Acadia Institute Project on Bioethics in American Society
Robert M. Veatch, Ph.D.

November 8, 1999. Second interview with Robert M. Veatch, Ph.D., Professor of Medical Ethics, The Kennedy Institute of Ethics, and Professor of Philosophy, Department of Philosophy, Georgetown University. The interview is being conducted by Judith P. Swazey, Ph.D., at Professor Veatch's office at the Kennedy Institute.

Swazey: Where we ended when we talked to you in March was your move from Hastings to Kennedy in 1979. What occasioned that?

Veatch: I had been at Hastings almost 10 years and I realized I had reached the point where continuing essentially to administer research groups was getting a bit tedious. I was in negotiations with Dan Callahan about becoming the Assistant Director of the Institute. But simultaneously a position became available here at the Kennedy Institute, and I was in conversation with Andre Hellegers about that position. Jim Childress had been here and decided to go back to the University of Virginia, and I was in conversation about essentially replacing him here at the Institute. The offer for the Assistant Director position at Hastings Center came at roughly the same time as the offer to come here, and the offer to come here was essentially to do my own work any way I wanted for the rest of my life...

Swazey: It would be a little hard to say no to that.

Veatch: It's an academic dream offer; not only secretarial support and office but also in the home of the best bioethics library in the world and the resources here are even better than I thought. It was an easy choice to make. I have never been very pleased at doing grant and contract research. The hoops one has to jump through to please the funder began to get to me. As long as one is doing research with a large group (such as at Hastings) there are enormous advantages. The intellectual stimulation was wonderful but the staff person's job was to write a coherent consensus statement, which meant I was always locked in to balancing the views of the other members of the group. I thought the opportunity to do my own independent work was a wonderful chance, so that is what led me to move.

Swazey: Did Dan understand your decision?

Veatch: I think so. We've remained on the best of terms, and for many years I continued to be very active at the Hastings Center. Soon after I left I was appointed as a fellow, so that relationship has been very good. So as far as I am concerned the Kennedy Institute and the Hastings Center have always had good cooperative working arrangements.

Swazey: How much cooperative work is actually done apart from individuals like yourself?

Veatch: Well, the people at the Kennedy Institute have worked on Hastings Center projects quite regularly. Several of us here are fellows of the Hastings Center. I've found it to be a good working relationship. It is the nature of the Kennedy Institute that we rely much less on outside people but we've had regular participation by Hastings Center people, as much as could be expected. Dan Callahan has given one of our named lectures and people from the Hastings Center have served as staff of the various courses we've taught and so forth. Most of our work, though, is teaching and independent research so we don't rely very heavily on anyone from the outside. The Kennedy Institute Journal has always published and relied on Hastings Center people for peer review, and we have always done that sort of thing for Hastings. I find it is a good working relationship.

Swazey: What would you characterize as some of the most influential or creative centers now in bioethics?

Veatch: Centers...

Swazey: Centers, programs...

Veatch: I don't know that I have a very creative answer. Certainly the work of the

Hastings Center and the Kennedy Institute remains. I find myself reading things and collaborating with people at Minnesota and at Penn. The Baylor/Rice program in Houston is certainly a major player still. We have had some cooperation in Europe. The Kennedy Institute works with the Bochum Center in Germany, in part because Hans-Martin Sass has appointments both places. We work with Waseda University in Japan because Rihito Kimura has appointments both places. As far as American centers go I suppose I have named the most obvious ones.

Swazey: Do they have common characteristics that lead you to say those are the key ones?

Veatch: I think it is more the range of subject matter, the style of work. It's also the case that Jeff Kahn, who is now the director in Minnesota, was a graduate of our program so we have known him for a long time. I have known Art Caplan (the developer of the Minnesota and Penn programs) since Hastings Center days.

Swazey: When you said style of work, elaborate on that.

Veatch: I would characterize the typical academic style in bioethics as interdisciplinary with heavy influences from philosophy, from law, from clinical medicine, with a much more ambiguous relationship with social sciences. We have always worked

with people in the social sciences but for the most part our methodology is not social science methodology. Now there are obvious exceptions to that. There are people who do empirical survey type research, and certainly the participant observation and in-depth interview work of the sort that you and Renée do gets read regularly, but I don't think we have anybody here at the Kennedy Institute that uses those methods as their primary methods.

Swazey: So you would characterize that as a style of work that is common to Hastings, Kennedy, Minnesota?

Veatch: Yes. There seems to be a clear sense that Penn is slightly different; maybe it is because of Art's character that he is more in communication with the lay press. But by and large the people at Penn are still doing interdisciplinary writing.

Swazey: Are there newer programs you have watched coming up that you think are going to take off?

Veatch: There are many programs.

Swazey: No one as far as I know knows how many, in fact, which is interesting.

Veatch: Well, in part the problem is that it depends on what you count. There certainly are many places where there is one person who gets a bit ambitious and he calls what he does or she does a program. And occasionally that person gets grants and runs conferences so he or she behaves a little like a program. No, I don't think it is clear how many there are but there are certainly dozens of things that could in one way or another be called a program. There are centers, for instance the University of Virginia, which doesn't bill itself as a program but has a core of people which is approaching a critical mass; Jim Childress, John Arras, Jonathan Moreno, and John Fletcher is still around and there are some others there. They co-hosted a recent conference on the Belmont Report.

