Bioethics ISSN 0269-9702
Volume 13 Number 3/4 1999

THE FOUNDATIONS OF BIOETHICS

ROBERT M. VEATCH

A physician friend of mine recently was caring for a critically ill infant who was dying. The infant's mother insisted that the infant be treated with maximal life support as long as possible. The physician told me that, as a physician, he had the right and the duty to refuse to provide treatment any longer because the effort was 'futile'. I pressed him about how he knew he was doing the morally right thing. When I did, he cited the opinion of an American professional physician organization of which he was a member. He seemed to believe that he could prove he was right by citing the moral stand of this group as if it were the definitive authority in biomedical ethics.

I pressed him again asking how he knew his group had the right answer. He then claimed that the majority of medical professional organizations in the United States held the same view. I, of course, could ask how he could know that unilaterally withholding care deemed futile was morally right just because the majority of American professional organizations believed it was. And then he might have appealed to some moral consensus of all medical professionals of all time throughout the world.

If he did, I still would not have been satisfied. I would have disagreed with him factually. It is clear that not all physicians in history have considered it morally right to unilaterally withhold treatment they deem futile. More critically, I would have disagreed with him epistemologically. I would have disagreed with his implication that one could prove a physician's behavior is morally right by appealing to the consensus of physician opinion. Even if all physicians throughout history have believed some behavior is morally right, that does not make them right. Had he then cited the opinion of a religious group or a national court or the International Court of Justice, I would have been left with the same question: how do we know a position in biomedical ethics is right just because some group or another approves?

At this point, ethics desperately searches for a foundation — a metaphysical rock-bottom, a grounding or source from whence

ethical rightness and wrongness emanates beyond which there is no further appeal. We are searching for the foundation of bioethics. It remains controversial whether finding such a foundation is possible or even whether it is worth pursuing.

Foundationalism is the doctrine that there is a definitive ground from which reasoning can begin. Foundationalism has its origin not in ethics, but epistemology. In the West, the problem traces back at least to Descartes, who sought the one piece of knowledge about which he could have no doubt.

In ethics we are concerned about two kinds of foundational questions: the metaphysical question and the epistemological one. The metaphysical question is what the ultimate source of moral truth is. The epistemological question is how we can know that moral truth. We seek the definitive way of knowing and understanding a universal moral truth.

RELATIVISM AND UNIVERSALISM IN BIOETHICS

We might doubt that there can be any single universal grounding for bioethical judgment. It is obvious that bioethical practices differ radically from one culture to another. However, some of those culturally specific judgments may simply be morally wrong. The medical ethics of National Socialism was. In other cases cross-cultural moral differences may result from different beliefs about the non-moral facts. Nevertheless, a pervasive belief survives that, when observers of a specific medical action in a particular culture and a particular time — such as my physician friend unilaterally withdrawing life from that baby — that the action is either right or wrong. We tend to think that all persons from whatever culture and time, when they think about this specific action in its specific cultural context, *ought* to reach the same moral conclusion. Thus the claim has nothing to do with whether the action would be right or wrong in some other culture with some other set of facts. Rather it has to do with whether all observers putting themselves in the specific context of the particular action ought to see it morally the same way.

Of course, no one claims that all observers would actually reach such agreement. The point is that we feel that they ought to. This is to suggest that it makes sense to carry on moral discourse globally in a way that would be nonsensical if we thought what was at stake was merely culture-bound taste or custom. This belief that there ought to be a correct answer to moral questions posed with a specific set of facts for a specific time and culture is what can be called *universalism*. It, in effect, holds that there is a single

foundation, a single grounding, for moral judgments about an individual instance of behavior in a particular factual context. What I offer is the claim that for ethical judgments (as opposed to matters of taste or preference) this universalism makes sense.

