. 1981. "The Tyranny of Principles." *Hastings Center Report* 11(6): 31–39.
- Veatch, Robert M. 1981. *A Theory of Medical Ethics*. New York: Basic Books.
- Zaner, Richard M. 1988. *Ethics and the Clinical Encounter*. Englewood Cliffs, NJ: Prentice-Hall.

BIOETHICS: AFRICAN-AMERICAN PERSPECTIVES



The type of healthcare delivery system used by a society says a great deal about what that society thinks of its most vulnerable citizens. African Americans in U.S. society have

historically been treated unfairly in every dimension of group and individual life—subjected to segregated and inferior medical services, housing, employment, education, as well as racist environmental policies and practices. These are all factors that determine the collective and individual health of African Americans, which has been, and continues to be, worse than that of white people in the United States.

Until recently, mainstream bioethics paid little attention to the role of race, racism, and ethnicity in bioethical discourse. As opposed to specific issues like stem cell research, abortion, or end-of-life discussions, race plays a role in every ethical conundrum from violation of informed consent to allocation of organ donations. Notably, over the last few years, more bioethicists are devoting serious scholarship to the examination of race as a topic for debate.

An African-American perspective on bioethical issues brings to the table concerns that are important to the health and well-being of African Americans, concerns that are marginalized in mainstream bioethics. They include racial disparities in health status; racial disparities in access to healthcare and technologies; continued medical research abuses; and other factors contributing to poor health such as toxic dumping in communities of color, poor housing, dangerous jobs, and lack of adequate health insurance. African-American perspectives address a major principle: The health disparities of U.S. racial and ethnic groups are a fundamental bioethics issue.

Bioethics Perspective I: Health Disparities

What are health disparities and why are they ethical violations? Olivia Carter-Pokras and Claudia Baquet discuss a number of definitions that have emerged since 1985, when the U.S. Department of Health and Human Services issued the *Report of the Secretary's Task Force on Black and Minority Health*. The Task Force defines health disparities as excess mortality of minorities as compared to that of whites. Healthy People 2010, whose goal is to eliminate disparities, defines them as differences that occur by gender, race or ethnicity, education or income, disability, and residence in rural localities. The National Institutes of Health (NIH) defines disparities as differences in incidence, prevalence, mortality, and burden of disease (Carter-Pokras and Baquet).

According to reports from the Centers for Disease Control (CDC), African Americans have higher death rates than whites due to cancers, diabetes, cirrhosis, homicide, AIDS, and cardiovascular diseases. Maternal death is between three and four times higher for black women than for white women. More white women have breast cancer, but the death rate is higher in black women and is increasing.