Swazey: So critical mass is one thing you need for a program?

Veatch: I think so.

Swazey: I assume you need not only numbers but the interdisciplinary mix.

Veatch: In one sense I think you could say that if you have four to six people you have enough for interdisciplinary work or at least you have got enough for a conversation among scholars. Programs that are smaller than that I think are just academic teaching positions or clinical positions that are in disguise.

Swazey: What is your take on the masters degree programs that are proliferating, in terms of how well they are training people and for what?

Veatch: I am sure what I will give you is a Georgetown read on the subject.

Swazey: That's fair.

Veatch: It has always been our view at Georgetown that a masters degree by itself is a degree that will leave someone not well enough trained to assume a professional role in the field. A masters degree by itself is good training for a research assistant position or a researcher position within some program but not sufficient for full professional or academic standing. We strongly discourage terminal masters degrees and have very few of them. We will not give any fellowships for terminal masters degrees and we almost never will admit somebody for a terminal masters degree except for those who come with a doctoral level or professional degree already in hand. So we have people in our program for a masters degree who already have an MD or law degree, or PhD in some other field. We use the masters degree to reorient people who are professionally credentialed in some other area. I would be hard-pressed to identify people who have come out of other programs with terminal masters degrees who strike me as making substantial

contributions in the field or making a professional level without doctoral-level degrees in other fields (such as law or medicine).

Swazey: Yes, my sense in looking at the programs that the students are either going to go on to get a terminal degree in something, or if they are not, they are enhancing their work as say an IRB administrator, or as you said a research assistant or whatever.

Veatch: If a physician is running an IRB and is serious about the work he or she is doing, getting a masters degree in bioethics would be very appropriate. But in most cases that will lead simply to a local contribution.

Swazey: What about a PhD in bioethics, which as you probably know a number of places is considering starting.

Veatch: Georgetown has thought about it from time to time and always reached the conclusion that anyone in bioethics should have a main professional credential in some academic discipline. We are open to that being several possible disciplines. Our main effort here at Georgetown is in philosophy, but more and more we're seeing the people we train in bioethics to be competent, fully credentialed in their parent discipline with a specialization in bioethics. I have always been open to the

possibility that a degree explicitly in bioethics might be a possibility. I would hope that if someone does such a degree it would include serious interdisciplinary preparation in philosophy and in social science, something of that sort. I suppose my bias comes from the fact that I was in a very interdisciplinary program for my own doctorate at Harvard. I spent a third of my time in philosophy, and a third in social science, and a third in the academic study of religion...and for one that can handle the angst of being on the borders of disciplines I find it a wonderful way to live. It is clear to me that people who are seriously trained in more than one discipline make a different kind of contribution to the field. Especially in the early days of what we call bioethics, (which I date from maybe 1970 or maybe the late 60's) the contributors were very interdisciplinary. It was not until the 80's that people in single disciplines emerged who became significant contributors who I think advanced the field.

Swazey: Some people who we have talked to about a PhD in bioethics are concerned that if it took hold over time, and I don't know what the time frame would be, it would restrict entry into the field.

Veatch: Well, I can't see how it would unless you also prohibited the more traditional ways of getting into bioethics by being fully credentialed in some academic discipline. If anything I think our problem has been that we have had people lateral into

bioethics with no training in bioethics. I think particularly of the lawyers and physicians but there are other examples in other disciplines as well in the very early days in theology and philosophy. The disciplines that are not involved in the formal study of ethics are all the disciplines except theology and philosophy. If someone laterals in, say as a law professor, that person has a lot of remedial work to do just in the basic jargon and methods of the academic study of ethics. I am assuming that if there is a degree in bioethics it would have to have serious preparation in the formal study of ethics in some way, and that would either be philosophy or for one who wants to study ethics descriptively, in the social sciences. I personally have backed into the study of the history of medical ethics and I have in a way regretted not being more formally trained in history. Aside from the study of the history of religion I did not have very strong preparation in the academic discipline of history and because of that I have always felt a little bit on the outside in doing historical work. On the other hand, when I read histories of medical ethics written by historians it is equally obvious to me that they are on the outside with regard to the formal philosophical categories. So one way or another scholars are going to have some deficits.

Swazey: That's right, and you had good social science training. That is not exactly equivalent to historiography, but Renée and I have talked for decades now about how compatible we are methodologically.

Veatch: Maybe I am wrong, but when I look at the study of the medical fields it strikes me that sociologists of medicine and historians of medicine are very different, in that the sociologists of medicine I know have PhD's in sociology and they specialize in medicine whereas the historians of medicine, at least classically the Hopkins people, are physicians who may get PhD's in the history of medicine mid-career, but their primary work and style is that of the clinician medical scientist rather than as a social scientist. I have a firm belief that those of us who work in interdisciplinary fields are heavily influenced by our first professional degree. It shapes our thought patterns, even our sense of what constitutes competent work. So in medical ethics I see an enormous difference between the physician who then goes into ethics and the ethicist who then goes into the study of medicine.