Relativism not really Ethics

The opposite of universalism is *relativism*. Relativism, in this sense, has nothing to do with the obvious fact that moral judgments must be relative to the specific facts of the setting. The feminist bioethicists have reminded this generation what situationalists did in the previous generation and other traditions have previously: even if there are universal principles of ethics, no moral rules apply for all time to all cultures and belief systems. The claim is that it makes sense to believe there is a single standard of moral rightness when we think of a moral choice in a particular context with a unique and particular set of facts. Universalism rejects *metaethical* relativism. This has nothing to do with the uniqueness of the facts of a particular moral decision. Metaethical relativism supports the belief that different observers may justifiably reach different moral conclusions because they may trace their moral judgments back to different foundations. The grounding for these judgments is one's own beliefs and values or the beliefs and commitments of one's own group. Judgments of this sort, I suggest, are really not *ethics* at all; they merely are determinations of approval by some societal standard of reference. One can always ask, 'Yes, I or my group approves of this behavior, but is it really ethical?' I am suggesting that for a normative judgment to be an ethical one, it must be made with reference to some single, ultimate standard. It must be universalist.

Universalism can include general, but relational or contextually specific, duties. The rule, 'All parents have duties to their children that take priority over those to other children in equal need,' is potentially universal. It could be affirmed based on some ultimate standard. It is conditioned on the unique relation between parent and child, but it is a universal principle in the sense that it could be affirmed as part of some universally grounded system of morality applicable to all — parents and non-parents alike.

Feminist bioethical theory focuses on special duties growing out of special relations, such as that of the mother.[1] Feminist

[1] For a discussion of these issues see Tong, Rosemarie. *Feminine and Feminist Ethics*. Belmont, CA: Wadsworth Publishing Company, 1993; Little, Margaret Olivia, ed.. *Feminist Perspectives on Bioethics,* special issue of *Kennedy Institute of Ethics Journal* 6 (1996), pp. 1–103.

bioethics need not be relativistic, however, by this understanding of universalism. Feminist theorists who really believe they have a perspective that is morally proper can affirm a theory of care dependent on particular relationships and still hold their view is universal. They can claim that those who reject their view that relationships are morally significant are *wrong*, not that they are just taking another cultural perspective.

The content of this universal, singular ground or foundation is controversial. For those whose ethic has a religious base their foundation is the will of the deity or his or her judgment of moral approval. To the extent their theology is monotheistic, they must believe in a single grounding of moral judgment. To the extent that a single god cannot approve and disapprove of a behavior at the same time, there is a single standard to which human, fallible moral judges either conform or fail to conform. Likewise, secular universalism holds there is some single grounding: the natural moral law, the dictates of reason, or some common morality shared by all reasonable people.

Foundational Epistemology

Foundationalism in bioethics also raises questions of epistemology. It is, of course, possible to hold that ethics must have a universal metaphysical grounding, but that there is no method among fallible humans for knowing the content of that grounding. Nevertheless, many hold that there must be some way of knowing the moral content of the ground or source of morality. Religious knowledge may come from revelation or reason; secular universalism as a foundation for biomedical ethics may be known through reason, empirical observation, or proper reflective equilibrium between moral principle and considered moral judgment.

Professionally Grounded Medical Ethics

Traditional medical ethics is often associated with the moral judgments of groups of medical professionals, often through various professional organizations. Various defenders of this professionally grounded medical ethics have appealed to the Hippocratic Oath or the Declaration of Geneva, both mere professional consensus statements — no matter that from time to time these professional statements get the physician's duty right. The original Hippocratic cult, from which we obtained an Oath which was long believed to be important, was part of a Greek

mystery religion, perhaps related to the Pythagoreans.[2] Modern sociology of the professions defines a profession by, among other things, the practice of the group writing its own code of ethics and claiming to have the authority to adjudicate its own moral disputes.[3] From the perspective of the claim that ethics must have an universal grounding, the Hippocratic Oath really does not even qualify as an ethic, at least in its original form. It gives an account of how those who are members of this cult believe they should practice medicine. It even goes so far as to proscribe surgery for members, not because surgery was believed to be ineffective or too dangerous or immoral in principle, but rather because it was to be left to other non-Hippocratic practitioners.[4]

Some professional medical groups state boldly that they are the source of the norms for their group, that they invent their own rules and standards.[5] The fact that their actions impact on patients who cannot be members of the group seems to escape them. For their kind of medical practice, the group is the ultimate source of the norms. Patients cannot be expected to understand the norms or challenge them.

