A Morality Based On Common Good Fails to Attract Sufficient Attention

By Daniel Callahan

In 1974, not long after the founding of the Kennedy Institute, Andre Hellegers was, with Albert Jonsen, the co-author of an interesting and important article on "Conceptual Foundations of Medical Care." In it, they described three domains of ethics: an ethic of duty, an ethic of virtue and an ethic of the common good. Those who recall the work and vitality of Dr. Hellegers will also recall the importance he attached to an ethic of the common good, and what I would like to suggest here is that this ethic has been the least developed in the recent history of bioethics. It is time that we returned to this task, one that is far broader than the issue of justice in healthcare allocation, taken by many to be the primary and most appropriate way of addressing issues of the common good.

It is perhaps not surprising that questions of the common good have been relatively neglected. Apart from the fact that the American political and social system is uneasy with the language of a "common good," the recent history of bioethics pressed the field in a different direction. In the work of Joseph Fletcher in the 1950s—especially in "Medicine and Morals" (1954)—the emphasis was on the expanded range of choice that biomedical progress would make possible, and the task of medical ethics was defined as the promotion of that choice, shortly to be transmuted in the 1970s into the now-dominant language of autonomy.

This emphasis on choice and autonomy was fully compatible with the major ethical issues that began to emerge in the 1960s, particularly the need for greater patient choice and for the protection of the subjects of biomedical research. With the advent of wide public, legislative and judicial interest in bioethics in the 1970s, there was the additional need for a relatively clear and usable set of moral principles to guide public policy and institutional practice. In the principles of autonomy, beneficence and justice, an ethic of duties was fashioned that has, ever since, served as a common and popular template to deal with the full range of bioethical problems.

While this ethic has been both forceful and helpful, it has also tended to minimize both an ethic of virtue and an ethic of the common good. (The writings of Edmund Pellegrino, I would note, have served wonderfully to keep the ethic of virtue alive and well; it is just that he has too few allies.) I want to focus my attention on the neglected ethic of the common good, where we seem little better off than we were in the early 1970s. While a general cultural reluctance to take up questions of the common good and a different set of early concerns in bioethics help explain some of the neglect, there is probably a still deeper reason.

My own guess is that the combination of a deep-seated skepticism about the possibility of real truth in ethics and a disputatious pluralistic society, have worked to create a general allergy to serious, substantive ethics. By that I mean a conception of morality that continues the ancient search for a substantive ethic of individual and societal ends, and one that is not afraid to speak of "the human good." We have, instead, gravitated to an ethic of principles, an ethic whose general character is far more procedural than substantive. Our enthusiasm for asserting the right of self-determination and moral autonomy is perfectly matched by our coolness toward public discussion about what might count as a proper—and moral—use of that autonomy.

We should by now, however, have seen how great is the loss that comes from this reluctance to talk about the individual and societal good. We will not be able to work out satisfactory responses to the biomedical problems of the future with an ethic of essentially procedural principles. The problems are too socially pervasive, too profound in their implications for individual lives and collective well-being for that to be satisfactory. Nothing less than a substantive ethic of human ends and purposes will do.

What would be the requirements of an ethic of the common good, carried out in this substantive vein? The first requirement is the most obvious: to overcome our reluctance to even think and talk in terms of a common good. We have been excessively intimidated by the imperative of a pluralistic society, that we must, in the name of social peace, give up the quest for a transcendent moral truth common to all. But that is to confuse some practical conditions of the political order, where pluralism is appropriate, with the task of ethics. That task should encompass a willingness to take on, and criticize, the moral views that characterize the society. It is not necessarily the task of ethics simply to promote social peace; its more important historical role is that of determining moral truth.

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New Ethics Rules Challenge Values Of Chinese Society

(In December, 1988, the Ministry of Health of the People’s Republic of China issued regulations regarding medical ethics for health-care professionals. The regulations were distributed to all hospitals and published in China Hospital Administration, No. 3, Vol. 9, 1989. Excerpts were published in Ren-mi-ri-bao, China’s leading national daily newspaper, on Dec. 12, 1988. An English translation of the regulations accompanies this article.)