Swazey: When I used to go to history of medicine meetings years ago, the most dreadful papers were usually by the retired physician who decided to become a historian. We used to say well gee, when we retire we will become surgeons or whatever. Who needs any training.

Veatch: Yes, even though there are historians of medicine who are considerably more competent than the retired guy who goes out and writes history; people like Chester Burns and Ludwig Edelstein are serious scholars. Nevertheless, I think

their work is qualitatively different from the work that is done by a historian who then chooses to go study medicine.

Swazey: I think you are right. There is a powerful imprinting by what you first do.

Veatch: The critical difference, it seems to me, is how agile the person is in the social science discipline, history or sociology, outside of the field of medicine. The physician who writes history may do a pretty good job of mastering the history of medicine but mastering the history of religion, the history of the surrounding culture, is an awful lot to ask of somebody mid-career after they have already been trained primarily in medicine. And I am sure exactly the same thing would apply in sociology, where a physician could master the literature in the sociology of medicine if he works hard for 10 or 20 years but there is a lot more to sociology; mastering Parsons is another story.

Swazey: I think those are very valid observations. We talked some about people in bioethics and the interdisciplinary mix. How would you characterize bioethics now; what is this beast? Do you see it as a profession, has it become a discipline? The people that we have talked to about this are all over the map.

Veatch: I still don't call it a discipline. I would be more comfortable calling it a field of

specialization. It is clear to me that people who call themselves "bioethicist", when they come together across disciplines, have a considerable common vocabulary and a common set of references in the literature. For example, sociologists, philosophers, clinicians, can handle certain groups of court cases quite nicely. In fact, better than a lawyer who is totally outside of bioethics. And the same, I think, is true of physicians or lawyers who have had some experience in bioethics. They are developed to the point where they can at least sling around the basic vocabulary and use it properly. At least get beneficence and nonmaleficence into the conversation and maybe deontology.

Swazey: What would it take to make it a discipline. What do you think a discipline consists of?

Veatch: I think of a discipline of having not only a common literature, which bioethics now does, but a common set of methods, standards for evaluation. In so far as bioethics has methods, all one could do would be to list out the methods of its parent disciplines, the methods of philosophy, sociology, history, law, clinical medicine. If I were asked, "well, beyond those disciplines is there a method for bioethics?" No, there is not. One can do bioethics by participant observation or by legal scholarship or historical scholarship, but as for doing it without relying on one or more parent disciplines, I just don't know how one would set out to do that.

Swazey: Or what you would do. Do you think bioethics could develop and should develop a methodology that people would say is "the methodology" of bioethics.

Veatch: I don't think so. I don't see any need to go beyond the methods that are available in those parent disciplines. Now in so far as the parent disciplines have methods that evolve and get refined, I hope that gets transferred into an applied area like bioethics, but I am not sure methodologically how bioethics could emerge beyond those other disciplines. What we do have in bioethics is people who are at least comfortable and have a working familiarity with disciplines outside their own parent discipline. A good example would be that I think I have a fair layman's working knowledge of legal scholarship, even though I have never formally studied law. I think most bioethicists have a fair working knowledge of certain narrow aspects of clinical medicine. You know, if you work on organ transplant and dialysis long enough you learn what a shunt is.

Swazey: That would be good to know even before you started.

Veatch: You learn the basic medical science but learn it narrowly. You may even know a fair amount about immunosuppression, but a bioethicist would not know the full range of medicine the way a well trained clinician might. In a subject where I have

worked for many years, like brain death, for instance, I can sit at a conference table with a neurologist and hold my own on the science, but if the neurologist takes me a little bit off the subject into some part of neurology I have never had to work on before, I am lost. So what the discipline brings is the capacity to take a narrow problem like brain death and see how it connects to the basic scientific discipline of neurology. I don't even pretend to have expertise broadly in neurology. I guess it is saying I am a little bit like the physician who writes history and learns narrow aspects of the field as well, but doesn't have the breadth that somebody who is a fully credentialed person in the field does.

Swazey: Some people have said they think there needs to be a bioethics methodology, and then do get stuck on what that would consist of unless they are, very staunch supporters of philosophy becoming even more of dominant.

Veatch: Even if you take that view, so you import all the methods of philosophy, that is not developing bioethics as a distinct discipline. I do believe that occasionally somebody working in an applied field like bioethics can make a contribution to the parent discipline. I may have mentioned to you before that I have recently published an article on directed donation of organs for transplant, which led me to a minor proposal for a modification of Rawls. In other words, by working long enough and hard enough on an applied problem in bioethics I encountered a set of

issues that led me back to basic theory. The theory was basic theory in philosophy, and I assume that a bioethicist who is a social scientist could do the same sort of thing. Whether it is in statistical methods in survey research or in more qualitative research, it may be that methods would get refined which then become a contribution to the parent discipline. But I don't think that means one have invented a new set of methods just for bioethics.

