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BIOETHICS AND THE PROBLEM OF PLURALISM*

By Donald C. Ainslie

I. Introduction

The state that we inhabit plays a significant role in shaping our lives. For not only do its institutions constrain the kinds of lives we can lead, but it also claims the right to punish us if our choices take us beyond what it deems to be appropriate limits. Political philosophers have traditionally tried to justify the state's power by appealing to their preferred theories of justice, as articulated in complex and wide-ranging moral theories—utilitarianism, Kantianism, and the like. One of John Rawls's greatest contributions to political philosophy has been his recognition that this is the wrong way for this field to approach its task. He points to what he calls "the fact of reasonable pluralism," which is the incontestable fact that in a free society people striving to lead their lives ethically will subscribe to conflicting moral and religious doctrines, many of which will be "reasonable" in the special sense of leaving their adherents willing to cooperate with those with whom they have moral disagreements.[1] And this means that political philosophers can no longer rely on any particular "comprehensive" doctrine in their attempts to justify the state. For doing so would be unfair to those who subscribe to a conflicting reasonable doctrine; it would mean that the coercive power of the state would not be justified *to them* in terms *they* can accept, even while they were forced to abide by its terms. Instead, Rawls suggests that the fundamentals of the state, that is, its "basic structure,"[2] should be governed by a "political conception of justice"—a set of norms for the basic structure of society—formulated not by appealing to any particular comprehensive doctrine, but by asking what those with reasonable and yet conflicting doctrines would agree to as the terms for their interaction.[3] Political philosophy is

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[1] John Rawls, *Political Liberalism* (New York: Columbia University Press, 1993), xvi–xviii. Note, then, that Rawls distinguishes between the fact of pluralism and the fact of *reasonable* pluralism (xvii). The former points only to the fact that people disagree about morality, sometimes quite radically. The latter points to those cases where these disagreements are reasonable, in a special sense noted here (see Section V below).

[2] Ibid., 257–88.

[3] Ibid., 11–15.

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thus a "freestanding" endeavor with its own burdens of justification; it is not merely the application to the state of an independently justified moral theory.[4]

Bioethicists, like political philosophers, are in the business of providing norms for institutions that have enormous power over us. For our lives are at least in part shaped by the condition of our bodies, and health-care professionals are empowered to intervene in our bodies with medications or surgery in order to help us in our attempts to overcome the constraints that disease and disability put on us. Bioethicists have sometimes tried to set the terms for the appropriate use of this biomedical power by appealing to their preferred moral theories—utilitarianism, Kantianism, and the like. I will argue in what follows that this is the wrong way for them to approach their task, for Rawls's insight about political philosophy also applies to bioethics: Insofar as bioethicists attempt to formulate policy—either public health policy or norms for the health professions—they too must come to terms with the fact of reasonable pluralism. And this means that bioethicists cannot simply appeal to their preferred comprehensive moral doctrine to justify their policy suggestions; instead, they must show that their suggestions are justified to those with reasonable and yet conflicting doctrines.

I argue for the applicability of the Rawlsian distinction to bioethics in the first four sections of this essay by considering three other attempts by bioethicists to come to terms with pluralism: the "principlism" of Tom Beauchamp and James Childress (Section II); autonomy-based approaches, such as that of Gerald Dworkin (Section III); and the partitioning strategy undertaken by H. Tristram Engelhardt, Jr. (Section IV). I will argue that, as they stand, each approach gets something right but ultimately fails to cope with the fact of reasonable pluralism adequately. I suggest in Section V, though, that a bioethical version of the Rawlsian distinction retains the insights that motivate each of them.

In Section VI, I go on to suggest that the Rawlsian distinction also helps to make sense of the recent emergence of what I call the *bioethics of everyday life*, which is the attempt to formulate not public policy or norms for health professionals, but comprehensive doctrines that address the moral issues posed for each of us by our biological nature—the human mode of reproduction, our susceptibility to disease and disability, our mortality. Finally, in Section VII, I explore some of the tensions that can emerge when the distinction between policy-oriented bioethics and the bioethics of everyday life is not recognized.

I should note at the outset that, although I argue for a Rawlsian approach to bioethics, I mean here only to endorse a bioethical analogue of the *methodology* he has developed for political philosophy. Rawls, of course, argues not only for the methodological point, but also for a particular

[4] Ibid., 10.

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conception of justice: the two principles that mandate, first, the protection of basic liberties and, second, fair equality of opportunity combined with the distribution of goods to benefit the least well off (the "difference principle").[5] I will remain neutral in what follows on the question of whether this particular conception of justice in fact meets the justificatory burden Rawls has set for himself.

II. "Principlism"

The most influential approach to bioethics today remains Beauchamp and Childress's so-called *principlism* as articulated in the five editions of their *Principles of Biomedical Ethics*.[6] From the first edition onward, they have motivated their view by appealing to what might be called the fact of *theoretical* pluralism, which is the fact that philosophers have been unable to reach a verdict on which ethical theory is best.[7] Beauchamp and Childress suggest that, even without this verdict, bioethicists can still resolve the practical controversies that arise in biomedicine not by applying any particular ethical theory, but instead by appealing to four mid-level prima facie principles: respect for autonomy, nonmaleficence, beneficence, and justice. Since versions of the four principles appear in most of the contending theories—utilitarians and Kantians, for example, both require people not to harm others, even if they offer different theoretical rationales for this requirement—bioethicists who disagree about moral theory can nonetheless use the principles to justify health-care policy suggestions without getting bogged down in intractable theoretical debate.[8]

To what extent does this count as an adequate response to pluralism? While it is true that many ethical theories contain versions of Beauchamp and Childress's principles, it is not too hard to think of comprehensive moral doctrines that reject at least one of them. For example, some Christian fundamentalists might reject the idea that those outside of a small class (adult male citizens who head households) merit having their autonomy respected. Why must a woman who subscribes to this view be forced to make her own medical decisions rather than have them made by

[5] John Rawls, *A Theory of Justice* (Cambridge, MA: Harvard University Press, 1971), 60–65, 302–3.

[6] Tom Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, eds. 1–5 (New York: Oxford University Press, 1979, 1983, 1989, 1994, 2001).

Note that the label "principlism" was first used as a term of disparagement (see K. Danner Clouser and Bernard Gert, "A Critique of Principlism," *Journal of Medicine and Philosophy* 15, no. 2 [1990]: 219–36), but Beauchamp and Childress have since adopted it for themselves.

[7] They themselves disagree on this matter. See Beauchamp and Childress, *Principles of Biomedical Ethics*, 40 (1st ed.), 40 (2d ed.), 44 (3d ed.), 110 (4th ed.), 376 (5th ed.).

[8] Ibid., 40 (1st ed.), 41 (2d ed.), 44–47 (3d ed.), 109–11 (4th ed.), 376–77 (5th ed.).

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the relevant man in her life?[9] A radical libertarian (a Randian objectivist, say) would not subscribe to either the principle of nonmaleficence or of beneficence. Why should such a person be prohibited from receiving from his doctor a treatment, say, an experimental drug thought to be clinically harmful, even though he willingly and knowingly requests it? Or why must a libertarian medical researcher limit her projects to those that she believes have a reasonable chance of improving on the standard of care, when she is able to find willing subjects who choose to undertake riskier experiments for suitable remuneration? Finally, differences over what justice requires were what brought Rawls to espouse his political version of liberalism in the first place. Why would justice in biomedicine be any less controversial? A Nietzschean might even think that *any* conception of justice is an unjustified constraint on one's power that only reflects the interests of the weak. Why, then, should he accept the organ-distribution network established by the state rather than pursuing a needed transplant by any means that he has at his disposal? My point is that in a pluralistic society, it is hard to believe that all citizens would find the four principles to be the appropriate framework for bioethics.[10]

Note that my concern is not merely the fact that we can imagine people who reject part of Beauchamp and Childress's view; after all, no philosophical view would be immune to imagined disagreements. The problem is that Beauchamp and Childress aim to have medical care structured by their four principles. What entitles them to require others to live by these principles? Why must others, in their struggles with reproduction, disease, suffering, and death, conform to principles over which some philosophical theories happen to coincide? Bioethicists' subscription to these principles and reliance on them for policy-making starts to look like the use of social power against those with less popular moral outlooks.

Beauchamp and Childress respond to this objection with two lines of thought. In the first three editions of *Principles of Biomedical Ethics*, they seem to take the plurality of moral theories to support a skeptical conclusion about their adequacy. Many of the moral theories might accurately capture some aspect of morality, but none of them fully accounts for all of it. Beauchamp and Childress then suggest that the four principles are approximations to what the best moral theory would yield were it to be formulated, and so are good enough to guide the resolution of pressing practical problems.[11] Thus, those who do not accept the princi-

[9] Even if health professionals willingly follow her request to have her husband make her decisions for her, she is still required to make this request, and in that sense she is still being forced to have her autonomy respected against her wishes.