By Hans-Martin Sass

The medical ethics regulations printed on the facing page are indicative of the challenges non-Western countries face when their traditional value systems confront modern medicine and the changes it brings in regard to efficacy, distribution and administration of health care. What follows is a brief guide to some of the more interesting aspects of the regulations:

1) Supported by millennia of Confucian administrative tradition and a few decades of Marxist party rule, the national health-care administration understands itself to be primarily responsible for fiduciary paternalism in setting the rules for professional moral conduct.

2) Medical ethics does not only cover traditional physician-patient relationships, but also cooperation among health-care professionals, including nurses and administrators. No distinctions are made between specific moral obligations of physicians and those of administrators or nurses.

3) The “interest of the patient” has to be the prime interest of the health-care worker. Good medical practice and ethics is understood as the practice of socialist humanitarianism. No obligation toward the Chinese government is mentioned in this code. This contrasts with the oath Soviet physicians take as well as the solemn vows sworn by East German medical school graduates.

4) The integration of moral expertise and technical expertise in the health-care profession is within the Confucian tradition. The physician traditionally had to study philosophy extensively, while the patient’s first obligation was to search for an “enlightened” physician.

5) The performance standard of individual health-care professionals as well as the standards of health-care providing institutions will be of relevance for individual career advancement and for rating hospitals.

Cao Zeyi, vice minister of health, has cited the following topics in medical ethics as the most challenging in administrative decision-making and in academic research in China:

- defining criteria for life and death in the presence of high-tech medicine;
- moral judgment regarding the continuation or withholding of treatment of brain dead or comatose patients;
- guaranteeing the physician’s obligations to patients will outweigh those to the public interest;
- balancing resource allocation of preventive and primary medicine against obligations in specialized medical and nursing care;
- respect for personal preferences such as individual requests for euthanasia;
- educating the public with regard to organ donation and autopsy, both of which have encountered strong resistance based on traditional Chinese values.

Bioethics Paradigm

By Warren Thomas Reich

An interdisciplinary Task Force on Experience as a Source of Bioethics has been meeting over the last year to prepare a book that makes an appeal for a new paradigm for bioethics. The task force argues for an experiential paradigm whose approach to moral reasoning is radically different from that employed in the principle-based paradigm that is typical of much of the bioethics literature in particular and of Anglo-American ethics generally.

While the principle-based approach has been useful and necessary, it is insufficient. The new paradigm does not deny a role for principles—particularly in negotiating certain differences of commitments to experienced values—but it takes moral experience as its starting point and as its point of primary emphasis. Under this approach, ethics does not deal so much with the application of principles as it does with the moral experiences of individuals, groups and institutions.

The task force, which is directed by the author of this article, is supported by the I.H. Page Center for Creative Thinking in Medicine, a division of the Cleveland Clinic Foundation. Other members are Patrick Heelan (philosophy, SUNY-Stony Brook), Dietmar Mieth (theological ethics, Tuebingen), Richard Zaner (philosophy of medicine, Vanderbilt), Eric Cassell, medicine, Cornell, Drew Leder (philosophy, Loyola College), William F. May (ethics, SMU), Albert Jonsen (history and ethics of medicine, University of Washington), Stanley Hauerwas (theological ethics, Duke), Clare Dalton (law, Northeastern), Caroline Whitbeck (philosophy of technology and policy, MIT), Patricia Benner (continued on back page).
Regulations On Criteria for Medical Ethics And Their Implementation

Article 1. The purpose of the criteria is to strengthen the development of a society based on socialist values, to improve the quality of professional ethics of health-care workers and to promote health services.

Article 2. Medical ethics, which is also called professional ethics of health-care workers, guides the value system the health-care workers should have, covering all aspects from doctor-patient relationships to doctor-doctor relationships. The criteria for medical ethics form the code of conduct for health-care workers in their medical practice.

