

**H. Tristram Engelhardt, Jr., ed.**

*Bioethics Critically Reconsidered: Having Second Thoughts.*

Dordrecht: Springer 2012.

209 pages

US\$139.00 (hardcover ISBN 978-94-007-2243-9)

As bioethics slips into an uncomfortable middle age there appears to be an increasing sense that it is in need of firmer foundations and a clearer appreciation of its own purpose. However it is unclear where this foundation might come from or what it might look like. On the one hand it might be that bioethics is simply in need of a ‘mission statement’, i.e., a social and cultural proclamation of purpose. Not all bioethicists would necessarily cleave to this purpose but it would be a central pillar around which to organize bioethical variety, i.e., this (inter)discipline, second order phenomena, topic and profession or service. Alternatively it may be that bioethics is in need of a meta-(bio)ethic—a commitment to a central, probably applied philosophical, ethos which can act to determine the core of the discipline *per se*. Sometimes these two possible responses become conflated as, for example, in some so-called ‘bioethical origin myths’ that present the contingency of certain occurrences and the subsequent development of bioethics in such a way that they appear to justify progressivist perspectives. Such views are less about the past of bioethics than its present and future. Such is the nature of the crisis prompted by middle age. *Bioethics Critically Reconsidered* is an idiosyncratic example of this middle age, but it does not seek to offer firm resolution through the determination of a cultural mission or meta-(bio)ethical foundation. Rather it is, as per the subtitle, a collection of second thoughts.

In one of the best essays in the collection, Iltis and Carpenter question whether bioethics can be considered a singular, cohesive enterprise. Their guiding simile is the comparison of bioethicists with teachers. Calling someone a teacher may mean a variety of things: we might be talking about a driving instructor, a guru, or a schoolteacher. The authors suggest we might think similarly about those we call bioethicists. They reject the idea that there is a necessary and sufficient ‘core’ to bioethics, identifying four axis of bioethical difference: disciplinary; functional diversity; sub-fields and specialization; and moral pluralism. Attempts to identify a core are, inevitably, also attempts to define bioethics normatively and, as such, they must rule out an aspect of contemporary bioethical activity. The attempt to do so can never be fully distinct from the ethical positions the resulting bioethics will produce. This meta-aspect of the bioethical enterprise cannot be considered a morally neutral enterprise.

For the most part these essays reflect Engelhardt’s view that bioethics results from a culture that has lost its religious sense and therefore lost the idea of morality as a unitary phenomenon. Furthermore, as Engelhardt suggests, whilst bioethics may have once sought to mitigate this loss and produce a common secular morality, this is not been possible as the death of god culminates in a crisis for all such metaphysical possibilities (6). Instead, as a product of secular modernity or ‘western culture’, bioethics is

unavoidably characterized by ‘multiple socio-historically-conditioned constructions of morality and of the significance of morality’ (6). The contributors to this volume seek to reassess bioethics in the light of this moral multiplicity. However, for the most part, one has the sense that almost all the contributors would hark back to moral metaphysics within which god is not dead and that therefore they, at least individually or as a function of their own ‘local moral worlds’, still have a sense of morality as a *metaphysically* unitary phenomenon. Thus, in reading these ‘second thoughts’ I often felt as if I was being drawn into a sophisticated and critical assessment of and engagement with moral pluralism articulated by those who were not themselves moral pluralists but recognized it as fundamental to the modern condition. This in itself is not, of course, overly problematic, as specific moral discourses must seek to maintain the space they require in the wider ‘meta-moral’—cultural and political—discourses. However, it was not always clear that the commentators appreciated that the framework of the meta-discourse cannot be morally neutral, that there is no cultural and political accommodation of moral plurality that is not, itself, morally charged.