[10] Note that I do not mean for all of the examples in this paragraph to be reasonable comprehensive doctrines in Rawls's sense. Part of what Beauchamp and Childress lack, I will argue, is a way to give a principled distinction between moral views we can tolerate and those we can reasonably restrict.

[11] Beauchamp and Childress, *Principles of Biomedical Ethics*, 41 (1st ed.), 42–43 (2d ed.), 46–47 (3d ed.).

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ples (the fundamentalist, the Randian, the Nietzschean) are in Beauchamp and Childress's eyes simply *wrong*. And this is the only reason they give for why principle-rejecting dissidents should be forced to accept biomedicine's being governed by their four principles.

In the more recent editions of *Principles of Biomedical Ethics*, Beauchamp and Childress give a somewhat different justification for their choice of principles by arguing that they offer a common-morality theory in the same family as that of W. D. Ross and William Frankena.[12] This approach "takes its basic premises directly from the morality shared in common by the members of a society—that is, unphilosophical common sense and tradition"[13]; the four principles are explicitations of what is implicit in common morality. Beauchamp and Childress now acknowledge the possibility that some might reject their principles, but they reply by ruling out certain traditions as merely "customary moralities"—presumably including the fundamentalism, Randian objectivism, and Nietzscheanism described above—not meriting consideration when formulating principles for biomedicine.[14] They fail, however, to give a criterion by means of which customary moralities can be distinguished from the common morality (other than that the former do not include the principles). This means that, as in the earlier editions, when they enunciate their four principles, Beauchamp and Childress seem ultimately to be relying on their own considered convictions about which morality is appropriate for medicine.

Now, Beauchamp and Childress's responses in both the earlier and latest editions will, of course, strike the dissidents as arbitrary and oppressive. Given that the people in question have their own reasons not to accept the principles, Beauchamp and Childress seem merely to be dogmatically affirming their private conception of morality as one all should be compelled to accept. This dispute allows us to shed light on the difference between the *theoretical* pluralism motivating Beauchamp and Childress's principlism and the *reasonable* pluralism of comprehensive doctrines standing behind Rawls's political liberalism. Beauchamp and Childress see morality as a loosely unified, complex structure that philosophers try to capture by means of an ethical theory. Theoretical pluralism simply reflects the complexity of the structure and the weakness of our philosophical capacities. The views of the fundamentalist and the Randian objectivist do not count as part of the fact of theoretical pluralism because they are not attempts to do moral theory. (The Nietzschean's rejection of

[12] Ibid., 100–109 (4th ed.), 401–8 (5th ed.). For Ross, see W. D. Ross, *The Right and the Good* (Oxford: Clarendon Press, 1930); and W. D. Ross, *The Foundations of Ethics* (Oxford: Clarendon Press, 1939). For Frankena, see William Frankena, *Ethics*, 2d ed. (Englewood Cliffs, NJ: Prentice-Hall, 1973); and William Frankena, *Thinking about Morality* (Ann Arbor: University of Michigan Press, 1980).

[13] Beauchamp and Childress, *Principles of Biomedical Ethics*, 100 (4th ed.). In the fifth edition, Beauchamp and Childress define "common morality" as "the set of norms that all morally serious people share"; see page 3 of that edition.

[14] Ibid., 100 (4th ed.), 403 (5th ed.).

the project of moral theory in Beauchamp and Childress's sense rules his view out for different reasons.) Rawls's fact of reasonable pluralism, in contrast, is a product not of philosophers' limitations, but of the general capacity that we all have to reason about how our lives should go.[15] And thus, for him, pluralism is not isolated to the level of ethical theory. Formulating a moral theory is one way to think about morality so as to come up with a comprehensive moral doctrine, but it is only one way. Religiously inspired adherence to tradition (perhaps the source for our fundamentalist's commitments), readings of popular texts circulating in the culture at large (our Randian), or a rejection of the idea that there is a true object for moral theory to study (our Nietzschean) are other possible ways of reaching a comprehensive doctrine. Rawls thus takes seriously the task of justifying social institutions to those who will be coercively constrained by them. He tries to show that insofar as people are reasonable, they should accept the conception of justice he proffers. (His justification for coercing the unreasonable is discussed in Section V below.) In contrast, not only do Beauchamp and Childress fail to acknowledge the real sense in which people have reasonable disagreements about morality—not just abstruse disagreements about moral theory—they also fail even to try to show why their own particular values should be used to constrain others.

Consider how my criticism of principlism differs from two other complaints that have been leveled against it.[16] On the one hand, philosophers K. Danner Clouser and Bernard Gert argue that since the four principles are disengaged from any particular theory, they are merely a grab bag of values offering no real direction for action. The problem is especially grave when the principles clash, say, in a case where respecting a patient's autonomy would require a health professional to harm the patient. Given that Beauchamp and Childress do not rank order their principles, they seem to offer no way to justify a claim that one principle is more important than another in the case at hand. The fact that the ethical theories that Beauchamp and Childress tend to emphasize in the early editions of *Principles of Biomedical Ethics*, utilitarianism and deontology, often do clash on exactly the issue of the relative priority of respect for autonomy, nonmaleficence, beneficence, and justice makes it especially hard to see how the move to principles avoids the evident conflict at the level of theories. Clouser and Gert argue that to avoid the problems afflicting Beauchamp and Childress's principlism, bioethics must turn to a particular ethical theory—in particular, Gert's theory of rules—so that practical conclusions

[15] Rawls says: "[A] plurality of reasonable yet incompatible comprehensive doctrines is the normal result of the exercise of human reason within the framework of the free institutions of a constitutional democratic regime" (Rawls, *Political Liberalism*, xvi).

[16] Bioethical theory and methodology have received an enormous amount of attention recently; see the selected bibliography compiled in Pat Milmoe McCarrick, "Principles and Theory in Bioethics," *Kennedy Institute of Ethics Journal* 5, no. 3 (1995): 279–86. See also the large collection of essays focusing on Beauchamp and Childress's approach, Ranaan Gillon, ed., *Principles of Health Care Ethics* (New York: John Wiley and Sons, 1994).

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can be seen to have a unified source that would allow for the resolution of conflicts between principles.[17]

But Clouser and Gert's suggestion only exacerbates the problem I have identified in Beauchamp and Childress's approach. For while the latter at least acknowledge the difficulties that come with structuring bioethics in terms of particular ethical theories, Clouser and Gert simply ignore the fact of pluralism both theoretical and otherwise. We have reasonable differences about which ethical theory is the best, and so grounding practical solutions to public bioethical problems in one particular theory is unfair to those who find it less than compelling. It forces them to have their lives constrained by the moral theory that Clouser and Gert prefer, even if they quite reasonably reject it.

Where Clouser and Gert criticize Beauchamp and Childress "from above," in terms of their lack of a unifying theory, the other major criticism of them has been "from below." Bioethicist Albert Jonsen and philosopher Stephen Toulmin have argued that bioethics is best accomplished *casuistically*, that is, reasoning analogically from settled cases, rather than attempting to impose on it general principles that fail to address the particularities of actual situations. This might be interpreted as a radical version of Beauchamp and Childress's approach. For Jonsen and Toulmin hold that not only are there disagreements about ethical theory, but these disagreements are also reflected in disagreements about principles (and in this they can be seen to second Clouser and Gert). However, they seem to think that we can nonetheless reach conclusions about cases that we can all acknowledge to be acceptable despite our different general moral commitments.[18]

Beauchamp and Childress have responded to this criticism by acknowledging that their principles, when taken by themselves, have little content. In order to apply them to specific cases, their content must first be specified to bring them into contact with the relevant issues, and then they must be balanced against one another when they conflict.[19] The best that can be hoped for is a kind of Rawlsian "reflective equilibrium" between the specified versions of the principles, previous resolutions of similar cases, and a proposed verdict for the case at hand.[20] Note that just

[17] Clouser and Gert, "A Critique of Principlism." See also Bernard Gert, Charles M. Culver, and K. Danner Clouser, *Bioethics: A Return to Fundamentals* (New York: Oxford University Press, 1997).

[18] Albert R. Jonsen and Stephen Toulmin, *The Abuse of Casuistry* (Berkeley: University of California Press, 1988), 18.

[19] Beauchamp and Childress, *Principles of Biomedical Ethics*, 28–37 (4th ed.), 15–23 (5th ed.).