Swazey: Since you think bioethics is not a discipline, and I must say I agree with you, is it also not a profession?

Veatch: I guess that depends on a lot on what you think a profession is, and I have a lot of doubts. I know much less clearly today than I did 20 years ago what a profession is.

Swazey: It is hard to find anything that isn't called a profession these days, no matter what occupation...

Veatch: On the other hand certain things that were historically called professions are beginning to look an awful lot more like occupations, if occupations is a word that can implies degrees word, and certainly physicianing, the archetypical profession, begins to look more and more like a business operation. I can't imagine saying I

am in the profession of bioethics. I can imagine saying bioethics is my field of specialization, and that even for short leads me to say that I am a bioethicist, that's okay, but I wouldn't think of that as a profession. If you ask me what my profession is I would say I am an academic, I am a professor, I am a researcher. People trained academically in ethics, and I am thinking primarily of religious ethics and philosophical ethics, have always referred to themselves as ethicists, and when they work in medicine and biology it is natural to call themselves bioethicists. Now the question arises, can a physician or a lawyer also be a bioethicist. There is very little discussion of it, but I think some people from what I would think of as the parent disciplines of ethics, philosophy and religion, have a little doubt about whether the term bioethicist should be used for those people not formally trained with ethics as their parent discipline. Generally you don't hear people say that very often, but my sense is that some ethicists have the attitude "If I can't call myself a physician by having worked around a hospital for 30 years, can a physician call himself an ethicist or a bioethicist by the fact that he has worked very hard at it for 30 years but never been formally trained."

Swazey: I think people who are not trained in ethics but work on the social value, or legal issues have the problem of being labeled or defined as an ethicist, usually by the media, but sometimes by people in their field. I think of George Annas...

Veatch: That is exactly who I had in mind.

Swazey: ...who goes nuts because he says, you know they never call me a health lawyer in the media, I am always a bioethicist. Renée and I are always being introduced as bioethicists and we start out by saying, no that's not what we are.

Veatch: Well, if you think of a bioethicist as anybody who specializes in the interdisciplinary field of ethics and health care or ethics and biology, then you and George fully qualify. But yet, there is another way that we use the term and George is very good at knowing the difference between being a lawyer (or being a health lawyer) and being a bioethicist.

Swazey: I guess Renée and I share George's sense that we have worked in these areas but we are not formally trained in either religious ethics or philosophical ethics and therefore we don't view ourselves technically as bioethicists, but it hard to escape that label.

Veatch: But underlying that is, I think, a more substantial issue and that's the question of whether there is such a thing as expertise in ethics. It is my view that there definitely is an expertise in the analysis of ethics, but I to this day have doubts that there is identifiable expertise in making ethical judgments, and I say that quite

carefully. There are obviously some people who make better ethical judgments than other people do, but I don't think we have formal methods of sorting people so we can identify a subgroup of the population we will call the ethics experts in places where Congress or the Supreme Court could go and check to find out what the correct ethical answers are. What that suggests is that in the field of ethics there is simultaneously an obvious expertise in Kant and there are some people who can describe Kant's efforts better than other people can, while at the same time we want to remain skeptical about being able to name the person who has expertise in wisdom. So, if you think of bioethics as the enterprise of offering opinions about ethical judgments, and bioethicists do a fair amount of that, there is no reason in my view to consider somebody formally trained in ethics to be better at it than somebody who has worked 30 years in the field but never had formal training in philosophy or religious ethics. On the other hand when it comes to disciplinary matters in the academic study of ethics, the thought that you can become a bioethicist just by dabbling at it for a long, long time, leaves many philosophers and religious ethicist slightly uncomfortable, just as it would leave a lawyer uncomfortable when I come along talking with George Annas if I were to claim I have done law for so long, I am sort of a lawyer. And George will remind me that that is not true and he is right.

Swazey: Okay, that is an important set of distinctions. I want to go to analytic philosophy

now. Now I know you personally did a lot of other things beside get training in analytic philosophy, but one thing that we are trying to understand and untangle is why philosopher-bioethicists in general have not drawn on areas like the Continental philosophers or even American pragmatism.

Veatch: That is a very good question. I do think there is emerging a little bit of interest in the pragmatists. Jonathan Moreno is a good example.

Swazey: As you know, one obvious answer is that most people trained in this country didn't get any training in Continental philosophy, but I think there are things beyond that.

Veatch: Bioethics is an American enterprise, at least it has its origin in the United States and our health care setting. American philosophy is largely analytical philosophy, at least the more prestigious institutions that were doing philosophy did it analytically. What that means is there are very few philosophers who are on the American scene and therefore asked to work for the President's Commission, or whatever, who have the tools of Continental philosophy. Now that's not entirely true. There are people like Dick Zaner and John Lachs, who have stuck to their Continental orientation. But they've never emerged with quite the prominence as those who are trained more analytically. Now, if my hypothesis is correct, that

should mean that if you look to the bioethics of Europe you would find more Continental philosophy. And I think you do. I remember my first trip to the Soviet Union about 1988, just as the Soviet Union was under a lot of tensions before it collapsed. We talked to the Russian philosophers who were doing bioethics in Russia. And these were not ideologues, but it was very hard to have a conversation. Their categories and their terminology was quite different from those of us from the Anglo-American West.