Article 3. The criteria for medical ethics include the following:
1. Heal the wounded, rescue the dying, and practice socialist humanitarianism. Keep the interests of the patient in your mind and try every means possible to relieve patient suffering.
2. Show respect to the patient’s dignity and rights and treat all patients alike, whatever their nationality, race, sex, occupation, social position and economic status is.
3. Services should be provided in a civil, dignified, amiable, sympathetic, kind-hearted and courteous way.
4. Be honest in performing medical practice and conscious in observing medical discipline and law. Do not seek personal benefits through medical practice.
5. Keep the secrets related to the patient’s illness and practice protective health-care service. In no case is one allowed to reveal the patient’s health secret or compromise privacy.
6. Learn from other doctors and work together in cooperation. Handle professional relations between colleagues correctly.
7. Be rigorous in learning and practicing medicine and work hard to improve knowledge, ability, skills and service.

Article 4. Education in medical ethics is mandated for the implementation of these regulations and for supporting medical-ethical attitudes. Therefore, good control and assessment of medical ethics must be a part of managing and evaluating hospitals. Good and poor performance of working groups have to be judged and assessed according to these standards.

Article 6. Education in medical ethics should be conducted positively and unremittingly through linking theories with practice aiming to achieve actual and concrete results. It should be the rule to educate new health-care workers in medical ethics before they start their service; in no case are they allowed to practice before they get such an education.

Article 7. Every hospital should work out rules and regulations for the evaluation of medical ethics and should have a particular department to carry out the evaluation, regularly and irregularly. The results of the evaluation should be kept in record files.

Article 8. The evaluation of medical ethics should include self-evaluation, social evaluation, department evaluation and higher-level evaluation. Social evaluation is of particular importance and the opinions of the patients and public should be considered and health service should be offered under the surveillance of the masses.

Article 9. The result of the evaluation should be considered as an important standard in employment, promotion, payment and the hiring of health-care workers.

Article 10. Practice the rewarding of the best and the punishment of the worst. Those who observe medical ethics criteria should be rewarded and those who fail to observe criteria of medical ethics should be criticized and punished accordingly.

Article 11. These criteria are suitable for all health-care workers, including doctors, nurses, technicians and health-care administrators at all levels in all hospitals and clinics.

Article 12. Provincial health-care offices may work out detailed rules for the implementation of these criteria.

Article 13. These criteria become valid on the date they are issued.

(Translated by Shi Da-pu, M.D., vice president of Xian Medical University and president of the Chinese Society for Medical Ethics.)
Ethic of Common Good Too Little Developed; Also Fails to Attract Sufficient Attention

Link to Health Care Established

There can be a tyranny of pluralism, especially when used to silence the hard work of asking just what is actually good for people. A good place to renew that quest would be to entertain, once again, the idea that it might be possible to fashion some ingredients for an ethic of the common good. The role of ethics should be to examine different ideas about the way people should live together and, in our context, to ask about the ways in which medical advances and values can affect our lives together.

Range of Choices

A second requirement is to examine the range of choices that can be made in the name of autonomy and to ask whether they are good choices. This kind of question can only meaningfully be answered by reference to some deep and serious notions of the good of individuals. Just what will lead to the good life for individuals, and how should individuals think through the moral choices that will be theirs to make? Not all uses of autonomy are equally valid or good uses. The fact that they are autonomous may serve to legitimate them in law, but in no way does it automatically legitimate them morally.

The sharp distinction often drawn between the public and private spheres of morality has done us little good in that respect, leading many to think that morality bears only on our public actions, not our private choices. The distinction is itself an artifact, for there are no set boundaries between the public and private spheres. We cannot, I believe, even have a meaningful public morality unless it is based on a solid private morality.

Autonomous Choices

We must, in any case, be willing to look once again at the moral validity of the content of our autonomous choices. Society has the obligation to allow individuals as much freedom and autonomy as possible. It is then the duty of those individuals, for their own sake as well as that of others, to determine what choices are good and bad, right and wrong. This is a discussion that should take place in the open. Pluralism should not be used as an excuse to avoid this task.