[20] Ibid., 20–28 (4th ed.), 397–401 (5th ed.). See also Norman Daniels's discussion of reflective equilibrium and bioethics in Norman Daniels, "Wide Reflective Equilibrium in Practice," in L. W. Sumner and Joseph Boyle, eds., *Philosophical Perspectives on Bioethics* (Toronto: University of Toronto Press, 1996), 96–114; and Norman Daniels et al., "Methodology," in Allen Buchanan et al., *From Chance to Choice: Genetics and Justice* (Cambridge: Cambridge University Press, 2000), 371–82.

as Beauchamp and Childress have acknowledged a need for casuistry as a complement to their principles (at least since the second edition of *Principles of Biomedical Ethics*[21]), Jonsen, too, has recently softened his critique, allowing some room for principles in his casuistic approach.[22]

But casuistry is no better a position than principlism is when it comes to pluralism. The problem is that some of the so-called settled cases that are supposed to be the starting point for our casuistical reasoning might themselves merely be the reflection of the social power of those who subscribe to one particular moral doctrine. Think of the traditional prohibition on all forms of euthanasia. Those who favor physician-assisted suicide and other forms of aid-in-dying will be tempted to see the prohibition on euthanasia as the result of the dominance in the West of the Christian commitment to the sanctity of life. They will be tempted to see it as a case of their being forced to lead their lives by a morality they reject. Thus, if bioethicists follow Jonsen and Toulmin by relying only on cases, they have no way to justify the outcomes of their casuistical reasoning to those who challenge it for relying on unstated assumptions that have their sources in particular comprehensive moral doctrines that are the objects of reasonable disagreement.

In sum, I have argued that Beauchamp and Childress and their critics never really come to grips with the fact of pluralism. Clouser and Gert simply ignore it, while Beauchamp and Childress and Jonsen and Toulmin attempt to explain it away as a philosophical epiphenomenon masking a deeper commitment to common morality or a tradition of fully resolved cases. I have argued that the fact of pluralism means that there is no such common morality or uncontroversial reservoir of cases. None of the bioethicists considered here, then, has given us a reason why others should be compelled to have their health care structured by moral outlooks that they can reasonably reject. Relying on the moral commitments of particular bioethicists to solve policy questions is arbitrary.

III. Autonomy

But perhaps, despite the existence of a plurality of comprehensive moral doctrines, there is one value that they all must share as a condition of their possibility—autonomy. It would then be possible to use this shared value to justify positions in bioethics, despite the general disagreement about other moral questions. Several bioethicists have endorsed this strategy (notably, Engelhardt does so in the first edition of his *Foundations of Bioethics*, the second edition of which is discussed in the following section[23]),

[21] Beauchamp and Childress, *Principles of Biomedical Ethics*, 48 (2d ed.).

[22] Albert Jonsen, "Casuistry: An Alternative or Complement to Principles?" *Kennedy Institute of Ethics Journal* 5, no. 3 (1995): 237–51.

[23] H. Tristram Engelhardt, Jr., *The Foundations of Bioethics*, eds. 1–2 (New York: Oxford University Press, 1986, 1996).

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but I will focus on Dworkin's version of it in *The Theory and Practice of Autonomy*, because his is a particularly clear discussion of the nature and value of autonomy.[24]

For Dworkin, autonomy is, loosely speaking, the ability we have to be in charge of our lives, to direct them in light of our own commitments and values. We are autonomous, then, because we are (usually) more than mere slaves to our passions. More specifically, he defines autonomy as "a second-order capacity of persons to reflect critically upon their first-order preferences, desires, wishes, and so forth and the capacity to accept or attempt to change these in light of higher-order preferences and values. By exercising such a capacity, persons define their nature, give meaning and coherence to their lives, and take responsibility for the kind of person they are."[25] Since Dworkin's notion of autonomy does not require us to order our lives by any specific preferences or values, being autonomous allows for the subscription to any particular comprehensive doctrine.[26]

But what moral status does autonomy have, given this view of it? Dworkin argues that it is of fundamental importance because it is partly constitutive of our being agents, of our *doing* something rather than our merely *witnessing* it happen to us.[27] He concludes that the subscriber to any comprehensive moral doctrine must value her autonomy, for it is that capacity that allows her to attempt to lead her life in terms of a moral doctrine in the first place.[28] This is not to say that it is the only morally significant value, or that it overrides all other values; however, Dworkin argues that before infringing on someone's autonomy, we have to take it seriously by showing that she herself would no longer want to live her life on her own terms in the circumstances in question.[29]

In his treatment of informed consent, Dworkin demonstrates how this conception of autonomy can resolve bioethical problems. The condition of our bodies is essential to our attempts to lead our lives, and so for us to be autonomous we need to be able to make the fundamental decisions about our bodies for ourselves. The moral importance of autonomy means that, in general, health professionals should get informed consent from patients before treating them. Health professionals should respect their patients' autonomy.[30]

Dworkin comes closer than Beauchamp and Childress to being able to justify his approach to those with substantive disagreements over com-

[24] Gerald Dworkin, *The Theory and Practice of Autonomy* (Cambridge: Cambridge University Press, 1988). Note that, although Dworkin is not specifically concerned with coming up with a theory for bioethics, he does rely on it in his discussions of informed consent and proxy consent.

[25] Ibid., 20; see also 108.

[26] Ibid., 29.

[27] Ibid., 29–32, 111–12.

[28] Ibid., 31–32.

[29] Ibid., 114–15.

[30] Ibid., 113.

prehensive doctrines. While they were left dismissing contenders as holding merely "customary" moralities, Dworkin tries to justify his claims *to* those who hold different moral commitments with the suggestion that they share with him a recognition of the importance of autonomy.[31] But it is here that I think he gets into trouble. For, as was the case with Beauchamp and Childress's principles, it is not too hard to think of comprehensive doctrines that do not attribute fundamental value to autonomy—even supposing that they accept Dworkin's conception of this philosophically controversial concept.

Consider, for example, a radical kind of Protestantism. Such a view might hold that our autonomy is exactly what gets us into moral trouble, for it installs *us*, not God, as the source of meaning in our lives. While Dworkin says that "[w]e desire to be recognized by others as the kind of creature capable of determining our own destiny,"[32] the radical Protestant thinks that this desire is a reflection of sinful pride; for him, our destiny is in the hands of God and the mysterious dispensations of his grace. Some forms of utilitarianism might also lead one to reject the value of autonomy. For it is surely possible that our being autonomous interferes with the maximization of welfare, pleasure, or preference satisfaction—whichever is posited as the ultimate goal. Our being able to shape our lives for ourselves might mean that we routinely overlook what is really of value in life, and instead opt for courses of action that decrease our collective well-being, cause one another pain, or increase the mutual frustration of our desires. Indeed, any moral doctrine that combines an emphasis on the overriding importance of our living according to a particular set of substantive values with a pessimism about the ability of most people to recognize those values will see autonomy as a mixed blessing, for it is the capacity that allows people to deviate from what really matters. Dworkin thinks that "[w]hat is valuable about autonomy is that the commitments and promises a person makes be ones he views as his,"[33] but the doctrines I have been describing take it to be more important that the commitments and promises someone makes be right than that he views them as his. It is one thing for a moral view to presuppose our being autonomous, and another for it to itself include a commitment to the value of autonomy.

This means that Dworkin's claim that autonomy is of fundamental moral importance is not as innocent as he suggests. Even though many comprehensive moral doctrines will include this value, some will not. If he is to continue to rely on autonomy as a shared value in justifications of policy for biomedicine, he must then give a reason why those who reject the value of autonomy should nonetheless accept the policy. Otherwise,

[31] Ibid., 10, 115.
[32] Ibid., 112.
[33] Ibid., 26.

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he, like Beauchamp and Childress, will end up in the position of arbitrarily imposing his moral commitments on others.

IV. Partitioning Friends and Strangers

In the first edition of his *Foundations of Bioethics*, Engelhardt, like Dworkin, offers an autonomy-based approach to bioethics. He argues that the plurality of moral outlooks leaves freedom as a common value that should be respected in structuring public institutions; thus, only when people consent can others legitimately interfere with their lives. But Engelhardt later worried that his libertarianism leaves him open to a criticism somewhat similar to that which I leveled against Dworkin in the previous section: What justifies using autonomy as the core value for bioethics when many people subscribe to moral doctrines that do not take autonomy to be morally important?[34] In the second edition of *Foundations of Bioethics*, Engelhardt tries to preserve his view by casting it in somewhat different terms. He makes a partition between "moral friends"—those who share a substantive moral outlook—and "moral strangers"—those who interact with one another without sharing common substantive values. He argues that since in pluralistic societies public problems must be resolved among strangers, what he calls the "principle of permission" is to guide resolutions of the traditional problems of bioethics; for, given the lack of a common morality among strangers, their permission is the primary noncoercive touchstone we can have to guide our interactions with them.[35] Note, then, that Engelhardt's partition is *population-based*; it hinges on how widely a moral outlook extends and how commonly it is shared. I think that there are problems on both sides of his partition, however.

