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CRITICAL STUDIES IN PHILOSOPHICAL MEDICAL ETHICS*

Philosophical medical ethics, or the philosophical scrutiny of ethical issues in modern medicine and health care, is a relatively recent phenomenon. In Anglo-American countries, philosophers have been professionally involved with these questions for little over two decades,[1] and in Continental Europe the interest is only just arising.[2] In Scandinavia and in Finland, some work has been done on medico-ethical topics by individual philosophers, but the development of any wider expertise in the field remains to be seen.[3]

The involvement of philosophers in medical ethics has not been greeted favourably from all quarters. In many countries, medical professionals have maintained that the moral and value basis of medical work can only be confused by philosophical analyses, and by the imposition of ethical theories upon real-life health care provision (Clements and Sider, 1983). Public health authorities, too, have often regarded philosophers as a threat to the status quo and against their own bureaucratic standing. However, the most remarkable example of adverse attitudes towards philosophical medical ethics is provided by the popular pressures currently prevailing in Germany. In June 1989 the Australian philosopher Peter Singer was actually prevented from giving academic lectures on euthanasia in Dortmund and Marburg (Singer, 1990), and in June 1990 The European Society for the Philosophy of Medicine and Health Care was forced to call off its annual conference in Bochum a fortnight before the opening, because the organisers could not guarantee the safety of the participants. A number of individuals and civic organisations in Germany have announced that there should be no open discussion on matters such as abortion, infanticide and euthanasia, since the mere public presentation of permissive views tends to undermine the belief that all human life is sacred, or worthy of protection.

The pressures against philosophical medical ethics have not, however, weakened its position - instead, the effect often seems to be the contrary. In 1989, for instance, the German demonstrators succeeded in preventing a few university lectures, but at the same time they provided Peter Singer with an opportunity to convey his controversial views to millions of people through the popular press and through television. On a smaller scale,

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the situation is quite similar when medical professionals in any country set out to protest against philosophical views: what would otherwise probably go unnoticed by the general public, may easily become a matter of focal national or local interest.

The scope of medical ethics is wide, covering the totality of everyday medical procedures and health care provision. Faced with this fact, some philosophers and hospital administrators have thought that the proper task of philosophical medical ethicists is to work in hospitals and medical centres, and to solve concrete everyday moral dilemmas in cooperation with the medical staff (Caplan, 1983). One of the main overall purposes of my dissertation, however, is to argue and to demonstrate that this view is mistaken. Philosophers do not have any special ability or training to solve particular moral problems which arise in face-to-face medical situations. Their undisputable knowledge of conceptual analysis and ethical theory makes them outstanding potential critics of current practices, and perhaps enables them to be reasonably skilful in drafting policy suggestions on a large scale. But the application of ethical theory to individual cases in health care provision is not characteristically a job for the philosopher.

Even when philosophical thinking is applied to large scale ethical issues in medicine and health care, it is not evident how theory and practice should be related to each other. Many philosophers have thought that ethically controversial policy problems in medicine can be solved by mechanically applying some preexistent moral theories to them (e.g., Hare 1975; Hare 1988). But the problem with this approach is that there are several mutually contradictory moral theories, yet no way of judging in absolute terms which one of them, if any, is universally valid.[4] Using any one of them as the only starting point for problem-solving in health care would, therefore, be question-begging.

My own suggestion in the dissertation is that the connection between theory and practice in medical ethics should be seen in a different light altogether. The philosopher's first task in tackling medico-ethical problems is to uncover and critically assess the views and theories that are currently held concerning the issues under examination. One should start by eliminating models which are self-contradictory or which do not harmonise with the deep moral and emotional convictions of the society in which they are enforced. The reason for ruling out self-contradictory views is obvious: having an inconsistent set of ethical principles amounts to having no ethical principles at all. The elimination of models which tend to violate the common morality and feelings prevailing in society is a more controversial matter. My point is that enforcing moral rules which are completely alien to those who are expected to follow them is often prone to be harmful in the end. The mere fact that many people condemn a view does not prove that the view is incorrect. But the imposition of controversial views upon dissenting people from above (by, for example, legal restrictions) may causally lead to harmful behaviour which completely outweighs the benefits of the intended regulation. In this latter case it would clearly be advisable not to enforce the views in question.

