The Foundations of Bioethics: Liberty and Life with Moral Diversity[1]

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For the attention that Rosemarie Tong, James Lennox, Tom Beauchamp, and Robert Sade have given to The Foundations of Bioethics I am very grateful. They have provided a careful and useful exploration of many of the ambiguities of that text. In taking account of their reflections, I will indicate how the text they have examined takes a position somewhat different from what they have assumed in the account they give. In that way, I will be able to respond to the issues they have raised as well as suggest how a different interpretation of Foundations can be sustained than the one they have offered. In that the arguments in Foundations (1986, 1996) are themselves somewhat lengthy, I will not recall them at length here. Instead, I will only rehearse the positions I have taken in Foundations. The result will be to indicate that, though in general I have sympathy with many of the concerns raised by Tong, Lennox, Beauchamp, and Sade in many respects when they are critical of Foundations, they are addressing issues other than those addressed by that work. What they take to be points for criticism of Foundations are rather issues raised regarding positions somewhat different from those advanced in Foundations. This allows me to be grateful for their reflections, while Foundations is not directly touched by their criticisms.

Let me turn first to the very interesting and careful reflections of Rosemarie Tong. From the perspective of her own concerns regarding feminist theory, she explores a number of themes quite similar to those that I addressed in Foundations from the perspective of my concerns regarding accounts of bioethics. Both Rosemarie Tong and I recognize the diversity of moralities, not merely moral theoretical accounts, which give rise to a diversity of feminisms, feminist theories, bioethical understandings, as well as bioethical accounts. We also both acknowledge that over against this diversity, both feminist theory and bioethical reflections in general must take account of the circumstances that we do not possess one common morality. There are not just different theoretical accounts of feminism and bioethics. There are divergent feminisms and disparate bioethical moral understandings.

In part, the difference in our responses to this state of affairs turns on a difference of terminology. The term "moral stranger," for example, is introduced in The Foundations not to indicate that persons are alien one to another such that they cannot understand the diversity of their positions nor the character of their conflicting moralities. Moral strangers are not equivalent to moral aliens. The term "moral strangers" is used to indicate that, when individuals do not share the same fundamental moral premises, rules of moral evidence, and rules of moral inference, or share a common recognition of persons in moral authority to give closure to a moral controversy, they will not be able to resolve their moral controversies by sound rational argument or authoritative closure. Instead, their debates will continue ad indefinitum, at least with respect to achieving a solution warranted by a closure justified in terms of a sound rational argument or moral authority. Their attempts to solve controversies in this context will either beg the question, involve an infinite regress, a circular argument, or the bold proclamation of a consensus that does not include those who disagree, but rather announces that their opinions and moral sentiments are

marginal and normatively insignificant, and therefore able to be dismissed. Matters will be in the confusion one in fact finds them when one turns to bioethical debates regarding abortion, euthanasia, or health care reform. The term "moral stranger" is used to underscore the existence as a matter of fact of real moral diversity, as well as to emphasize the unavailability of a theoretical perspective from which to set this moral diversity aside, at least in terms of the content-full moral differences that limit the character of this diversity.

As a fact of the matter, moral strangers are often affective friends. Indeed, individuals are often married to moral strangers. To be a moral stranger to another is not to experience or regard the other as a moral alien, but rather to recognize that one does not share moral resources sufficient to the task of bringing most of the moral controversies one shares with the other to closure by sound rational argument or by an appeal to a person who all will recognize to be in moral authority to resolve such disputes. Given her use of the term "moral acquaintances," I believe Rosemarie Tong and I are in agreement in this regard, though our terminology may seem to separate. With a better understanding of my terminology, it is not the case that I am of the opinion that, in this post-modern world, we have "few moral friends." At least, I know as a fact of the matter that I have a great number of moral friends. Indeed, as Rosemarie Tong correctly observes, and to use her terminology as I have recast it, we have many moral acquaintances. She and I would likely also be of the opinion that there are in addition persons who are truly moral enemies. We are likely even to be in significant agreement regarding how to characterize many of them: those who use malevolent and/or unconsented-to force against the morally innocent.