Consider, first, his account of how moral friends should behave. Suppose a doctor is treating a patient who shares his moral commitments.[36] If these commitments endorse medical paternalism, it would follow that the doctor could deceive the patient or treat her without first obtaining her consent. This ignores the possibility that the patient's illness might lead her to change her moral outlook, to cease being "friends" with the physician. Our moral commitments are dynamic, but Engelhardt, by treating them as static, ends up requiring people to receive medical care according to whatever comprehensive doctrine they have previously endorsed, leaving them no room to gain moral insight from their struggles with illness and disease.

[34] Engelhardt, *The Foundations of Bioethics*, xi (2d ed.).

[35] Ibid., 67–84. Engelhardt admits that this is a mere relabeling of the principle of autonomy from his argument of the first edition; see ibid., xi (2d ed.).

[36] At times, Engelhardt wants to say that patients and health professionals are by definition strangers (ibid., 295–96), but he also allows that they can be moral friends—even to the extent that health-care institutions can be structured to serve a community the members of which share a moral outlook (ibid., 290, 313, 357 [2d ed.]).

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Engelhardt's account of how moral strangers should interact is also too quick. For he ignores the way in which many of our deepest values are expressed not in our behavior toward those with whom we share a common morality, but in our treatment of those from outside our community. Think of the Good Samaritan of Christian lore, who counts as a moral model for his aid to strangers. In contrast, a radically xenophobic moral outlook might require one to treat the stranger as a lesser being, or to ignore his existence altogether. Even though we might find the former behavior supererogatory and the latter vicious, Engelhardt has to acknowledge that not all comprehensive doctrines will make sense in the same way of how we should interact with strangers.

It follows that Engelhardt's assumption that moral strangers must structure their interactions by the principle of permission does not really allow him to escape the accusation I leveled against Dworkin: He has presented a view that dogmatically values autonomy, even though there are moral disagreements about how best to respond to strangers. And, once more, the issue is not the mere fact of such disagreement, but that Engelhardt wants to constrain others to live in terms of values that they need not accept.

V. A Liberal Partition

The three approaches to bioethics that I have examined can all be seen to share a common flaw. Even while acknowledging to various degrees the fact of pluralism, each nonetheless aspires to reach some general moral conclusions that have widespread applicability. Beauchamp and Childress's suggestion that their four principles are part of a common morality means that they apply not just to biomedicine but more broadly[37]; Dworkin claims that autonomy is fundamentally valuable; and Engelhardt, even while accepting that there are different communities of moral friends, suggests that all relations of moral strangers be structured by permission. It follows that each sees bioethics as the application of a previously established set of moral claims to biomedical problems. For them, bioethics is not a freestanding endeavor, but one supported by independently justified moral conclusions. I object to this move in each of the three cases for the same reason: The fact of reasonable pluralism means that we do not agree on which comprehensive moral doctrine is best, and so an attempt to support bioethical conclusions in terms of one

[37] Beauchamp seems to deny this when he says that his and Childress's "set of principles was developed specifically for biomedical ethics and was never presented as a comprehensive ethical theory" (Tom Beauchamp, "Principlism and Its Alleged Competitors," *Kennedy Institute of Ethics Journal* 5, no. 3 [1995]: 182). While it is true that their principles were never presented as a comprehensive theory, they did treat them as an approximation to such a theory independently of their connection with bioethics. As I noted in Section II, they held that this is why their principles were the appropriate tools for addressing the pressing nature of the policy problems connected with bioethics.

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such doctrine (or a fragment thereof) will then amount to arbitrarily requiring those who reasonably reject it to live by it nonetheless.

What is the alternative? My suggestion is that bioethics should be seen as freestanding in relation to comprehensive moral doctrines, just as Rawls thinks that political philosophy is. In each case, the norms that are to apply to all members of society—whether as citizens or as participants in the delivery of health care—are justified not by appeal to any particular comprehensive doctrine, but in terms that those with conflicting yet reasonable doctrines can accept. Where Engelhardt makes a *population-based* partition, I am urging a *task-oriented* partition. When considering how best we should live, what we should value, whom we should admire, and so on, we must rely on comprehensive moral doctrines with their aspirations toward a general theory of the good. But when attempting to formulate policy that will put limits on what any of us can do with our lives, theorists—in political philosophy and policy-oriented bioethics—must show to those whose lives are to be constrained that they have reason to accept it despite their disagreements over comprehensive doctrines.

The appropriateness of the Rawlsian distinction for formulating policies on the allocation of scarce resources or the distribution of health care—questions directly linked to justice in health care—is especially clear. These questions are best treated in terms of the proper organization of the basic structure of society. But, interestingly, Rawls himself has never addressed these issues largely because, as he admits, the complexities arising from human embodiment drop from view in his theory.[38] He emphasizes that the political conception of justice he endorses is to act as an ideal, something that we should use as a goal as we go about the messy business of reforming our particular society. We are to construct a conception of justice that best serves our sense of ourselves as sources of value *throughout complete, healthy lives*—as agents with fairly clear comprehensive moral doctrines, coherent life-plans formulated in light of these doctrines, and the rational capacities needed for living together with other such agents—all the while recognizing the many ways in which we fall short of this description.[39] Hence, Rawls builds many assumptions into the "original position," which is the thought experiment that he uses to formulate his preferred political conception of justice.[40] Most notably for our purposes, he assumes that all members of society are able to participate in the bargaining through which the basic structure of society is determined. This feature of the thought experiment models the assumption that all members of society have the capacities necessary for holding a comprehensive moral outlook, even if they might not actually have spent time articulating the details of their own particular outlook. Of

[38] Rawls, *Political Liberalism*, 184.
[39] Ibid., 281–85. See also Rawls, *A Theory of Justice*, 8–9, 245–46.
[40] Rawls, *A Theory of Justice*, 17–22. See also Rawls, *Political Liberalism*, 22–28.

course, there are times in all of our lives when we do not have these capacities, in particular, when we are infants, suffer from illness, or are near death. Moreover, some people—those with severe mental disabilities, for example—never have the requisite capacities. Since Rawls's ideal theory does not give us direct help with these less-than-ideal situations, we are left with the task of "extending" his principles to apply to them.[41]

One central question for bioethics arises when we move from the ideal to the nonideal case: What is the duty of the state to its citizens when they are in need of health care? Given my desire in this essay to stay neutral on the content that a political conception of justice should have, I cannot hope to answer this question here.[42] But it is important to note that the move to nonideal theory that any such answer would require does not mean that we could once more resort to idiosyncratic features of particular comprehensive moral doctrines. For, if an answer is to be justified to all members of society, we should continue to use what Rawls calls "public reason," that is, reason based in the recognition that we are to cooperate on reasonable terms with those who differ from us in their substantive moral commitments. I do not mean to suggest that seeing an issue like the right to health care from a Rawlsian perspective guarantees that there is an easy resolution. It is by no means clear what position on health care can be justified to people who have reasonable disagreements about the nature of justice, the duty of charity, the moral status of the body, and so on. What Rawls helps us to see is that the task of bioethicists is not to resolve these disagreements, but to see what policy can be justified to people despite their disagreements.[43]

But what of the people who are not interested in cooperating with those with whom they have moral disagreements, such as the justice-rejecting Nietzschean described above (in Section II), who wants to procure organs for transplant in whatever manner he can, rather than go through the state-approved process? Recall that my complaint with Beauchamp and Childress's approach was that they had no reply to someone who rejects their principle of justice; his life was to be restricted by that principle even

[41] Rawls, *Political Liberalism*, 20–21, 185–86.

[42] Norman Daniels uses a Rawlsian strategy to confront the problem of whether justice could require a state to offer its citizens health care when they reasonably differ on the moral importance of bodily health. His solution is to draw an analogy with Rawls's principle of fair equality of opportunity. Just as the state must guarantee that offices and positions are open to all who have the relevant skills and talents, it should also aim to preserve people's access to the range of life-plans that would be open to them were they to be healthy throughout their lives; see Norman Daniels, *Just Health Care* (Cambridge: Cambridge University Press, 1985), 19–58. Even though Daniels's argument draws only on the version of Rawls's theory in *A Theory of Justice*—before Rawls acknowledged the significance of the fact of reasonable pluralism and the need for a political conception of justice—Rawls supports Daniels's approach at *Political Liberalism*, 184.