Swazey: What had they been schooled in philosophically?

Veatch: Well, partially Marxist/Leninist thought, which you would expect. But also German and French philosophers that the Americans that I was with weren't terribly comfortable with, any more than the Russians were comfortable with the British and the Americans.

Swazey: Do you have people working here at Kennedy on a visiting basis who are trained in Continental schools?

Veatch: Well, we have Hans-Martin Sass who's here permanently on a joint appointment with the University of Bochum. We have people who come through as visiting researchers to do their own work, usually on sabbatical, who certainly have a

much more Continental orientation. Also, Warren Reich, who was here until recently was more oriented to Continental thought as several in our Philosophy Department.

Swazey: To the extent that you have inter-scholarly discussion, do you find those same communication problems that you found with the Russian bioethicists?

Veatch: Not as dramatically, but…

Swazey: But it's there?

Veatch: It's there. Now, Georgetown is unusual in that among American universities, it is famous as a place where you can do Continental philosophy, like Northwestern and Indiana University. So we occasionally get a graduate student who wants to draw on those resources.

Swazey: It's been interesting to us as we've watched stirrings or mumblings about community, for instance at the Belmont Revisited Conference. People have to editorialize, I think inappropriately seized on communitarianism, which is not the same as community, and there's a very deep lack of familiarity with the European concept of solidarity.

Veatch: The code word in a Catholic university is not solidarity but the common good.

Swazey: That's right.

Veatch: And we see that when the analytical philosophers here hit up against people trained in Catholic moral theology.

Swazey: Is there a dialogue that can get going to try to bridge those lacunae in, both knowledge and understanding? Because it seems to me it's an enormously important area.

Veatch: Yes, but I would be surprised if that dialogue has its roots in bioethics. I suppose it could, but in a way you're asking a question for the academic study of philosophy, about analytic and Continental philosophers talking to each other.

Swazey: Right. Although to the extent that bioethicists are becoming any more interested in social justice issues and so forth, it seems to me they need to be able to dialogue about things like, what do we mean by the common good and not be locked into their ideological boxes.

Veatch: I've seen literature over the years on the question of what do we mean by the

common good. Often it's handled in rather analytical ways. What's the difference between the common good and maximizing of aggregate utility. Things of that sort.

Swazey: You said in March that there were lingering questions about why there hasn't been more social science input in bioethics. Can you talk about that a little more?

Veatch: Well, I don't know that I have any great insights. It's certainly the case that empirical work has had rather low standing in bioethics. And by empirical work, I mean what empirical social scientists themselves might actually think of as not terribly creative; survey researches. If you've seen nursing masters dissertations in social science research, you know what I'm talking about.

Swazey: Yes.

Veatch: I'm not talking about the sort of thing that you and Renée do. I guess that means the real question is why is it that there is not more of the more creative qualitative work?

Swazey: Or good quantitative work; there certainly is good quantitative analyses.

Veatch: We get a Charles Bosk, who certainly has played a significant role, as well as your work and Renée's. Why isn't there more of that? Is it there in sociology and it just doesn't get expressed in terms of the study of bioethics?

Swazey: I think there are clearly problems on both sides, because the social sciences are not in the best of academic shape. My own sense is that for fairly purist philosopher-bioethicists, there hasn't been sense that they need a grounding in what is to analyze what ought to be. And I'm, I'm partly reflecting what I've heard a number of people I've interviewed in recent months say, as they've talked about the tension between social science and bioethics. Their sense, too, is that Renée and I have qualitative research or even descriptive ethics simply isn't that important in bioethics or, say, good health services survey research where you get a grounding in what the health system really is, what's going on now.

Veatch: I certainly have always relied on one kind of quantitative research and that is descriptive accounts of physician and patient behavior, for instance, advance directives behavior. I've done a little bit of writing recently relying very heavily on the survey research that attempts to measure what physicians believe patients want in their terminal care. That kind of survey research when it's done well is very useful. I guess what I'm concerned about is the lack of the more subtle and rich conceptual work that I see in very few social scientists. I guess maybe this is

a question that applies not only from the philosophy side but from the social science side. To give you a personal example, there is a person who teaches medical sociology here at Georgetown, but I couldn't tell you who he is let alone what sort of work he does.

Swazey: And he may not know the Kennedy Institute.

Veatch: Well, I'm sure he doesn't…at least we've never had any interactions.

Swazey: Let me flip this. I don't know what the answer is to try to defuse this problem, and I think as you said, it cuts both ways. There are issues about the caliber of the social science work. And social scientists, I think are, trained, and I can say this because I wasn't trained in sociology, to consider it inappropriate to take, ethical positions or get into the arena of even an ethical analysis. They're just supposed to present "these are the facts."

Veatch: It's fine if they don't want to take ethical positions. But it seems to me that they should be willing to use their skills to understand the dynamic of an ethical dispute.

Swazey: Oh I agree. That's descriptive ethics, which...