Yet in her otherwise very careful attention to Foundations, Rosemarie Tong does not take sufficient account of the circumstance that in Foundations I am not offering an account of my own content-full moral perspective, nor of the world as I hold it ought to be. Rather, under circumstances in which there is real moral diversity, Foundations shoulders the task of giving an account of the justifications for the use of coercive force, which coercive force is necessary for much of health care policy. Foundations shoulders the task of giving an account of the morality and moral authority moral strangers can share when they wish to resolve moral controversies in a morally authoritative fashion in the absence of understanding the requirements of God or possessing a common understanding of moral rationality. As a consequence, Foundations leads to the recognition that a secular bioethics will allow much that individuals from particular religious and secular moral perspectives will regard as significantly wrongheaded. As a result, I have at least as much, if not more, concern about euthanasia than that voiced by Rosemarie Tong. After all, I am an Orthodox Christian and I hold that euthanasia and abortion are seriously immoral acts. Foundations acknowledges, however, that the immorality of those acts cannot be understood in general secular terms.

In recognizing the irresolvability of many moral controversies through sound rational argument, Foundations leads by default to a libertarian account of the state and of secular health care policy, a secular moral understanding which must acquiesce in real moral diversity and much that some will know is very evil. This account will also recognize the difference between the morality of a secular pluralist society and the morality of particular moral communities. Here I would suspect as well that Rosemarie Tong and I are in agreement with regard to the role of that practical discourse which respectfully and

peaceably engages those with whom one has significant moral differences. Foundations explicitly acknowledges the role of peaceable conversion, while opposing coercive interference with the consensual acts of individuals and the functioning of consensual communities. Rosemarie Tong and I may be in disagreement with regard to the character of such conversions, but that circumstance does not bear against the point at issue: the offer of such discourse is always appropriate in the face of moral diversity. It is important to recognize that, despite such discourse, diversity will remain. In fact, it will often be better articulated as the result of that discourse. Discourse between moral strangers may lead not to conversion and consensus, but rather to a better appreciation of the moral differences and disagreements that separate. When the actions undertaken are with the consent of those involved, much must be tolerated which we may recognize to be morally inappropriate, indeed evil. Here, as well, Rosemarie Tong and I will find ourselves in significant agreement. The peaceable activities which Foundations argues a secular state must tolerate are not endorsed as good activities by that work or its author.

James Lennox and I may be in greater agreement than a superficial reading of his essay may suggest. First, endorsing a Kantian epistemology does not entail holding that one creates a world that conforms to one's theoretical hopes. Indeed, Kant held that we bring with us necessary conditions for the possibility of empirical knowledge, which conditions cannot be chosen and cannot be eschewed. With regard to Aristotle, Lennox and I are in full agreement. As I indicated in Foundations, Aristotle was drawn upon by Thomas Aquinas and then later by Thomists to give an account of natural law which, when fused with stoic and peculiarly Western Christian assumptions, led to a cluster of views that were influential in medicine. However, the positions produced are not Aristotle's.

More significantly, much of what Lennox says with regard to health, disease, and evolution, Foundations concedes with respect to an understanding of how one could address the species-typical character of humans from the perspective of zoology. Foundations takes as its task an account of clinical medicine, a social practice which is not immediately directed to knowing truly, but rather to acting effectively, while taking into account a complex cluster of non-epistemic concerns, including financial costs. The language of disease, illness, and health in clinical medicine functions as part of a practice in which warrants are sought either to authorize certain interventions or to forego interventions without violating established commitments for treatment.

To appreciate the use of disease and illness language as therapy warrants, one might consider how managed care invokes cost considerations to determine where a line should be drawn as to what does or does not merit treatment. For example, a complex of cost-benefit considerations are invoked when drawing a line between that level of diastolic blood pressure that will be understood to be normal, and that understood to be abnormal, to constitute hypertension, so as to warrant a therapeutic intervention of a particular sort. In determining where to draw the line between health and disease, one will not simply attend to the likely outcomes of hypertension, such as coronary artery disease, or stroke. One will attend as well to the costs of treating such hypertension, where the costs brought into consideration will not simply be financial costs, but the various morbidities associated with the available treatments. Since there will be various views about how properly to balance costs with lives saved, as well as the side effects of various treatments with the

benefits of various treatments, the creation of any particular line between normal and abnormal blood pressure will be just that. It will be a creation that will take into account balancings of harms and benefits. Moreover, in that such lines function within social institutions, the drawing of lines will implicitly or explicitly involve compromises among different views by different stakeholders. It is for this reason that Foundations in chapter 5, to which James Lennox has given such thoughtful attention, completes its arguments by exploring the various stagings of cancer created by such groups as American Joint Committee for Cancer Staging and End-Results Reporting.