I have coined the first, critical aspect of the philosopher's work 'cognitive deprogramming', as its function is to denounce opinions received through education.[5] The philosopher's second task in medical ethics is more constructive in nature, and I have labelled it 'rational reconstruction'. When the elimination of inconsistent and emotionally unacceptable views has been completed, philosophical ethicists are normally expected to express their own normative accounts of the issues under consideration. To avoid the difficulties which have led to the dismissal of earlier views, they must, of course, proceed cautiously at this stage, trying to observe as well as they can the twin requirements of logic and prevailing moral feelings. In other words, the critical assessment of moral judgements - which is clearly the philosopher's main task in medical ethics - should be extended to one's own proposals as well as to the opinions of others (M. Häyry, 1991a).

As regards the relationship between theory and practice, my proposed model implies that medico-ethical theories can be proven to be *false* either in absolute terms (by uncovering logical inconsistencies) or relative to the society where they are enforced (by showing their emotional unacceptability). In the latter case, the falsehood of a theory is tested by the expected consequences of its application to medical practice. On the other hand, whether theories in medical ethics can, strictly speaking, be *verified* or not is another matter. Philosophers can, of course, make sure that their own solution is not subject to the critique they have employed against the views of others. In this sense theories of medical ethics can be improved, and genuine progress is possible in philosophical medical ethics. But the nature of philosophy is such that some questions are perennial. As far as answers to these questions are concerned, the ultimate validity of medico-ethical theories remains open to dispute.

It is perhaps no coincidence that the first medical issues tackled extensively by modern-day philosophers - abortion and euthanasia - are strongly connected with some of the most enduring issues in moral philosophy: the beginning and end of human life, the wrongness of taking lives and the wrongness of allowing suffering, conflicting beliefs and interests, and the roles of autonomy and voluntariness in ethical decision-making. The interest moral philosophers have shown towards medical matters since the beginning of the 1970s was not exclusively motivated by genuine commitment to problems in health care. Medical ethics was also instrumental in reviving normative ethical thinking in philosophy, and medical issues were often seen as suitable testing grounds for abstract theorising (Toulmin, 1982).

In the articles which form the body of my dissertation, I have tried to maintain a baglance between the assessment of real-life policies and the clarification of philosophical arguments. The medical problems dealt with in the articles include abortion and infanticide (M. Häyry, 1989; 1990; 1991b), AIDS (M. Häyry and H. Häyry, 1989), vaccination programmes (H. Häyry and M. Häyry, 1989), anti-smoking policies in Finland (H. Häyry, M. Häyry and Karjalainen, 1989), resource allocation in health care (M. Häyry and H. Häyry, 1990), euthanasia (H. Häyry and M. Häyry, 1990), and quality-of-life measurements in medicine (M. Häyry, 1991c). The philosophical issues which cut across this field include the value of beginning human life and the value of reproductive freedom, choices between conflicting interests and interest groups, distributive justice and redistribution, and the significance of individual freedom, personal autonomy and self-determination. Let me present two examples to show how philosophical considerations can be brought to bear upon choices of health care policy and legislation.

My first example is the abortion issue. From the viewpoint of philosophical medical ethics, the question of terminating pregnancies by medical means is in many ways generously rewarding. When one wishes to defend liberal abortion policies, as I have done, the major charm lies in the fact that the falsification of certain conservative views is all that is needed to back up more liberal solutions. It is not necessary to make complex auxiliary hypotheses or to employ fanciful additional premises: a pure critique in itself will make a good case for reproductive freedom.

The defence of liberal abortion policies can be started from a line of argument that I have coined 'Catholic', and which is designed to justify an extremely restrictive view of abortion. According to this view, terminations are wrong because when they are performed, innocent human beings, whose lives are sacred, are killed in the process. The liberal response to the argument is that innocence and humanity do not by themselves suffice to guarantee the inviolability of one's life. Only those beings who are capable of considering themselves as continuing subjects of mental states have such an interest in the continuation of their own existence that they can be said to have a right to life. These fortunate creatures are usually called in the literature 'persons'. Obviously, the criterion of personhood is not fulfilled by fetuses at any stage of

their development, and the initial argument based on their alleged rights fails.

The conservative opponent of abortion can, at this point, admit that fetuses are not actual persons, but note that they are *potential persons,* i.e. that they possess the capacity of developing into persons if the relevant natural processes are not interfered with. But although it is true that even unborn human beings are potential persons, it is quite another matter whether the fact is morally significant or not. In the dissertation I have examined several meanings of the term 'potentiality' to clarify the situation, but the results are, in each case, discouraging for the conservative view (M. Häyry, 1991b). Potential beings of a given kind simply do not seem to be universally entitled to the same things that actual beings of the same kind are. And given that potential personhood does not provide fetuses with a right to live, the conservative argument collapses and the way is wide open to liberal abortion policies and legislation.