[43] As Rawls points out when discussing the problem of abortion, "[r]easonable political conceptions of justice do not always lead to the same conclusion," in which case deciding by a vote might be the best means to settle issues of public policy (John Rawls, "The Idea of Public Reason Revisited," *University of Chicago Law Review* 64, no. 3 [1997]: 798).

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though he did not accept it as part of his comprehensive moral doctrine. But what alternative is there? What are we to do with those whose moral commitments lead them to reject the political conception of justice (whatever its content turns out to be) that is to ground all social policies in a liberal society?

Rawls's solution to this problem involves a distinction between what he calls *reasonable* and *unreasonable* comprehensive doctrines.[44] A comprehensive doctrine is reasonable if it includes an acceptance of the fact of pluralism and a concomitant willingness to live within the terms set down by the political conception of justice. Thus, a reasonable comprehensive doctrine does not claim to contain a moral truth to which the rest of society should be forced to adhere, whether those people accept the tenets of that doctrine or not. An unreasonable comprehensive doctrine leads its subscribers to reject the idea of cooperation with those whose comprehensive doctrines differ from theirs. It is people who are intolerant in this sense—in their unwillingness to live peacefully, on terms acceptable to all, among those with whom they have moral disagreements—whom Rawls thinks that a liberal society cannot tolerate. Accordingly, he argues that the state can legitimately take steps to prevent those with unreasonable comprehensive doctrines from interfering with the lives of others.[45]

Rawls's distinction allows for a response to the justice-rejecting Nietzschean different from that of Beauchamp and Childress. They can only arbitrarily dismiss his moral doctrine as an instance of merely "customary" morality; he must subscribe to their principle of justice because it is an approximation to the moral truth whether he recognizes it or not. But Rawls allows us to say not that we are compelling him to accept our particular moral commitments, but that since justice is what allows us to live together *despite* our different moral commitments, we can compel him to follow its terms simply in order for society to be possible.

While it is fairly easy to see the applicability of the Rawlsian approach to those bioethical issues having to do with justice, it is less easy to apply it to bioethical questions concerning the physician-patient relationship and other aspects of professional ethics, because they do not concern the basic structure of society. Indeed, it might seem that these bioethical questions become quite trivial once Rawls's approach to political philosophy has been accepted. For if the basic structure of society were to conform to a political conception of justice, individuals would be free to

[44] Rawls, *Political Liberalism*, 58–66.

[45] Rawls points out, however, that the mere fact that people hold an unreasonable doctrine does not legitimate the state's limiting their freedom. For they might also hold that they are required to follow the law even when it supports what they see to be immoral kinds of behavior. It is only when people who are pursuing their unreasonable moral doctrine actively interfere with others that the state should step in to protect the victims of their activities; see Rawls, *A Theory of Justice*, 216–21.

do business with one another within these constraints as they saw fit. But it might seem, then, that the physician-patient relationship is one more contract between free individuals. The only moral constraints on it would seem to be identical to those imposed on any contractual exchange, namely, those required by the basic structure. Any particular agreement reached by the physician and the patient within these fairly broad constraints would be morally acceptable in the same way that any agreement reached between, say, a mechanic and a car owner within these constraints would be morally acceptable.[46]

There is some truth to this characterization of the physician-patient relationship, but if it were the whole story, then just as there is no need for a branch of ethics devoted to the mechanic–car owner relationship, there would be no need for an endeavor like bioethics. The problem, of course, is that in medicine, as opposed to car repair, the contract in question concerns our bodies, not our cars.[47] Even though different comprehensive moral doctrines will ascribe different values to our bodies—indeed, different doctrines will understand the metaphysics of our relation to our bodies differently (compare Christian asceticism with a hedonistic aestheticism)—they nonetheless must be recognized as having a special place in our lives. They are, after all, the unique[48] vehicles for our lives, the artificial and organic replaceability of some parts notwithstanding. What we can do in the world thus depends on our physical condition; pain and suffering can undermine even our capacity to think clearly. This means that we cannot remain neutral about our bodies in the way we might about a car. A harm to my body is a harm *to me*, even if my moral commitments require me to rise above the limits that my body puts on me.[49]

[46] See Robert Veatch, "Models for Ethical Medicine in a Revolutionary Age," *Hastings Center Report* 2, no. 3 (1972): 5–7, for a discussion of models of the physician-patient relationship that endorses, as I do in what follows, a contractual model that includes certain constraints on what health professionals can offer in establishing the contract.

[47] See Dworkin, *The Theory and Practice of Autonomy*, 113–14, for a similar account of the special place of the body.

[48] Some comprehensive doctrines do allow for the possibility of reincarnation. Nonetheless, even on these views, one's body *for a given lifetime* is irreplaceable.

[49] Political philosophy acknowledges the special status of the body in its treatment of punishment, which ultimately involves a bodily intervention of some sort, such as medication, amputation, the physical restriction of movement, or the infliction of pain; even the payment of a fine must be enforceable by bodily measures, and a bodily measure must be supplied as an alternative for those lacking monetary resources. Now, if citizens were allowed to decide for themselves on which occasions such bodily interventions were warranted, the one receiving the punishment could reasonably complain that he or she was being treated unfairly. Thus, the state should instead set up a monopoly on bodily interventions—a legal and penal system—that is fair to all, one that those in the original position would recognize as needed, given the evident necessity of an enforcement mechanism for the preservation of society. Accordingly, the *political conception of the person*, which Rawls uses to characterize citizens within a political conception of justice (Rawls, *Political Liberalism*, 29–35), must include as a complement a *political conception of the body*. Each person is entitled to integrate the status of embodiment into her comprehensive doctrine in any

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But given the significance of our bodies to us, who should be allowed to intervene in them? Given that our different comprehensive doctrines lead us to make sense of this significance in diverse ways, health professionals cannot simply appeal to their own particular doctrines in deciding to operate on someone, to give her drugs, or the like, even if they do it with the best intentions. For if the intervention fails to accord with the person's comprehensive doctrine, she has been given no reason to accept the intervention; she can legitimately view it as an assault. And, as our discussion of Engelhardt (in Section IV) revealed, the fact that she might at any time revise her doctrine makes this problem even more acute.[50] The doctrine of informed consent offers a solution to this problem, however, by allowing each of us to use our own comprehensive doctrines to decide what happens to our bodies, if that is at all possible. It thus sets up conditions for bodily access that we can all accept, despite our different moral commitments.

Notice how this treatment of informed consent differs from that of Dworkin. He grounds his justification in a conception of autonomy that he takes to be fundamentally valuable. And this means that he takes himself to be justified in requiring even those who fail to recognize this value—a radical Protestant or a fundamentalist committed to patriarchy—to have their lives constrained by it. On my view, however, no claim is being made about the ultimate moral importance of autonomy since that issue is best left to people to deal with in their own comprehensive doctrines. Instead, we say to those who do not value autonomy that their informed consent is still necessary in medical care, not because they should hold this value, but because the terms for our living together in a society despite our different moral commitments require that each person make her own decisions about her body (even if her decision is to defer to the relevant man in her life). For this is the only way to allow each of us to subscribe to our own moral doctrines and yet still live together.

My analysis of the status of the body in a liberal approach also offers us a way to understand the remaining two principles that Beauchamp and Childress invoke—beneficence and nonmaleficence. Once we recognize that we must allow our own comprehensive values to remain paramount in issues arising from our embodiment, we must also consider how to enable us best to have them play this role. For when we are sick or otherwise in need of health care, we are especially vulnerable and open to exploitation. In particular, we are unable to negotiate contracts on a case-

reasonable fashion, but the state preserves a right to bodily access (when mandated by a suitably constituted system of justice) in order to enforce the norms that make society possible.

Note that the issue of punishment takes us beyond ideal theory, where there is an assumption of full compliance (Rawls, *A Theory of Justice*, 145, but see also ibid., 240–41). Thus, the body plays a role in extending ideal theory in two respects: in accounting for responses to injustice and in accounting for natural limitations such as disease and disability.

[50] See Rawls, *Political Liberalism*, 30.

by-case basis with those who offer medical services.[51] Instead, bioethicists rightly urge that the medical profession itself must be structured in keeping with an understanding of the significance of bodily interventions. In reflecting on what this structure should look like, they ask: How can medical care be arranged so as best to guarantee that patients consent freely to the actions done to their bodies? And, given the desperation that often comes with illness, how can patients be protected from possible exploitation at the hands of medical-service providers? The principles that health professionals should act in their patients' best interests (beneficence) and in such a way that does not harm them (nonmaleficence)—where what a patient's interests are and what counts as a harm are left to him to decide for himself, if possible—are the answers to these questions. Patients are thus able to take at face value the information offered to them about the details of their care; they will be in a better position to decide which health choices most reflect their own values—that is, to make an informed choice.