The claims of Foundations regarding the social construction of clinical medical reality does not involve denying that medicine takes into account biological facts of the matter. Nor does it involve holding that the information to which medicine as a healing practice should direct its attention should exclude what we have come to understand with respect to human evolution. Nor does it involve denying that there can be better or worse explanations of disease. Instead, the claim is that medical classifications are not directed immediately to providing a true picture of the world, but rather to providing a clinically useful picture. Clinical classifications are robustly instrumental. So, too, is the articulation of explanatory accounts in clinical medicine. They are shaped by a set of non-epistemic concerns which recast clinical medical explanations in the service of cost effective treatment, while recognizing all along that there will be competing understandings of costs, benefits, and how to weigh them. In such circumstances, different accounts can be better or worse with regard to their aiding in the realization of the goals set for clinical medicine.

This is not to deny that "medical concepts such as health and disease can be grounded in the biological sciences" (Lennox, p.78). Rather, it is to observe that they are not simply grounded in the biological sciences. Lennox recognizes this when he acknowledges that "many 'extra-scientific' values play a role in the practice of diagnostic inquiry, classification, and treatment [and that] the very act of deciding that a physical condition deserves the label 'disease' is an act of evaluation" (p.77). It is rather in addition that an account of clinical medicine requires observing that what physicians learn from biology is embedded in a set of practices that direct physicians to engage in particular diagnostic and therapeutic interventions, while taking into account the likely costs and benefits of possible interventions, including financial costs and benefits. Even the decision whether one should attempt to know reality better by means of further diagnostic interventions is itself always properly embedded in considerations of the morbidity, mortality, financial and social costs of such acquisition of medical knowledge.

In some cases, these considerations will address the biological facts of the matter with only a very light hand. James Lennox speaks of his encounter with hepatitis and that he contacted the least vexatious of what he terms the three viruses that cause hepatitis. His very useful illustration brings one to observe that there are in fact a number of viruses etiologically involved in hepatitis. How many one wishes to worry about in a clinical context, that is, how one wishes to direct the expensive attention of physicians to etiology, will depend on which distinctions make what difference for whom, when, and with what costs. Even to call all of these diseases hepatitis will be a choice among different ways in which one might direct the clinical attention of physicians. Much of Lennox's concern

about the hepatitis he did not contract stems from the auto-immune reactions that such viruses can precipitate. The long-term problems are not simply those that come from the liver. As a consequence, are such diseases from these other viruses best spoken of as causing hepatitis, thus directing primary attention to that one organ? Or are they best placed under the rubric of auto-immune responses and immunological defects as one creates clinical classifications and the arrangements of medical textbooks? Foundations notes that the choices one makes in such circumstances are fashioned in terms of the clinical orientation or attention one wishes to convey to physicians in particular, and to health care systems in general. One highlights one explanation rather than another because of the clinical usefulness of a particular choice. Clinically different ways of regarding what is the "same disease" from a biological perspective will be better or worse, more or less useful, depending on the specialty, the health care system, and the therapeutic resources available. Choices will be better or worse depending not just on the facts of the matter but on how one orders the goals at stake.

A similar gloss can be given to James Lennox's reflections on alcoholism and liver function (Lennox, p.80). For example, it is known that not only is drinking pleasurable, but drinking is also negatively correlated with the development of coronary artery disease.[2] Since all of us will die, much of medical treatment involves choices among different likelihoods of dying from one disease rather than another. As a consequence, it would not be implausible for public health physicians to consider how one might balance risks of ethanol damage to the liver, with the risk of coronary artery disease. Public health norms with regard to drinking could then appropriately take into consideration balancings of harms to different organs, not only taking account of the impact on life expectancy, but also the costs for coronary bypass operations versus liver transplants, the pleasure of wine versus the morbidity of other drugs employed to lower cholesterol, etc. Though in some biological sense the standard of proper liver function is biologically grounded (Lennox, p.80), clinical standards for liver function and for public health recommendations with regard to alcohol use in a clinical context are not merely biologically grounded. They also reflect a range of cost-benefit considerations that surely include life expectancy, but not simply life expectancy (Lennox, p.80).