The third requirement is that of an examination of medicine and health care in the common life of society. What are the ends and purposes that our society should be pursuing and what is the place of the pursuit of health in that context? What kind of health, and how much, do we need for a good society? We need to ask this kind of question not simply because increasingly expensive medical resources will force some limits and priority setting, but also because we need to know better how to situate the desire for health in the lives of individuals. Health itself, we often forget, makes little sense as a goal pursued for its own sake. Good health is needed to pursue other ends and purposes.

Broad Vision

The relationship of health and the common good can profitably be explored by trying to set the provision of health care within some broad vision of the good of individuals. How much and what kind of health should we pursue in our individual lives and how do we relate that pursuit to all the other things we need to flourish as individuals? We also need to understand health care in relation to such other societal goods as education, housing, economic development, culture and recreation, and those amenities that make for a full and rich social life.

To deal with questions of this kind we need to reflect on what should, or might, be the proper goals of medicine. We need to ask simultaneously, (a) what kind of individuals we should strive to be and what kind of society we ought to become, and (b) what the proper ends of medicine would be within the context of the answers we find to the other questions. We cannot, that is, talk about the ends of medicine apart from talking about human ends more generally without encompassing within that effort a consideration of the possibilities for changing and reshaping the human condition that medicine and medical progress make possible.

(Dr. Callahan is director of the Hastings Center. This article was adapted by him from the 1989 Andre Hellegers Memorial Lecture, which he delivered.)
Books

Recent Acquisitions

(New additions to the collection of the National Reference Center for Bioethics Literature.)

Beauchamp, Tom L. and Childress, James F., PRINCIPLES OF BIOMEDICAL ETHICS. New York: Oxford University Press, 1989. 470 p. (Third edition.) The principles of respect for autonomy, nonmaleficence, beneficence, and justice are investigated along with "rules" in professional-patient relationships and other moral values.

Glover, Jonathan, et al. ETHICS OF NEW REPRODUCTIVE TECHNOLOGIES: THE GLOVER REPORT TO THE EUROPEAN COMMISSION. DeKalb, IL: Northern Illinois University Press, 1989. 159 p. Sponsored by the European Commission, the report of its Working Party deals with issues surrounding sperm and ova donation, including donor recruitment and anonymity and impact upon the parents, children and family; surrogate motherhood; the unborn and research and aspects of fetal transplants, principles of human experimentation, and monitoring of research; and deciding who will be born or the use of gene therapy, genetic engineering and sex selection.

McCormick, Richard A. THE CRITICAL CALLING: REFLECTIONS ON MORAL DILEMMAS SINCE VATICAN II. Washington, DC: Georgetown University Press, 1989. 414 p. Moral theology and bioethical dilemmas are presented from a Catholic perspective. Dissent in the Church, the roles played by those who teach in the Church, and theological debate are discussed. How the ethical questions of sterilization, sexuality, euthanasia, and genetic technology are viewed in the Catholic community is examined.

Miles, Steven H. and Gomez, Carlos F. PROTOCOLS FOR ELECTIVE USE OF LIFE-SUSTAINING TREATMENTS: A DESIGN GUIDE. New York: Springer, 1989. 154 p. This work was originally published as the O.T.A. report: "Institutional Protocols for Decisions About Life-Sustaining Treatments." The evolution and objectives of health-care facility agendas are reviewed along with protocol development and implementation. Recommendations are made to include provisions for ethical principles, techniques for decision-making, and implementation of decision in the protocol formats.

Palmer, Larry I. LAW, MEDICINE AND SOCIAL JUSTICE. Louisville, KY: Westminster/John Knox Press, 1989. 175 p. The right to health and the physician-patient relationship are described. Other ethical issues such as hospital responsibilities to experimental subjects, caring for the critically ill and health care for children are examined in the light of caring and justice.

Potter, Van Rensselaer. GLOBAL BIOETHICS: BUILD-ING ON THE LEOPOLD LEGACY. East Lansing, MI: Michigan State University Press, 1988. 203 p. Ethical issues from euthanasia to the use of new reproductve technologies and the control of fertility are explored especially as they have an impact on the ecology of the world. "A Bioethical Creed for Individuals" is outlined in the appendix.