Veatch: What Renée did with the non-heartbeating cadaver; she sees things that the untrained eye doesn't see. And in the end whether she took a stance, or whether you all took a stance on the artificial heart, isn't as important as the kind of rich analysis that's brought from the social scientists. Now, if I'm asked to identify young social scientists who might be part of an interdisciplinary project at Hastings today, I'm a little hard pressed to identify what the young generational equivalent of our group is. Do you know Laura Siminoff? I think she's a thoughtful person and is certainly plugged into the bioethics network. We didn't talk about Case Western Reserve. That's certainly another cluster of people doing serious work. But I can't name many others that I would identify as people from the social sciences who could play a constructive role in an interdisciplinary bioethics project.

Swazey: Can you point to younger people who are quote "bioethicists" who you think are going to move up and take scholarly leadership positions or sort of administrative leadership positions or both? Who's the new generation going to be?

Veatch: I could name off 10 or 20 I suppose, but I'd probably miss some along the way. I mentioned Jeff Kahn, if that's the generation you're talking about. There are a couple people at Penn who I think have promise. Peter Ubell for instance. Jeremy Sugarman at Duke. Jeff Bostik at Utah. They are probably in their forties.

They're not fresh PhD's. But they're emerging into leadership roles, and they also are physicians. Other physicians in that age group include: Stephen Post, Steve Miles, John Lantos, Dan Sulnasy, Linda and Zeke Emanuel, Carl Elliott. They are all at least somewhat cross-trained in bioethics, but they don't seem to be having the creative impact that the generation trained in the 1960's did.

Swazey: But the point is you think there is a cohort there in that generation…

Veatch: Yes, I think so. Eric Meslin's another product of our shop, who's the key staff person for NBAC.

Swazey: I told Eric he's made history. He's the first philosopher who's head of one of the commissions.

Veatch: Yes, I hadn't thought about that. But that's true.

Swazey: He hadn't either. He was quite taken aback.

Veatch: Who else would I name? Lainie Ross? These are a generation younger than I am.

Swazey: Are there people in religious studies that you think are…

Veatch: I'm very discouraged about the lack of emerging leadership in religious studies in bioethics. If you start with the premise that from 1965 to 1975 the leaders in bioethics were virtually all out of religious ethics, there's an absence of similar scholarly potential today. Courtney Campbell at Oregon would come to mind. There are probably a couple of others; I really have to think hard to identify the people out of religious studies.

Swazey: We've had that response also from other people in religious studies and Theology, like Jim Childress, or Jim Gustafson. And also when I've asked people in health law who they would name. People like Alex. They really strain. They're concerned.

Veatch: I think there are young lawyers coming along. Do you have Rob Olick's name in your working vocabulary? He's the lawyer at Iowa, with a PhD out of this program. He's been around for a while. He's not fresh out of academia.

Swazey: But he's got that double training.

Veatch: That's right. He's got the double training. I think he's a serious scholar as well as someone who's well grounded in law. Ben Rich at Colorado. He's not a young man, though. There's a woman named Mary Anderlik in Houston. She's also

dual credentialed and actually her first degree is in law and her second degree I think is in religious studies, a PhD in religious studies. She did her work on the ethics of managed care. She's got a book in the pipeline.

Swazey: Where is bioethics going? Do you have a crystal ball?

Veatch: I have more of a sense of where bioethics is going substantively than I do academically. I think we're headed for a period where there is intellectual dissonance, in that if you simply take what exists in the field of bioethics today you realize that it is incompatible with the basic working assumptions of the way medicine is practiced. To give you one example, it is still the premise of health care that physicians know best and that in managed care it's the doctor who ought to be making the calls. Today's news had some story about a major health insurer that has just changed its policy and their bureaucrats will no longer make the final choices. The final choice will be made by the physician. They're playing to the common folk wisdom that in medicine the doctor really knows best. That is just incompatible with what most bioethicists, and most social scientists would say today. I hate to overuse Kuhn, but I think we're heading for a paradigm shift where we'll eventually be able to say, "Of course the doctor doesn't know best, and that's not an insult to the doctor. It's just the nature of medical choice that you can't rely solely on the facts that a clinician can learn in a textbook combined

with his clever diagnostic skills." The essence of decision making will increasingly be seen as something that is necessarily dependent upon culture as well as on the physician's individual value preferences. I think we're just starting down the road of realizing what the radical implications are of what a lot of theorists have been saying over the last two or three decades. I probably won't live long enough to see that fully played out but I'm quite confident that by the middle of the next century decision making in medicine will be something radically different from what the ideal is today. That's not a comment on the academic development of the field of bioethics. But it suggests that the standard literature in bioethics is way out in front of the working model in the minds of practitioners and policy makers and insurance bureaucrats and politicians. I find it absurd that an insurance company would say the doctor should make the final call, once one realizes that there are some very marginal things that medicine can do. Very expensive marginal things can be done where a good physician who is loyal to his patient is going to want those things. And the whole purpose of an insurance bureaucracy is to make sure that not everybody gets everything they want.