Because in clinical medicine findings of disease and health reflect background considerations of the proper warrants for making diagnostic determinations and engaging in therapeutic interventions, ideals of anatomical structure, as well as of physiological and mental function, are not only biological (Lennox, p.80). Nor will it be sufficient in the establishment of such diagnostic and therapeutic warrants to attend only to "biological conditions or the outcomes of evolution" (Lennox, p.79 Foundations 202). On the one hand, I have not denied that such attempts can be fruitful with regard to reconstructing important concerns on the part of zoologists who are interested in knowing truly rather than acting within a social practice such as clinical medicine effectively. On the other hand, I have denied that it is possible to give an account of clinical medicine and its use of disease classifications without acknowledging the socially constructed character of clinical medical reality. Accounts of what should count as disease, futile treatments, etc., reflect not merely the facts of the matter, but a complex set of considerations about how to engage explanations and affirm particular values in order effectively to avoid and/or treat particular ways of suffering.

My response here has not been directly to engage the considerations that James Lennox raises. Rather, I have resituated them in what I take to be the context for an appropriate understanding of clinical references to illness, disease, and health. Once these considerations are resituated, one can then also bring feminist and other approaches to reappraising the use of such language in clinical contexts, all without presupposing that one is claiming to refashion biological reality as James Lennox suggests in his gloss on Mendel's study of inherited characteristics. One is recognizing that the reality of clinical medicine is not only biological but social. Clinical medical reality as a social construct which is structured to direct behavior must in part be stipulated by convention. Here, again, the example of the creation of various nomenclatures for the staging of cancer is heuristic. It is here that concerns regarding the democratization of reality should be salient. Moreover, it is here as well that moral rights of privacy for individuals and communities must also be taken into account so that different communities can peaceably establish and act upon different diagnostic and therapeutic understandings reflecting their own moral commitments. In chapters 4 and 8, Foundations turns to this issue when addressing the possibility of numerous parallel medical systems guided by different moral understandings. Such moral understandings will not simply be reflected in what is judged to be appropriate or inappropriate behavior, but also in how one appropriately uses the medical language of disease, illness, futility, etc.

Though Foundations shares a great deal with the concerns of Rosemarie Tong, and though much of the concerns raised by James Lennox can be acknowledged while not setting aside the central arguments in chapter 5 of Foundations, Tom Beauchamp and I may indeed be in more significant disagreement. Indeed, his position sets me over against him on the side of Rosemarie Tong. Tong and I both take moral diversity seriously and acknowledge that all do not in fact share one common morality. To make plausible his account of bioethics, Beauchamp must presuppose the background existence of a common morality to which one can turn through a common set of middle-level principles and/or casuistic devices so that theoretical disagreement can be set aside in actual agreement regarding particular cases and particular policies. He also appears to hold that the exclusion of particular moral choices through an appeal to a procedural morality grounded in the authorization of persons commits one to a particular content-full morality.

But most astonishing in the paper of Tom Beauchamp is his adamant refusal to recognize the deep moral controversies that characterize the actual bioethical disputes framing the headlines in newspapers around the world. There are real and significant disputes not just regarding abortion, third-party assisted reproduction, and suicide, but regarding what should count as justice, fairness, and equality. Different notions of the good, as well as different notions of human flourishing, divide individuals and moral communities and frame the very character of contemporary bioethical disputes. Here it must be noted that Robert Sade seems not to appreciate the difficulty in establishing the authority of different social mediation among different understandings of human flourishing. Granted, that may not be that difficult, once he has embraced the view that living with contradiction may not be better than living without contradiction. Surely, it is the case that Foundations does not offer a moral or aesthetic ground for celebrating living without contradiction. However, once one has embraced a real contradiction, everything follows such that one can surely understand that it will not be possible to resolve

controversies by sound rational argument. To return to Beauchamp, the claim is not that there will not be circumstances in which most understandings of beneficence will lead to similar responses: saving the toddler in the middle of the street. The point is rather that all real understandings of beneficence are thick. Is it beneficent, for example, to provide euthanasia and abortion for teenagers who cannot themselves afford it? Answers to such questions can only be found within particular moral communities, and the particular answers will divide the communities.