Now, just as my account of autonomy differs from Dworkin's, so also my analysis of beneficence and nonmaleficence differs from Beauchamp and Childress's. Consider, for example, the Randian libertarians described above (in Section II). For Beauchamp and Childress, the libertarian who wants a treatment that he knows is harmful should be denied it because of the moral restrictions on physicians' harming their patients, even if he does not himself recognize the force of that restriction. On my view, the prohibition is not based on a moral claim that we should all respect—such a claim belongs only in comprehensive doctrines. Instead, it is based on the pragmatic need to structure health-care institutions to promote patients' capacity to consent freely to care. A similar argument can be made in response to the libertarian's rejection of the beneficence-derived argument that medical research should only be done on human subjects if it has a potential benefit. And this means that, unlike Beauchamp and Childress who leave their principles unranked (for which they were criticized by Clouser and Gert), autonomy on my view has priority over beneficence and nonmaleficence in the realm of the physician-patient relationship, while justice has priority in the realm of health-care institutions.

Of course, only in ideal theory will all patients have the capacities necessary for consenting to medical procedures (and only in ideal theory can we assume that the background institutions make this free consent possible). And thus a new set of questions arises when bioethicists attempt to take a theory oriented around the consent of the competent as

[51] The institutional complexity of modern medicine makes this point readily apparent. A hospital, for example, cannot tailor its procedures to meet the exact requirements of each individual who enters it; instead, the institution aims to promote beneficent and nonmaleficent care, leaving patients the right to make the final choices about their care within those constraints.

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the precondition for medical intervention and to "extend" it (in Rawls's sense) to apply to those who are temporarily or permanently incompetent. In the approach to bioethics that I have been describing, such extensions must take as their starting point the plurality of reasonable comprehensive doctrines. There is still room for much controversy and disagreement here. As was the case with applications of Beauchamp and Childress's principles, we will need to balance our proposed resolutions for the nonideal cases with our views about the ideal situation until we reach reflective equilibrium.

The liberal approach to bioethics that I have argued for here preserves much of the insight of the bioethicists I examined in Sections II–IV. Like Engelhardt, I think that there is a difference between the values people rely on in their everyday lives and those that are appropriate for setting bioethical policy, even though we make the partition differently. Like Dworkin, I retain a notion of respect for autonomy, though where he sees this capacity as fundamentally valuable, I see its importance as resulting from the reasonable terms of agreement for living in a pluralistic society. And, like Beauchamp and Childress, I think that the four principles usefully sum up the moral concerns relevant to biomedicine; however, where they think the principles are part of a common morality, I see them as deriving from reflections on how to structure health care in a way which is fair to those with differing moral commitments.

VI. The Bioethics of Everyday Life

We have seen that the liberal partition for bioethics that I have been advocating would require structuring health-care institutions so that people can live in terms of their own reasonable comprehensive doctrines when it comes to disease and health. Notice, however, that the liberal partition has another consequence for bioethics. Since it demands that we be able to make decisions about health and disease for ourselves, our comprehensive doctrines must be able to offer us guidance on these matters. But, just as contemporary bioethics got its start when policymakers found themselves somewhat at a loss when first confronted with the revolution in medical technology, so also many of us are ill-prepared to come to terms with the decisions we must face in the current medical world. Our comprehensive doctrines often fail to equip us adequately for what liberal bioethical policies impose on us.

The liberal partition, then, not only requires that bioethicists formulate norms for biomedical policy using the fact of reasonable pluralism as their starting point, it also requires that they engage in what I call the *bioethics of everyday life*—a consideration of what values we ought to hold on issues relating to our status as embodied beings who suffer from illness and death, who can alter our bodies cosmetically, who can infect

one another with various diseases, who can find out about some aspects of our biological futures through genetic testing, and so on.[52] The aim here is not to formulate policies that everyone must be compelled to accept, but to explore the moral options open to us when we try to make sense of our biological natures. This involves elaborating and extending our comprehensive doctrines, all the while recognizing that reasonable people might reach different verdicts in this domain.

The two tasks—policy-oriented bioethics and the bioethics of everyday life—are complementary; they are not just two different perspectives from which the same issues can be addressed. For example, consider the policy question: When is it acceptable for health professionals to withhold or withdraw life-sustaining treatments from patients? There is an equivalent question from patients' perspectives: Can patients require that their physicians remove them from (or keep them attached to) life-sustaining treatments? Neither of these asks a question in the bioethics of everyday life. For they still fundamentally concern a question of policy, one that must be answered in light of the fact that reasonable people differ in their moral convictions about the end of life and the physician-patient relationship. The complementary question from the bioethics of everyday life to these two policy-oriented questions asks: What is the morally preferable way to die—ongoing medical treatment, which is likely to lead to a lingering decline but leaves open the possibility of recovery, or an almost certain death by having the treatment in question removed? Answering this question will require thinking through the disvalue of death, and the moral significance of acquiescence to it as opposed to struggle against it. Such an answer will likely involve a consideration of some of the deepest moral issues, such as the source of meaning in life and the importance of our directing the shape of our lives. (How answers to this bioethics-of-everyday-life question make a difference for bioethicists' answers to the two policy questions posed above is the topic of Section VII.)

At the moment, most bioethicists devote their time to the policy-oriented issues. Beauchamp and Childress, for example, say that bioethics

[52] The German rationalists, from Baron Christian von Wolff onward, constitute one tradition of moral thought that has recognized the need for a bioethics of everyday life, that is, for a consideration of the moral questions posed by our biological natures. See, for example, Kant's discussion of "man's duty to himself as an animal being," where he rejects such things as castration (to improve one's singing career), selling one's hair, gluttony, and nonreproductive sexual activities, in Immanuel Kant, *The Metaphysics of Morals*, trans. Mary Gregor (Cambridge: Cambridge University Press, 1991), 218–24.

Engelhardt sometimes sounds as if he means by his "bioethics of moral friends"—bioethics for those who share comprehensive doctrines—what I call the bioethics of everyday life; see Engelhardt, *The Foundations of Bioethics*, 14, 74–75 (2d ed.). But sometimes he restricts all kinds of bioethics to the policy-oriented questions, as when he says that "moral visions give rise to content-full bioethics and offer substantive guidance about how one should properly act as patient, physician, nurse, or citizen framing health care policy. This volume does not address these moralities and the bioethics they support. It does not explore the particular content-full morality that ought to shape the bioethics and guide the health care policy through which moral friends can collaborate" (ibid., 102).

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explores "the moral obligations of *health professionals* and *society* in meeting the needs of the sick and injured."[53] Engelhardt similarly says that bioethics "is an attempt to resolve an intellectual quandary: 'How can I consistently understand what is right conduct in the health care professions and in the biomedical sciences, and justify it to others?'"[54] But a small number of bioethicists (in addition to some bioethically minded theologians) have taken up what I call the bioethics of everyday life. For example, Thomas Murray looks at the moral significance of children not to formulate policies on abortion and the new reproductive technologies, but to investigate what is at stake morally in our natural and artificial ways of creating new life.[55] Laura Purdy explores not whether the state should ban reproduction that is likely to lead to the birth of a child with a severe genetic disorder, but what moral obligations this knowledge imposes on those contemplating reproduction.[56] John Hardwig asks whether we sometimes have a duty to die, instead of examining the extent to which health professionals should work toward prolonging life.[57] Rosalind Hursthouse is concerned not with the permissibility of abortion, but with how our choices with regard to it manifest virtues or vices.[58]

My analysis helps to show the importance of this kind of work. For without ongoing exploration in the bioethics of everyday life, policy-oriented bioethics ends up being somewhat incoherent, at least in its liberal guise. For why set up policies that promote the ability of people to make decisions for themselves if they are not equipped to do so? At the moment, most comprehensive doctrines, especially nonreligious ones, have little to say about the moral significance of our struggles with disease, our reproductive choices, and the like, even though bioethical policy often requires that we address these very issues. Imagine a comparable situation in political philosophy: a liberal state combined with a lack of attention to how we should live. Philosophers here would be urging the state to recognize the importance of people's living by their own values, but would also at the same time be refusing to treat those values as being important enough to merit study and reflection. Bioethicists, like moral philosophers, must work on both sides of the partition I am advocating.