Somewhat more sophisticated defenders of professional medical codes convert their metaphysical claim into an epistemological one. They claim that even though the moral standards come from some more ultimate source beyond the profession, such as divine authority or secular reason, only those in the profession can know what these standards are.[6] Lay people, apparently, are supposed to take the professional group's word that they have the proper understanding of the norms. Patients are left with no reason to feel the norms are relevant to them.

The Hippocratic Oath goes so far as to prohibit transmitting the secrets of the cult to those outside the group. The

[2] Edelstein, Ludwig. 'The Hippocratic Oath: Text, Translation and Interpretation.' *Ancient Medicine: Selected Papers of Ludwig Edelstein.* Temkin, Owsei, and C. Lilian Temkin, editors. Baltimore, Maryland: The Johns Hopkins Press, 1967, pp. 3–64.

[3] Barber, Bernard. 'Some Problems in the Sociology of the Professions.' *Daedalus* 92 (1963):669–688; Hughes, Everett C. 'Professions.' *Daedalus* 92 (1963):655–668.

[4] Edelstein, Ludwig. 'The Hippocratic Oath: Text, Translation and Interpretation.' *Ancient Medicine: Selected Papers of Ludwig Edelstein.* Temkin, Owsei, and C. Lilian Temkin, editors. Baltimore, Maryland: The Johns Hopkins Press, 1967, pp. 3–64.

[5] Roth, Russell B. 'Medicine's Ethical Responsibilities.' *Journal of the American Medical Association* 215 (1971):1956–1968.

[6] For example, Brock, Lord. 'Euthanasia.' *Proceedings of the Royal Society of Medicine*(July 1970), pp. 661–63.

Hippocratic group is not the only professional group taking this view. The sixteenth century Japanese Group that wrote the Seventeen Rules of Enjuin took the view that their physicians should not tell nonmembers what they are taught.[7] Even in the twentieth century, this has often been the view of professional groups.

In the 1970s when I was conducting research on British medical ethics, I asked the British Medical Association for a copy of its code only to be told that it was confidential and could not be shared with nonmembers. I visited Britain with fear and trembling until the Association relented and made public its opinion of the duties of its members. This view that only members of the professional group have authority to determine or articulate what the norms are for professional/lay relations is technically the view that only those in the group can know the foundation of the ethics of the way to treat patients. Both lay people and health professionals must forever reject that elitist metaethics. The Hippocratic Oath and the Declaration of Geneva must be firmly rejected in favor of codes which lay people help write. The Hippocratic ethic is dead. It should be allowed to rest in peace.

In 1979, when the American Medical Association was rewriting its code of ethics, the far-sighted future leader of the group, James Todd, acknowledged that increasingly the public would be responsible for determining the ethical duties of physician.[8] Nevertheless, to this day, the assessment of the medical ethical positions of the AMA is in the hands of a group that does not have a single lay person involved.

Professionally generated codes, in principle, are unacceptable. Even if the content is correct, the process is archaic. If ethics is a matter that is, in principle, understandable and accessible to all, then the codifications of the proper practice must involve public discourse and public agreement. The professional codes, whether from the national medical associations, the World Medical Association, or any other private group must be abandoned and replaced with public standards such as those in the United Nations Declaration of Human Rights and the Council of Europe's 'Convention for Protection of Human Rights and Biomedicine,'[9]

[7] Bowers, John Z. *Western Medical Pioneers in Feudal Japan.* Baltimore: The Johns Hopkins University Press, 1970, pp. 8–10.

[8] Todd, James S. 'Report of the Ad Hoc Committee on The Principles of Medical Ethics [of the American Medical Association].' unpublished report, [1979].

[9] Council of Europe. 'Convention for Protection of Human Rights and Biomedicine.' *Kennedy Institute of Ethics Journal* 7 (1997):277–90.

the Chinese National People's Congress health care ethics standards, or some other group with a national or international perspective that includes both patients and providers. The foundation of ethics for actions involving medical professionals and the rest of us must be more universal and more accessible rather than being the sole province of professional medical groups.

VALUES, VIRTUES, AND PRINCIPLES

The implications of a more universal foundation are quite different for various aspects of normative medical ethical theory. A full theory will have three normative elements: a theory of values (axiology), a theory of virtue, and a theory of principles of right conduct. It is crucial not only to keep these three elements separate, but also to see why it will be hard to ground the first two in a universal foundation, but essential that the third be so grounded.