Beauchamp is correct about the sparseness of the principle of permission, while Sade appears to miss what is at issue. If persons are separated by different views of beneficence and human flourishing, and if persons do not share the same understanding of God or culture, or of fundamental moral premises, rules of evidence and inference, they can only act with common moral authority if they draw that authority from their common permission. In the absence of common moral premises, rules of evidence or inference, when confronted with actual content-full moral issues, the debates cannot be settled unless the parties agree to a settlement. A conclusion cannot be reached by sound rational argument without begging the question, engaging in an infinite regress, or pursuing a circular argument.

Foundations in chapter 2 thus begins with a destructive argument that shows why one cannot come by rational argument to the substantive morality that Beauchamp wishes to presuppose. As this argument shows, different rankings of important moral concerns such as liberty, equality, security, and prosperity lead to quite different understandings of moral probity and human flourishing. Post-modernity is nothing more than the recognition that sound rational argument cannot bridge the gulf established by different foundational premises. However, one can agree to reach across differences and collaborate. This is the point about permission that Sade misunderstands. It is not that permission or peaceableness are valued. Rather, it is that authority can be drawn from permission, even when sound rational arguments fail. The argument is not that force cannot bring closure to a dispute. The argument is rather that, if one wishes authority for force and cannot derive it from a common understanding of either God or reason, one can still derive it from the permission of those who participate. The appeal to permission functions as the transcendental ground that grounds the moral world that can be shared by moral strangers. One must surely explore under what circumstances one is using others coercively, and this will lead one to a more careful exploration of some of the issues Sade addresses regarding coercion.

Sade does not appear to have read chapter 4 of Foundations with sufficient care, for he interprets my account of the Lockean proviso as being a basis for state taxation, though this is explicitly denied. His assumptions regarding payments due to sultans in Kuwait, rather than to all disadvantaged through infringements of the Lockean proviso, simply have no foundation. In any event, even if inclinations toward property have roots in human nature, human nature is likely polymorphic so that at some level negotiations regarding rights in real property will be unavoidable. So, too, will negotiations be unavoidable as different views of human flourishing collide. If one wishes to resolve such controversies by an appeal to justified force, and if all do not understand which force God anoints, and since we do not share common foundational moral premises regarding flourishing, etc.,

the only authority to which we can appeal is the agreement of those who decide to collaborate.

It is for this reason that bioethics in our contemporary world does best when it focuses on procedural expedience such as free and informed consent, contracts, advance directives, rights to be left alone, and the various appurtenances of moral life that depend on agreement. Beauchamp and I part company where I join company with Rosemarie Tong: Tong and I acknowledge the unavoidability of recognizing moral diversity. Though Sade and I join in recognizing the importance of a limited state, I do not think he can derive the justification for his desires from his thick notion of flourishing or his substantive interpretations of human nature. Sade's difficulty lies in part, perhaps, in his confusing social life with that of the moral community. It is surely not the case that Engelhardt "finds the communal ethic he is looking for, not in a thick, content-full moral system, but in a much thinner structure based on the principle of permission" (p.85). As Foundations makes plain, here Sade is closer to Beauchamp in presupposing that we can share a content-full morality. The irony of the matter is that Sade and Beauchamp do not agree about that morality. Such is the post-modern condition in which we find ourselves. Foundations does not suggest that we deny this diversity. Instead, it suggests a way in which we can reach across it and understanding a morality that can with moral authority even bind moral strangers.

Endnotes

1. I am in debt to Mark J. Cherry for his suggestions regarding earlier drafts of this paper.

2. See, for example, Fuchs, C.S., *et al*, 1995, 'Alcohol consumption and mortality among women,' *NEJM* 332, pp.1245- 1250; Gaziano, J.M., *et al*, 1993, 'Moderate alcohol intake, increased levels of high density lipoprotein and its subfractions, and decreased risk of myocardial infarction,' *NEJM* 329, pp.1829-1834; and Smit, J.W., *et al*, 1995, 'Effects of alcohol fluvastatin on lipid metabolism and hepatic functioning,' *Annals of Internal Medicine* 122, pp.678-680.