In any case, I think that what's being said in the field of bioethics by scholars is just incompatible with the way medicine is being practiced today.

Swazey: So in that sense you see at least some of the literature as being proactive? I mean,

is it calling attention to the way medicine *is* going rather than the way the medical profession sees it?

Veatch: I think it's calling into question the fundamental presuppositions of medical decision making, where the existing model is that if one is a good medical scientist, who is very competent technically, and a sensitive clinician, who observes his/her patient very well, that clinician can figure out what is best for the patient. In the middle of the 20th century you went from these technical and chronicle skills to a prescription without patient involvement. The patient literally couldn't even be told what he was being given. By the end of the 20th century the physician changed, but only marginally. He or she could tell the patient what the recommended treatment was and, if the patient is foolish enough, he or she had the right to decline. But the working model still is that the doctor will figure out what is best for the patient, at least in the normal case. There are these special cases about whether to withdraw a ventilator or something similar, where the physician has realized that different people in different cultures have different ways of thinking, but those are thought of as special cases.

As far as I can see what all the theorists are saying is that same insight that clinical judgments necessarily incorporate cultural and individual value preferences applies to literally everything that is being done in medicine. And once that sinks in, I think we'll have a very different model for practicing

medicine. Right now we have increasingly realized that there are certain physicians who fail to fulfill the traditional model. They are either incompetent or they are self-interested. They take bribes, steal abusable drugs, or cheat on insurance or whatever. That is not a terribly interesting insight from an ethicist's point of view. What I think most theorists are saying is now, even if you solve all those problems, there is still a complete misfit between the working assumptions of the whole institution of medicine and the insights that can be gleaned from bioethics theory.

Swazey: Who would you name as the major theorists who are doing this body of thinking and analysis?

Veatch: I think I could name you 200 people in bioethics who would have no trouble with what I am saying: if you say to them, "you know, every medical judgment that is made has some values incorporated into it," or "you know, there are some things that are so marginal that a good insurance system ought not to provide it even though it is marginally in the patients interest." I can name you 200 theorists who'd say "Yes, of course, what else is new?" In fact, I wrote one of these millennial papers for a journal that wants reflections on the new millennium. I've written about six of them. But, I was saying things of this sort and the peer reviewers said, "so what else is new?" Which is correct. I wasn't saying anything

other than describing what I thought was the consensus of theorists today. But, if I were to say something like this to a normal practicing clinician, or a politician, or an insurance bureaucrat, this is radical stuff. And they really can't even grasp what the implication is.

Swazey: Is it being said to them? Are you or other bioethicists starting in on this dialogue?

Veatch: Oh, I think the dialogue has begun. But we're at the point where people are kind of talking past one another. I'll say something in a clinical case conference about the cultural setting of the patient being critical in deciding what is right for the patient. And the clinician will say "Yes, yes of course, but I'll call my colleague and find out what we should do for the patient. I'll rely on the traditional mechanisms of looking at the studies, looking at the textbooks." Just totally missing the implications of my remark. On the one hand he says, "Yes of course, the patient's culture is very important." But on the other he says, "Nevertheless my job is to make the decision for the patient and I'll do that by relying on peer reviewed research and other very traditional criteria."

Swazey: Of course, a talking past each other, as you know, went on in sociology and medicine for decades as well.

Veatch: Well, there are ways in which the sociologists could be helpful in helping us work through this transition.

Swazey: I think so.

Veatch: They at least have categories that would be useful.

Swazey: And a lot of research. But, the point I was making was that all those years that sociology was in medical schools and all that teaching was going on even in clinical settings, it didn't take very well either.

Veatch: But I've seen many clinicians who find the social scientist useful, if the social scientist can get the patient over their cultural hang ups in order to get the patient to do what the physician prescribed.

Swazey: Right. Be compliant.

Veatch: Yes. The very concept of compliance…

Swazey: I wish that word could be stricken.

Veatch: Well, I've come out against it. I've even written a couple little articles against it. It's another example of something where if a bioethicist sits a clinician down and discusses for an hour or so how muddled the concept of compliance is, they'll say "Yes, yes, I guess you're right. There may be good cultural reasons why patients are not being compliant. But, how can I use you in order to get this patient to do what's right."

Swazey: Okay, sort of a final big question, then I'll let you get back to your work. You may want to give it a short answer. It's about the global bioethics/universalism box, which is a big one and we talked about it some in March. You said then that bioethicists of your generation are still very worried about the excesses of both cultural relativism and bioethical imperialism. Are there ways that those tensions can be resolved, perhaps in the contexts of the social sciences and religion and bioethics. It's a big web of issues, but I think they're all interrelated.

Veatch: There's still a lot going on. There's an issue of the journal Bioethics on global bioethics that came out of the Tokyo meeting, [of the IAB] which means that the International Association of Bioethics really has this question on its agenda.

Swazey: Are we seeing ethical imperialism in terms of U.S. bioethics being the model that a lot of people think needs to be imported around the globe?