Three Elements of Normative Theory: The Theory of Value

A theory of values or a theory of the good provides an account of what the basic goods are. The good may turn out to be pleasure or happiness or perhaps items on some longer list such as moral goodness, truth, aesthetic beauty, and, for the religiously inclined, some eschatological good such as the beatific vision, nirvana, or some other notion of the sacred. In the theory of John Rawls, the primary goods play the role of intrinsic goods. In any health care ethic, health itself is certain to be among the intrinsic goods. Unless one is a pure Kantian, a normative ethic must include some account of the good in order to satisfy the consequentialist demands of maximizing utility and distributing the good justly.

What is crucial, however, is that it is hard to imagine a foundationalist account of the theory of value that would be persuasive. Some theories of the good[10] explicate the good as being whatever someone prefers or whatever satisfies desires (preference theories and satisfaction theories, respectively). Clearly, there is no universal account of the good that everyone

[10] For a helpful account see Parfit, Derek, 'What Makes Someone's Life Go Best.' *Reasons and Persons*. Oxford: Clarendon Press, 1984, pp. 493–503; Gert, Bernard. 'Rationality, Human Nature, and Lists.' *Ethics* 100 (1990):279-300; DeGrazia, David. 'Value Theory and the Best Interests Standard.' *Bioethics* 9 (1995):50–61.

should be expected to share. Even with more objective theories of the good, those in which one is believed to be either right or wrong in understanding what the good is, it is hard to imagine any epistemology that would lead to world agreement on what counts as an intrinsic good. Moreover, it is hard to see why such agreement is necessary. Medical relationships can function very well — indeed perhaps better — if physician and patient interact without any assumptions that they agree on what counts as a good result.

It seems obvious that it is utterly impossible for the health professional to claim expertise on determining what counts as the good for the patient. Any realistic theory of the good will include not only health, but other 'nonhealth' goods. To be an expert on determining the overall good for the patient, one would have to be an expert on balancing health against these other sometimes competing goods. Physicians surely have no such expertise. In fact, they are specialists who are uniquely committed to health. As such, they ought to be biased when it comes to balancing health and other goods.

They can be shown to hold atypical views even when it comes to deciding what will promote a person's health. Health is a complex and ambiguous term involving longevity, absence of disease, freedom from pain and suffering, and prospects for a healthful future. Even among these health-related goods there is often conflict. Yet physicians have no claim to expertise in balancing these competing health goods and can be shown to balance them in atypical ways. For example, in the mid-twentieth century Western physicians gave unusually high value to preserving life at the expense of great suffering even when it left patients very seriously debilitated. The question of the proper balance among these medical goods is one that expertise in medical science cannot resolve. Since physicians make value tradeoffs and normative principle choices in predictably atypical ways, they are systematically worse than average in determining what will benefit the patient.

Fortunately, in medicine, as long as the task is to promote the good of the patient, we need not rely on physicians having expertise in knowing what is truly, objectively good for the patient. Patients can often (but obviously not always) provide that information more reliably. When they cannot, they have some surrogate — a spouse, family, or designated proxy — who has that responsibility. In rare cases in which the surrogate is incapable or unwilling to provide this information reliably, public mechanisms, such as court review, are the closest we have

to a method for objectivity. Surely, a public review with opportunity for due process, appeal of doubtful judgment, and public scrutiny is more reliable than the private, systematically biased guess of an isolated attending physician. Thus, not only is a theory of value something that is difficult to ground in a universal foundation; fortunately, there is no need to find any such grounding. At most certain broad agreement on some terrible health states can be expected.

The Theory of the Virtues

We are in a similar situation with regard to the virtues. Virtues are persistent dispositions or traits of character that incline toward a morally praiseworthy life. We have seen a resurgence in virtue theory in the last two decades.[11] The most plausible account of feminist care theory is that it is a part of a larger effort to return ethics to a focus on the virtues.[12] In care theory, care is put forward as the prevailing or dominant virtue, at least for health care interactions.