Perhaps the best example of this is the essay ‘Bioethics as Political Ideology’ where, *pace* Fox and Swazey (‘Examining American Bioethics: Its Problems and Prospects’, *Cambridge Quarterly of Healthcare Ethics* 14(4) [2005]: 361-73), Mark J. Cherry argues for the conclusion that ‘bioethics should extricate itself from the culture wars’ (100). He examines the discourse of ‘human rights’ and takes it to task for masquerading as a universal moral theory rather than a political and legal discourse. He then critiques this political and legal discourse for closing down what he considers to be legitimate aspects of moral plurality. His solution is to envisage a (free) marketplace of moral ideas as, he thinks, ‘[m]arkets are not affirmed as good in themselves...but are simply the result of respecting the moral authority of persons over themselves and their private property’ (114). However, arguably it is not tenable to propose the market as a morally neutral manner of social organization. Furthermore, given Cherry’s earlier discussion of the rights of the family over their children’s medical treatment, he would appear to be suggesting that children are the ‘private property’ of their parents, saying the ‘rights of persons over themselves, and even over their children, will foreclose what many envision to be worthwhile goals’ (114).

One of these worthwhile goals Cherry perceives to be morally foreclosed is the provision of healthcare, or healthcare insurance, for those who cannot afford it. The existence of such disenfranchised individuals is an aspect of contemporary market capitalism and not the exercise of individual moral authority. Those who cannot afford healthcare should be understood as constrained by the social structure and existing within a socio-economic stratum that is the result of the supposedly morally neutral market. Their ‘choices’ regarding healthcare and healthcare insurance are structurally constrained: It is not that they do not want healthcare insurance and the state is imposing it on them; it is simply that they cannot afford it and so have no choice at all.

Cherry also deserves to be taken to task for suggesting that Fox and Swazey propose solving the bioethical culture wars through appeal to international human rights law. This view is imputed to them on the basis of a citation that leads one to a bullet point

amongst a list of ‘certain nodal areas of concern and contention’ generated from an examination of the literature and interviews with bioethicists. There is a range of other identified areas and it is not clear where they stand on the question of the problematic ‘distinction between bioethical and human rights issues and of a line of demarcation between bioethics and international human rights law’ (Fox and Swazey, *op. cit.*, 362). However, what is clear is that they would not direct bioethical attention either solely or even predominantly to human rights as a solution to bioethics involvement in the culture wars, as Cherry appears to suggest. Whilst Cherry is right that bioethics must move past the culture wars, it is his own perspective—not that of Fox and Swazey—that makes the greater contribution its perpetuation.

If Cherry’s essay is the one that holds least personal appeal then McCullough’s mapping of the tension between two different aspects of bioethical thought holds the most. He contrasts, first, a reformist ‘applied ethics’ which perceives the ethical problems of medicine as its domain (with the result that the medical profession becomes ethically ‘deprofessionalised’) and, second, a more intellectual and interdisciplinary branch which, often through an appreciation of the profession’s history of ethical thought, comprehends the essentially ethical nature of medical practice. McCullough argues that the fundamental aim of medicine and medical practitioners—to do their patients good—is seen as troublingly paternalist by ‘deprofessionalising bioethics’ and, in an attempt to restore the balance of power, the ‘inequality’ of the doctor-patient relationship is recast in contractual terms. However, according to Pilnick and Dingwall (‘On the Remarkable Persistence of Asymmetry in Doctor/Patient Interaction’, *Social Science & Medicine* 72(8) [2011]:1374–82), the asymmetry of the doctor/patient interaction is remarkably persistent precisely because it is functionally central to the relationship between professionals and their clients. (We might note that this claim applies to professions *properly constituted*, i.e., to professions which are socially institutionalized and therefore have a formal ethical commitment to their clients [cf., E. Freidson, *Professionalism, the Third Logic: On the Practice of Knowledge*, Chicago, IL: University of Chicago Press 2001; & K. M. Macdonald, *The Sociology of the Professions*, London: Sage 1995]. It may not apply to pseudo professionals such as ‘IT professionals’ or ‘real estate professionals’ or, for that matter, professional bioethicists or clinical ethics consultants.) This is, essentially, the perspective articulated by McCullough. It presents a fundamental challenge to bioethics to work with, within, and for professional medicine on the everyday ethical issues that arise in the context of practice. Furthermore, we should do so with a sense that because we are not in a position to act, we are not, ultimately, morally responsible and are not, therefore, in a position to be the ultimate arbiters of right and wrong, good and bad. On this view bioethicists should not interpose themselves between the healthcare profession and its patients nor claim ownership of the ethical aspects of practice so as to seek formal professional status for themselves. Instead bioethics, and bioethicists, should be a resource on which the medical profession, and medical professionals, can draw as part of their own engagement with the ethics medical practice.