Veatch: There may be some of that. When I hear ethical imperialism what I usually hear is references to the judgments or the answers in bioethics. Not the academic methodology. Even in the U.S. our methodology is very pluralistic now. With feminist bioethics and virtue theories and casuistry. The debate over principlism, I think, has almost played itself out. It's not as active as it was three or four years ago. The fear I hear expressed is, the imperialism of American value judgments, (and the most interesting charges are whether Americans are being imperialistic in their love of autonomy and individualism). We're debating not methods and theory, but substantive commitments and priorities. Have you seen Ruth Macklin's book?

Swazey: Yes, I've read it.

Veatch: I wrote a review of it.

Swazey: Has your review been published?

Veatch: I don't think so. It will be in Theoretical Medicine. I'm very sympathetic to what she was doing. I suppose one thing that would be helpful would be if observant analysts, particularly social scientists, could help those who are most guilty of the imperialism to realize how parochial their views are.

Swazey: Yes, I think Ruth, works very hard at accommodating values in different cultures with notions of universal human rights, and it's a tough set of issues.

Veatch: Well, there's certainly a difference between universal human rights as expressed in international bodies using more global criteria and the Bill of Rights of the American Constitution.

Swazey: That's right, and I think sometimes that gets mixed up -- when we talk about universal human rights we're talking about our version, which is not what the rest of the world necessarily abides by.

Veatch: Yes. We have the advantage now of serious work outside the United States. The Council of Europe's Declaration…whatever it's called. That's a very solid piece of work and it gives a framework that certainly is influenced by the American discussion but you can't say that it's read straight off of imperialist American propagation of its philosophy. I don't know if it's just my experience, but I've had a lot more Asian contact in the last five years or so. And some of that is I think quite constructive. We did a book here at the Kennedy Institute on advanced directives German, Japanese, and U.S. perspectives with a side project on Hispanic-American perspectives. That was a constructive collaboration. Equal numbers of scholars from the three major cultures were involved. Meetings

in all three countries. The Germans and the Japanese are learning. They understand the American discussion. They've read our literature. They're getting better at not just parroting that literature but indicating how their culture differs.

Swazey: Right. And how they may modify our viewpoints.

Veatch: One of the Japanese participants in this advanced directive project, who actually had some training at Harvard, was talking about the role of the individual in the family in advanced directive-setting in Japan. He said we're learning about the rights of the individual patient, the right of the patient to say no, and the individual is taking over some of these decisions from the family in the more traditional pattern. Unfortunately, individualism is going to win out. And then he went on to give the case for the more traditional Japanese view.

Swazey: That would be a huge cultural change, talk about paradigm change.

Veatch: Well, I think for some time the Japanese have recognized the shift, but here's a very articulate scholar not only describing the shift very well, but making the case for the traditional approach where the individual isn't left all out there by himself having to make these tough choices. So, it was a very nice paper, because after describing the victory of the American individual rights perspective, his tone was,

"what a shame."

Swazey: I still can't believe that they won't have a lot of nuances that aren't very Japanese, though.

Veatch: Well, the Japanese that we've dealt with are Western educated, so…

Swazey: That would make a big difference.

Veatch: So, there's a sense in which we're not really getting to the true Japanese view. And we get some of the same with our German connections as well but it's particularly difficult in Japan and even worse in China. The Chinese medical ethicists I deal with, the leader was a professor of Western philosophy in the Mao Tse Dung regime. So, his loyalty was okay, he survived. But his job was to teach Western culture. And now after the changes in China, he can be much more open, and he has real ambivalence. If you say something critical about the Chinese handling of abortion or something, he'll give you a good Chinese defense. But then if you say something nasty about Western individualism he'll give you a good defense of Western individualism. He's good. And he's got whole cadre of younger Chinese medical ethicists working with him. A couple of them seem very promising.

Swazey: I remember many years ago a very wise Chinese scholar saying to Renée and me, as we were discussing the concept of personhood, "you have to understand that in China the individual is a social community," and that really sort of wraps it up culturally. Do you think eventually there may be a two-way flow where we will learn from and modify some of our bioethical views?

Veatch: I think so. One of the outcomes of this advanced directive project was that at least the participants, I think, have a much more respectful notion of the Japanese situation and also the uniqueness of the German situation. Several of the American participants in this advanced directive project are quite liberal. They're ready to defend physician assisted suicide, the legalization of active euthanasia, and the like. And a couple of Germans really let us have it. They said "do you realize what euthanasia means in Germany?" And they did a very nice job of explaining why the historical setting of Germany made euthanasia something that was radically different from what it is in either the Netherlands or the United States.

Swazey: But apart from hopefully a greater understanding of where their societies are coming from, which would be wonderful in itself, do you think, for example, as we appreciate more about Japanese or Chinese culture and the role of the family in the community, it could feed back and help modify our sort of extreme

individualism?

Veatch: I think we're already beginning to see little hints that that is the case. I mentioned the exchanges in this three-country collaboration. The Americans learned things. And I think that's beginning to show up in their writing. It is a little bit harder to criticize the Japanese role of the family in medical decision making than it was before that project, and I expect that will spill over into American views although I rather doubt that the United States will ever surrender its emphasis on individualism.

END OF INTERVIEW