Unfortunately, there is more controversy and confusion over the theory of the virtues than there is over the theory of value. Some virtues are so platitudinous that they are expected to generate no resistence. Compassion, humaneness, benevolence, and care, itself, insofar as these are virtues, seem to generate little opposition. However, when one tries to explicate the specific content, we get nothing like agreement. Moreover, there are other candidates for the list of virtues that are far from platitudes: the Homeric and Vedic hatred of enemies,[13] the Confucian 'filial

[11] MacIntyre, Alasdair. *After Virtue*. Notre Dame, Indiana: University of Notre Dame Press, 1981; Hauerwas, Stanley. *Vision and Virtue*. Notre Dame, Indiana: University of Notre Dame Press, 1981; Shelp, Earl E., Ed. *Virtues and Medicine*. Dordrecht, Holland: D. Reidel Publishing Co., 1985; Drane, James F. *Becoming a God Doctor: The Place of Virtue and Character in Medical Ethics*. Kansas City, MO: Sheed & Ward, 1988.

[12] Knowlden, Virginia. 'The Virtue of Caring in Nursing.' In: Leininger, Madeleine M., ed. *Ethical and Moral Dimensions of Care*. Detroit, MI: Wayne State University Press, 1990, pp. 89–94; Salsberry, Pamela J. 'Caring, Virtue Theory, and a Foundation for Nursing Ethics.' *Scholarly Inquiry for Nursing Practice* 6 (2)(1992 Summer):155–167; Curzer, Howard J. 'Is Care a Virtue for Health Care Professionals?' *Journal of Medicine and Philosophy* 18 (1)(1993 Feb):51–69; Veatch, Robert M.. 'The Place of Care in Ethical Theory.' *The Journal of Medicine and Philosophy: The Chaos of Care and Care Theory* 23(2, 1998):210–24.

[13] Ferngren, Gary B., and Darrel W. Amundsen. 'Virtue and Health/ Medicine in Pre-Christian Antiquity.' In *Virtues and Medicine*. Edited by Earl E. Shelp. Dordrecht: Reidel, 1985, pp. 3–22.

piety,'[14] or my personal favorite (for purposes of showing that a virtue can be controversial), female subservience to husbands, are all virtues about which some disagreement can be expected. Of all the elements in ethical theory, the theory of the virtues probably is hardest to trace back to foundations. Ferngren and Amundsen show that there is a cacophony of candidates for lists of virtues. Some that are central to one culture are ignored by anther or even considered to be traits that are despised.[15]

Again, however, it is not clear that we really have a need for a foundational grounding for a theory of the virtues. For some components of ethics, certainly the virtues are critically important, but for others perhaps less so.[16] For ethics within the small, sectarian community — within the *Gemeinschaft* — perhaps nothing is more critical. Members of a small group, a family or a religious sect, care deeply not only about right action, but also about the character of the actor. We want our children to act virtuously, perhaps even more than to engage in the right behavior.

But it is within the small, closely interacting, sectarian group there is the most agreement on the virtues. Sometimes that agreement is not even premised on the claim that the group's prime virtues are universal, that is, that all should agree with them. We may be quite content to treat certain virtues as character traits that are uniquely recognized within the group. According to this view, they need not be supported universally or even be seen as having a universal grounding. It is enough that those within our group share an agreed upon set of character traits that are deemed praiseworthy. For interaction among strangers, it may be quite sufficient if we can count on morally correct conduct, regardless of the character of the actor engaging in that conduct.

The Theory of Principles of Right Action

That brings us to the theory of the principles of right conduct. Here we find a small set of principles that describe the right-making characteristics of actions and rules. The focus is on the rightness of the conduct, not the character of the actor. It should

[14] Unschuld, Paul U. 'Confucianism.' *Encyclopedia of Bioethics*, Second Edition. Edited by Warren T. Reich. New York: Macmillan, 1995, pp. 465–69.

[15] Ferngren, Gary B., and Darrel W. Amundsen. 'Virtue and Health/ Medicine in Pre-Christian Antiquity.' In *Virtues and Medicine*. Edited by Earl E. Shelp. Dordrecht: Reidel, 1985, pp. 3–22.