My second example is resource allocation in health care. Public authorities in the West are nowadays often faced with the problem that medical treatments which could save lives and cure diseases are too expensive to be provided to everyone within the limits of current health budgets. As all people seem to be equally entitled to public health care, authorities find themselves in a difficult situation. On what grounds can they make allocation decisions which are both relatively efficient and reasonably fair?

The pragmatic criteria which have been introduced in response to the question include, for instance, medical need, the prospect of medical success and future life expectancy, as well as past contribution and expected future contribution to the welfare of the community. In the dissertation I have gone to some lengths to show that none of the offered solutions is in the end acceptable (M. Häyry and H. Häyry, 1990). Medical needs and prospects vary considerably, making universal comparisons impossible. Expected life years as a criterion automatically leads to preferential treatment of the young at the expense of the old, which is blatantly unfair. And the individual's contributions to societal life are often defined in ways which lead to favouritism and injustice. When a lay committee assessed the social worth of people who needed haemodialysis in the United States in the 1960s, Sunday-school teachers and scout leaders were systematically preferred to people who were not equally keen on preserving the middle-class American way of life (Sanders and Dukeminier, 1968).

But if the authorities reject all pragmatic criteria, the options which remain open to them are few and unattractive. Some theorists have played with the idea of randomising allocation choices in health care provision. But although random procedures are, in a formal sense, fair - everyone stands an equal chance - it would probably be rather difficult to accustom people to the idea of hospital lotteries for expensive treatments. The solution introduced in the dissertation is that medical resources should be increased by taking money from other sectors of the national budget. The prolongation of life and the improvement of health are clearly needs which ought to be met before less basic needs can be taken into account in the allocation of public funds. This conclusion is, however, considerably more controversial than the conclusion of my argument on abortion.

From the philosopher's viewpoint, the question of resource allocation is both more and less interesting than, for instance, the abortion issue. One can draw reasonably reliable critical conclusions with regard to pragmatic criteria, which are often believed to be the solution. But when it comes to positive results, the situation is more complex. The suggestion that more money should be given for medical purposes from other sectors of the budget certainly does not follow from the critical conclusions. In one sense, this makes the resource allocation issue disappointing. In another sense, however, it makes it all the more challenging. Difficult and even insolvable questions are and always will be a part of the philosopher's lot, in medical ethics as much as in other areas.

NOTES

* *Lectio praecursoria*, 13 December 1990, University of Helsinki. The lecture is based on my doctoral dissertation, entitled *Critical Studies in Philosophical Medical Ethics*. The dissertation consists of ten original articles and a summary. The summary has been published as Nr. 2/1990 of the series *Reports from the Department of Philosophy, University of Helsinki*. The original articles have also been published under one cover, with the summary, by the Department of Philosophy, University of Helsinki in 1990.

1. One of the first original articles in modern philosophical medical ethics was Judith Jarvis Thomson's 'A defense of abortion' (1971), which appeared in the (then) newly founded American journal Philosophy & Public Affairs. This article was followed by an extensive and heated debate concerning the rights and wrongs of abortion and, later on, infanticide and the new reproductive technologies. In England, Philippa Foot in 1967 had already published her classic article 'The problem of abortion and the doctrine of the double effect' (Foot 1978), but this contribution would probably have gone unnoticed without the discussion on Thomson's article.
2. The European Society for Philosophy of Medicine and Health Care (ESPMH), which is the organ for joint (Continental) European efforts to develop the philosophical study of medicine and medical ethics, was founded in Maastricht, The Netherlands, 19 August 1987.
3. See Airaksinen and Vuorio (1988) and Lindahl (1988). The first doctoral dissertation on philosophical medical ethics in Finland was Heta Häyry's Freedom, Autonomy, and the Limits of Medical Paternalism (1991), which was publicly examined by permission of the Faculty of Social Sciences at the University of Helsinki, 14 November 1990.
4. R.M, Hare, for instance, relies upon his 'preference utilitarian' theory (1981). Others, however, have thought that the proper basis for medical ethics is either some version of Kantian or Rawlsian theory, or the Bible, or the proper virtues of medical professionals.
5. 'Cognitive deprogramming' bears a resemblance to the method of 'cognitive psychotherapy' introduced by Brandt (1979). By cognitive psychotherapy Brandt proposes to distinguish between rational and irrational desires: the former variety of desires cannot be removed by certain cognitive exercises made by the individual, whereas the latter can. The core idea utilised by Brandt goes back to the associationist psychology of James Mill and earlier British utilitarians. The difference between Brandt's method and mine is that he concentrates on individual rationality and morality, while my focus is on the societal level.

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