The theme of essays by Trotter, Bishop and Engelhardt is the prevalent but oxymoronic understanding of bioethics as a morally neutral enterprise. Trotter considers the cultural and political influence of the 1960’s, the decade in which bioethics was

gestated. The influence is summarized by the moral mantra, ‘Do your own thing, as long as it doesn’t hurt anyone else’, and traced through sections on: ‘Escaping Normalcy’ (individualism and autonomy); ‘Making Love Not War’ (the enduring yen for ethical universalism exhibited by bioethics and, one might add, most modern moral philosophy and maintained in the face of actual plurality); and ‘Sticking it to the Man’ (bioethics’ rebellion against moral traditionalism). Taking in, again, a moral rejection of universal healthcare, these sections drive towards the conclusion that hippie freedom is illusory and it is as much of a ‘totalizing social movement’ as any other utopian vision.

Engelhardt’s contribution reflects on the contradictions of the professional clinical ethics consultant. One might assume that the role of the clinical ethicist is to offer morally normative advice to healthcare practitioners. However, in the context of moral pluralism, this is not an acceptable role. The professional ethicist is limited to examining various moral perspectives and articulating their implications and assumptions, not the endorsement of any one substantive moral vision. Certainly ethicists offer ‘a cluster of other services’ (151) such as dispute mediation, risk management, and explore legal and governance grey areas in a manner consistent with the established medico-ethico-legal ethos (165), but they rarely offer determinate moral guidance.

Taking up this perspective, Bishop considers the socially constructed nature of the clinical ethicist and the healthcare ethics consultation they provide. It is the sole essay in a section entitled ‘The Incredible Search for Bioethical Professionalism’, and it examines the contradictions generated by the clinical ethicists’ claim to be members of a profession whilst also maintaining there is not such thing as ethical or moral expertise, at least insofar as a claim to expertise involves ‘goods or ends’ (i.e., producing ethical truth) rather than ‘skills or processes’ (i.e., producing ethical analyses) (182). With reference to the American Society for Bioethics and Humanities (ASBH) publication *Core Competencies of Healthcare Consultation*, Bishop presents the case for considering the ethicists to be involved in the bureaucratic management of a supposedly value neutral, efficient and effective process which produces ‘ethics’, rather than in a positive articulation of values which, through active engagement with others, augments the ethical practice of healthcare professionals and the moral aims of medical practice. There is a contradiction at the heart of the clinical ethicist’s project that involves the claim to professional objectivity. This usually indicates ethical neutrality yet, on pain of clinical ethics being restricted to the ethical bureaucracy, this claim of the clinical ethicist cannot, surely, be maintained outside of content-full ethical commitments.

The contributors to this volume can, in the main, be considered moral conservatives but, nevertheless, they are meta-ethical radicals. In contrast, the bioethical mainstream is morally radical but meta-ethically conservative. The essays presented here offer serious challenges both to the bioethical mainstream and the assumptions that underlie its projects and to those who thought middle age would be a time of consolidation, professionalization and the articulation of a coherent identity for bioethics.

**Nathan Emmerich**  
Queen’s University Belfast