[16] Veatch, Robert M. 'Against Virtue: A Deontological Critique of Virtue Theory in Medical Ethics.' In *Virtue and Medicine*, pp. 329–345. Edited by Earl Shelp. Dordrecht: D. Reidel Publishing Company, 1985.

be clear that it is possible to engage in the publicly verifiable morally correct action even though it is not carried out manifesting the proper virtue. For example, if beneficence is a right-making characteristic of actions and benevolence is a virtuous disposition, it is possible to be malevolently beneficent, that is to do the right thing with an evil character. It is also possible to be benevolently maleficent, that is, to engage in a harmful action while having a disposition to do good.

If there is a mismatch between the action and the virtue from which it is undertaken, it is a complicated question to determine which is morally more important. While in small, intimate groups such as a family, we may be more concerned about the virtuous character than the right action, in action among strangers — in large-scale social settings — we may well be more concerned about the right conduct than virtuous character.

Virtually all health care today is interaction in large group social settings among people who are essentially strangers. If one has a heart attack while visiting in a foreign culture and is taken to the nearest hospital, it would be virtually impossible to establish whether those who provide care do so based on some set of virtues that the patient would approve. It would be comparatively easy to agree on certain general norms of right conduct. It would be even easier to establish that agreed upon general norms of right conduct were satisfied.

Norms of right conduct are variously expressed as principles, duties, rights, or moral rules. What is critical is that they be sufficiently abstract to identify general norms and the norms apply to conduct, not the character of the actor who engages in the conduct. Almost all bioethical theorists who work on the norms of conduct agree that there is a very substantial convergence on what those norms are. There is no rule that there must be four principles. Various principlists point to beneficence and nonmaleficence, respect for persons through respect for autonomy, fidelity, veracity, avoidance of killing, and justice.[17] Similar norms with similar content arise among rights theorists[18] and those who talk about the moral rules.[19]

[17] Veatch, Robert M. *A Theory of Medical Ethics*. New York: Basic Books, 1981; Beauchamp, Tom L., and James F. Childress, Editors. *Principles of Biomedical Ethics*. Fourth Edition. New York: Oxford University Press, 1994.

[18] Dworkin, Ronald. *Taking Rights Seriously*. Cambridge, MA: Harvard University Press, 1977; Feinberg, Joel. *Rights, Justice, and the Bounds of Liberty: Essays in Social Philosophy*. Princeton, NJ: Princeton University Press, 1980.

[19] Gert, Bernard. *Morality: A New Justification of the Moral Rules*. New York: Oxford, 1988.

Undoubtedly, we cannot agree on what the foundational source of these norms are — whether it is a deity, reason, or the laws of nature; whether the grounding requires religious interpretation or secular. Nevertheless, there is remarkable world-wide agreement not only that there is a foundation for these norms, but also on their content. That the United Nations can adopt a Universal Declaration of Human Rights is quite remarkable. One can't imagine similar world-wide statements on the intrinsic values or goods humans should pursue or the virtues that humans should possess. A 'Universal Declaration of Human Virtues' would be quite unthinkable.

Of course, the convergence is not perfect. There continue to be battles over the precise list of principles — whether veracity and fidelity are independent principles or, instead, they are derivative from autonomy or respect for persons, for example. Some lists include justice as an independent distributional principle, while others handle such questions using the principles of utility or autonomy. Moreover, there is divergence when it comes to the *specification* of the principles in specific domains of action[20] and the derivation of moral rules from the principles. But the point is that there is *substantial* convergence. We at least have enough of a common vocabulary and conceptualization of the principles that we can identify the remaining areas that are in dispute.

It appears that when it comes to general principles of morally right conduct, we have some semblance of a convergence, an agreement that there are norms that apply to all people, independent of nationality, race, or religious persuasion. It is in those norms that the interests of the oppressed are protected. That is a way of saying that we agree there is a universal foundation for conduct in biomedical ethics. Fortunately, it is in conduct that such agreement is essential.

Kennedy Institute of Ethics
Georgetown University

[20] Richardson, Henry S. 'Specifying Norms as a Way to Resolve Concrete Ethical Problems.' *Philosophy and Public Affairs* 19 (1990):279–310.