As Murray, Purdy, Hardwig, and Hursthouse show, bioethicists need not engage in the bioethics of everyday life with the aim of compelling others to live by the conclusions they reach. Rather, they try to articulate as best as they can how they see the relevant issue and why they reach the

[53] Beauchamp and Childress, *Principles of Biomedical Ethics*, 3 (4th ed.) (emphasis added).
[54] Engelhardt, *The Foundations of Bioethics*, 9 (1st ed.).
[55] Thomas Murray, *The Worth of a Child* (Berkeley: University of California Press, 1996).
[56] Laura Purdy, "Genetics and Reproductive Risk: Can Having Children Be Immoral?" in Laura Purdy, *Reproducing Persons: Issues in Feminist Bioethics* (Ithaca, NY: Cornell University Press, 1996), 39–49.
[57] John Hardwig, "Is There a Duty to Die?" *Hastings Center Report* 27, no. 2 (1997): 34–42.
[58] Rosalind Hursthouse, "Virtue Theory and Abortion," *Philosophy and Public Affairs* 20, no. 3 (1991): 223–46; Rosalind Hursthouse, *Beginning Lives* (Oxford: Basil Blackwell, 1987).

conclusions they do. They might convince others, or they might inspire them to come up with alternative views. In any case, this sort of public discussion will help to equip all of us as we struggle with the problems that our biological natures pose for us, whether we are patients or not.

VII. Conflicts and Overlaps

I have suggested that bioethics is comprised of two tasks, each with different standards of justification. On the one hand, there is the bioethics of everyday life, the attempt to extend comprehensive moral doctrines to apply to the issues posed for us by our biological natures. What an acceptable justification is here will depend on what the doctrine in question allows for; it might require appeal to canonical texts, a derivation from the categorical imperative, or a proof of utility maximization. On the other hand, there is policy-oriented bioethics, which examines health policy and norms for the health professions. Any such policy will be justified only if it takes the fact of reasonable pluralism—the fact that reasonable people will reach different conclusions in the bioethics of everyday life—as its starting point. I will conclude my discussion here by examining how these two tasks fit together, first by looking at what happens when they conflict, and then by turning to how they can be integrated.

The most obvious problem arises when a bioethicist relies on her or his comprehensive doctrine when addressing policy questions; indeed, in Sections II–IV, I accused Beauchamp and Childress, Dworkin, and Engelhardt of doing just this. The fact that bioethicists tend to neglect questions in the bioethics of everyday life makes it especially easy for them to make illegitimate appeals to their comprehensive doctrines while treating policy questions; this lack of attention leaves these bioethicists ignorant of the reasonable disagreements people may have about the moral features of their embodiment. Without ongoing public debate over these questions, how are bioethicists supposed to know the variety of attitudes that people might adopt in relation to their bodies? And this means that a bioethicist could end up inadvertently relying on his own comprehensive doctrine when formulating policy without realizing that others might have quite different moral convictions were they to consider the relevant issue.[59] Consider a recent example: Concerns about the medical effects of silicone breast implants led the United States Food and Drug Adminis-

[59] The same problem can afflict clinical bioethicists. As Bette-Jane Crigger points out, the practice of ethics consultation sometimes "holds peril insofar as it may . . . work toward imposing a particular, content-laden vision of what the dominant culture perceives to be morally most significant and most appropriate—for example, valuing the autonomy of individual patients over the interests of others" (Bette-Jane Crigger, "Negotiating the Moral Order: Paradoxes of Ethics Consultation," *Kennedy Institute of Ethics Journal* 5, no. 2 [1995]: 90).

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tration (FDA) to restrict their use. Women who want implantation as a form of reconstruction after a mastectomy are still allowed to have implants on demand (albeit in a loosely structured clinical study), but cosmetic implantation is now possible only through a few restricted clinical trials. The liberal approach to bioethics I have been supporting might turn out not to endorse this response to the implant crisis, since controlling access to implants based on a distinction in the motives women have for undergoing this procedure might constitute an unacceptable infringement on women's right to make sense of their bodies using their own comprehensive doctrines. Even if, according to many of our comprehensive moral outlooks, cosmetic breast enhancement seems to be a frivolous choice, it is by no means clear that the state should take this choice away from women.[60]

In addition to the problem of bioethicists' policy recommendations crossing the boundary into the bioethics of everyday life, the converse is also possible. People might adopt positions in the bioethics of everyday life that lead them to interfere unreasonably with the attempts of others to live by their own convictions in this realm. Consider, for example, the case of parents who choose to have their daughters undergo circumcision,[61] or the many men within the North American gay community who believe that those who have tested positive for the human immunodeficiency virus (HIV) need not disclose this fact to their sexual partners, so long as they practice safer sex.[62] It might be that these positions in the bioethics of everyday life cannot be tolerated in a liberal society in that they stop others from making sense of their embodiment for themselves; indeed, both practices are illegal in at least some jurisdictions.[63]

Showing the unacceptability of these positions is a task for bioethicists that would return them to the realm of policy. They would have to show that health professionals are right to interfere in these activities, or that the state is justified in putting up legal barriers to them. As a first step to this end, bioethicists would have to be clear as to exactly how these people conceive of their activities in light of their respective comprehensive doctrines. Such "moral anthropology" is necessary if bioethicists are to avoid the trap of declaring values to be unreasonable (in Rawls's sense)

[60] See Lisa Parker, "Social Justice, Federal Paternalism, and Feminism: Breast Implantation in the Cultural Context of Female Beauty," *Kennedy Institute of Ethics Journal* 3, no. 1 (1993): 57–76.

For genetic counseling as another case where comprehensive values might have infiltrated treatments of bioethical policy, see Abby Lippman, "Prenatal Genetic Testing and Screening: Constructing Needs and Reinforcing Inequities," *American Journal of Law and Medicine* 17, nos. 1–2 (1991): 15–50; and Angus Clarke, "Is Non-Directive Genetic Counselling Possible?" *The Lancet* 338, no. 8773 (1991): 998–1001.

[61] See Sandra D. Lane and Robert A. Rubinstein, "Judging the Other: Responding to Traditional Female Genital Surgeries," *Hastings Center Report* 26, no. 3 (1996): 31–40.

[62] See Donald C. Ainslie, "Questioning Bioethics: AIDS, Sexual Ethics, and the Duty to Warn," *Hastings Center Report* 29, no. 5 (1999): 26–35.

[63] Lane and Rubinstein, "Judging the Other"; Ainslie, "Questioning Bioethics."

merely because they are foreign or novel. They would then have to show that the doctrines in question stop their subscribers from being able to live on reasonable terms with others with whom they might have moral disagreements. For only then will limitations on the activities of these people be justified *to* them.[64] If bioethicists were to try to show that these positions in the bioethics of everyday life were wrong tout court, though, they would once again have fallen into the trap of using their own comprehensive doctrines to resolve policy issues.

But how will those whose commitments in the bioethics of everyday life are deemed unreasonable—say, the family considering circumcision of their daughter or the nondisclosing sexually active man with HIV—respond to a policy that limits their activities? They might refuse to acknowledge its rationale, treating it merely as the imposition on them of a foreign set of values. They would only recognize the policy, then, to the extent that they worry about facing the penalties that go with it. The likely effect of this would be to drive the proscribed practice underground. If this were to happen, the policy could hardly be thought to be stable, that is, one that people could reliably expect others to be following in their dealings with one another.

Rawls points out in his discussion of justice that citizens could respond to the political arrangements of their state in a similar way. They could view them not as articulating what their comprehensive doctrines endorse as the legitimate moral parameters for their common dealings, but as rules to be accommodated out of fear of the sanctions that come with violating them, or out of a recognition that, given the competing comprehensive doctrines current in the society, compromise is the only means to avoiding civil strife. Rawls calls this kind of response to the problem of pluralism a modus vivendi. And he points out that this response to justice leaves society inherently unstable, in that it would be threatened any time those committed to any one particular comprehensive doctrine gained enough power for them to think that they could either renegotiate the social compromise to their advantage or abandon it entirely so as to enforce their convictions on others. Rawls argues that stability instead arises when citizens recognize that, given the fact of reasonable pluralism, a political conception of justice ought to apply to the basic structure. And this means that they must be able to see the legitimacy of the political order from within their own, particular comprehensive doctrines. A just society must have an "overlapping consensus" of such doctrines.[65]

[64] Rawls would call this a case of "reasoning from conjecture," in that the bioethicists conjecture about the comprehensive doctrine of their interlocutors in order to show *to them* how certain features of public policy can be seen as reasonable on their own terms; see Rawls, "The Idea of Public Reason Revisited," 783, 786–87.

[65] Rawls, *Political Liberalism*, 133–72.

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Rawls shows us here a second way in which people might respond to bioethical policies that constrain their options in everyday life. Rather than continuing with the proscribed practice underground, they might revise their commitments in order to acknowledge the need to live with others on terms that are fair to all. They might recognize from within their own comprehensive doctrines the importance of the liberal approach to bioethical policy. Bioethicists could play an important role here in helping to show those with diverse moral commitments that they can nonetheless agree on policies for biomedicine.[66] For only when there is an overlapping consensus of comprehensive doctrines will the policies be stable. Note, then, that where Beauchamp and Childress think that bioethical policy could be grounded in a common morality, my suggestion is that it is better seen as the focus of an overlapping consensus of comprehensive explorations of the bioethics of everyday life.[67]

[66] An example of what I have in mind is Ronald Dworkin's treatment of abortion and euthanasia in Ronald Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom* (New York: Knopf, 1993), where he tries to show that people with deep disagreements about the morality of abortion can nonetheless accept a liberal abortion policy.

[67] Dan Brock also recognizes the need for an overlapping consensus in order for bioethical policy to be stable in Dan Brock, "Public Moral Discourse," in Sumner and Boyle, eds., *Philosophical Perspectives on Bioethics*, 293–94.

My argument that bioethics needs an overlapping consensus helps to reveal further how my Rawlsian version of liberalism in bioethics differs from Engelhardt's liberal bioethics. For he explicitly rejects the overlapping consensus for three reasons; see Engelhardt, *The Foundations of Bioethics*, 59–64 (2d ed.). First, he thinks that Rawls's principles, such as fair equality of opportunity, are not such as to achieve a consensus. All that is needed is for individuals to recognize that, since the state is a union of strangers, it must rely on the principle of permission. Second, Engelhardt worries that what appears to be an overlapping consensus may actually be citizens' acquiescing to whatever powers control the state. Third, he suggests that Rawls's claim that comprehensive doctrines in the overlapping consensus must be reasonable serves an ideological function, ruling certain moral outlooks out of court on the basis of controversial moral commitments.

None of these criticisms seems to me to hit the mark. Engelhardt's first point seems in fact to support Rawls; for when individuals recognize *from within* their own comprehensive doctrines the appropriateness of a conception of justice that is fair to all, those doctrines fall within the overlapping consensus. Rawls and Engelhardt differ on what the appropriate such conception would be, and how it would be justified, but Engelhardt seems at this point to acknowledge that citizens need to see the moral appropriateness of the conception of justice *for themselves*. Engelhardt's friends/strangers distinction gets him in trouble here, as it blinds him to the need for our substantive moral outlooks (which he identifies as relevant only when we are among friends) to endorse the political arrangement if the state is to be stable.

Engelhardt's second point seems to treat Rawls's overlapping consensus as if it were an empirical notion rather than a normative one. For the *appearance* of a consensus that he worries about is not the *existence* of one as Rawls understands it. If people are merely acquiescing to a political arrangement out of pragmatic concerns, it counts as a mere modus vivendi, the stability of which would be undermined whenever the power balances in society shift.

Engelhardt's third complaint, about reasonableness, also seems to be based on a misunderstanding. He takes reasonableness to be a substantive notion, committing Rawls to a particular moral outlook. But, in fact, reasonableness for Rawls only points to a willingness to live with others on terms that are acceptable to all; it is thus a formal notion rather than a substantive one.

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My account of the need for a Rawlsian overlapping consensus in bioethics is especially helpful for understanding how health professionals sometimes respond to the limits that bioethical policies have put on their activities. Whereas on the old paternalistic ethic that dominated in the health professions before the rise of bioethics physicians were entitled to make many of the important decisions for their patients (often without even consulting them), now (competent) patients are recognized as the ultimate authorities about what should be done to them. But, too often, it seems, health professionals treat the current bioethical requirements—getting informed consent from patients, respecting their directives for their treatment, and the like—not as moral demands, but as regulations imposed on them from outside either from hospital bureaucracies or the legal system. Accordingly, if the outside sanctions look to be easily avoided in a given instance, health professionals will opt to duck the requirements. This would explain the empirical findings that show that health professionals are aware of their ethical duties, but nonetheless avoid them with some frequency.[68] If this interpretation of health professionals' response to bioethics is correct, they see it merely as something to be accommodated, not as articulating the legitimate moral parameters for their work. The old medical paternalism has only gone underground; it has not been superseded.

This goes to illustrate that some health professionals currently seem to treat the standard bioethical requirements as a modus vivendi, as a compromise they put up with in order to get on with their business. This could simply be the result of a reluctance of health professionals, especially physicians, to cede the power they had in the old paternalistic arrangement, but a more philosophical reason for their continued allegiance to this arrangement (and concomitant resistance to bioethics) can also be found. For medical paternalism is not merely a result of health professionals' arrogance or self-interest; it is the expression of *their* bioethics of everyday life—their everyday lives, after all, include a disproportionate amount of caring for the sick and injured. And lying behind their bioethics of everyday life is a comprehensive doctrine that emphasizes the moral significance of the emotionally challenging and often difficult work they undertake promoting, preserving, or prolong-

[68] After several studies had shown that there is significant resistance among physicians to taking seriously the revolution bioethics has tried to bring about in physician-patient interactions, the massive Study to Understand Prognosis and Preferences for Outcomes and Risks of Treatment (SUPPORT) was undertaken in an attempt to clarify how physicians treat extremely ill patients. It found that physicians frequently respond inappropriately to dying patients' requests not to be resuscitated or to cease treatments. Moreover, an experimental intervention designed by the researchers to rectify this problem was found to have no impact on this or other related aspects of care for the dying. See Alfred Connors et al., "A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients," *Journal of the American Medical Association* 274, no. 20 (1995): 1591–98. For a series of discussions of the meaning of the SUPPORT study, see the various essays in *Hastings Center Report* 25, no. 6, "Dying Well in the Hospital: The Lessons of SUPPORT" special supplement (1995).

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ing human life. And thus, to them, medical work is not merely a profession but a *vocation*; devoting oneself to helping others in their struggles with disease is a route toward an especially meaningful life. In this moral worldview, the importance of what health professionals do entitles them to guide their patients toward the outcomes that would best respect health- and life-oriented values, no matter what the patients think of the matter.[69]

Bioethicists oppose medical paternalism with an alternative patient-centered ethic. But if they fail to make the Rawlsian distinction—that is, to base their opposition to medical paternalism in policies that take reasonable pluralism as their ground—they seem to offer health professionals only an alternative comprehensive doctrine, one that emphasizes the moral value of patient self-determination instead of the special moral place of a medical vocation. But many health professionals seem unconvinced that a patient-centered ethic *as a comprehensive doctrine* is more reasonable than their current medicine-as-vocation doctrine. This would explain why bioethics seems to them to be an alien force to be accommodated rather than an articulation of the appropriate norms for their work. For bioethicists, if they do not take as their starting point the fact of reasonable pluralism, fail to justify their claims *to* those whose comprehensive doctrines do not happen to yield a coincident set of requirements.

The solution to this problem is for bioethicists to show that their policies are not meant as *direct* challenges to the comprehensive doctrines by means of which health professionals understand their work; bioethicists should not be in the business of forcing their own private moral views on others. Instead, liberal bioethical policy articulates (among other things) norms for the health professions that are fair to those—both the professionals and their patients—with reasonable yet competing versions of such doctrines. This is not to say that the conception will not challenge health professionals' old, paternalistic, medicine-as-vocation doctrine. But it will not do so by declaring it false or in error; rather, that aspect of the doctrine that calls for health professionals to use their technical expertise to make decisions *for* their patients will be shown to be unreasonable (in Rawls's sense) by being unfair to the patients who are on the receiving ends of these decisions. As bioethicists have often urged, reminding health professionals that they too are potential patients could help to make this unfairness palpable to them. They almost certainly would want to use their own comprehensive doctrines to guide their own care. Why should other patients be any

[69] I do not mean to suggest that all health professionals hold this comprehensive doctrine. Some might treat their work as *mere* work—highly remunerative and intellectually challenging, but with no special moral content.

different?[70] One hopes that, in time, the various comprehensive doctrines that sustain health professionals would come to recognize liberal policies as the appropriate framework for their dealings with patients. The overlapping consensus that is necessary for stability in bioethics then would be one that included both the comprehensive doctrines that allow physicians and other health professionals to make sense of their morally fraught labor as well as those doctrines that the rest of us rely on in coming to terms with our biological natures.

Philosophy, University of Toronto

[70] It is true that health professionals have had the opportunity to integrate into their comprehensive doctrines whatever moral insight they have gleaned from their experience with treating disease. And this means that they will be more prepared than will most patients to confront whatever moral challenges their illnesses pose. But the fact of reasonable pluralism applies here, too, in that different health professionals will make sense of their experiences in diverse ways. No one health professional's moral views, then, should be privileged in the construction of health policies, even if the collective insight of health-care providers (and of others with first-hand experience with disease, such as the disabled, survivors of various conditions, or family caregivers) can be an extremely useful resource for bioethicists in both their policy endeavors and their explorations of the bioethics of everyday life.

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