Veatch, Robert M. DEATH, DYING AND THE BIOLOGICAL REVOLUTION: OUR LAST QUEST FOR RESPONSIBILITY. New Haven, CT: Yale University Press, 1989. 292 p. (Revised edition.) The different definitions of death are described from technical, ethical, and public policy viewpoints. The right to refuse treatment by competent patients is considered along with the refusal of treatment for incompetent patients. Other issues handled are truth-telling, organ transplantation, and natural death as opposed to prolonged life. (By Marlene Johnson)

New Bibliography

Ready in November

The new Bibliography of Bioethics, Vol. 15 (1989), will be available to Kennedy Institute members in early November. The new edition has the most pages to date and there are more abstracts with the citations. Edited by LeRoy Walters, director of the Center for Bioethics, and Tamar Joy Kahn, senior indexer for the on-line data base, BIOETHICS LINE, this work offers comprehensive access to ethical, legal and public policy issues in health care and biomedical research.

There are 2,400 citations listed by subject in the new volume. Each is accompanied by descriptive keywords offering topical information about the document; about 20 per cent of the citations have abstracts. There are over 70 subject entries arranged alphabetically. The bibliography is published by the Kennedy Institute and the new volume is available to members at $10 off the $45 list price. Make checks payable to the Kennedy Institute of Ethics and mail to Bibliography of Bioethics, Kennedy Institute of Ethics, Georgetown University, Washington, DC, 20057.
Bioethics Paradigm Relies on Experience

(continued from page 2)

(physiological nursing, U. Cal. San Francisco), and Allen Dyer (psychiatry, Albany Medical College).

In contrast to the principle-based approach, which assigns to autonomy a kind of objectivity and distancing from experience that are typical of post-Enlightenment assumptions about the self, the experience-based paradigm begins with the relevant subjective experiences of illness, vulnerability and suffering in the patient; and the experiences of solidarity/isolationism, trust/mistrust and benevolence/paternalism in the physician-patient relationship.

Starts with Praxis

The experience-based paradigm starts with praxis, interpreting it in an analogical-inductive fashion and relying on the tradition of practical moral reasoning (phronesis)—as used, for example, in casuistry. Instead of using only discursive reasoning that employs concepts, the experiential paradigm seeks to reinstate the roles of images, metaphors and narrative as conveyors of and instruments for interpreting moral experience. In this context, intuition plays an important role.

By examining and clarifying the implications of the experience-based paradigm, the work of the task force will expand the range of significant questions for bioethics (from sensational quandary cases to the day-to-day moral problems in health care), the moral language to be used (from the universal language of concept and norm to the voice of the handicapped, women and minorities), the moral orientation assumed for ethics (from the quest for rules of fairness to the fostering of caring), the “beneficiaries” of ethics (from physicians and policy-makers to lay persons), the foundation of moral responsibility (from duty to character and value) and the participants in the dialogue (from ethicist and professional to literary artists and family).

Roundup

- The 117th annual meeting of the American Public Health Association in Chicago from Oct. 22 to Oct. 26, will consider questions of “ethics and equity in public health.” Special sessions will include Does Public Health Equal Social Justice (Daniel E. Beauchamp, Ph. D. deputy commissioner, New York State Department of Health), Overcoming the Barriers to Access to Reproductive Services and Prenatal Care (Reed V. Tuckson, commissioner of health, District of Columbia), Closing the Generation Gap: Intergeneration Equity (Jonathan Moreno, Ph. D., George Washington University), and a range of sessions on closing the poverty gap, closing the access gap and closing the environmental gap.

- The University of Nebraska at Lincoln is sponsoring a conference from March 29 to March 31, 1990, titled Conference on Moral Problems in the Professions: Advocacy, Institutional Ethics and Role Responsibilities. Papers are being solicited on the following topics: advocacy, corporate responsibility, definition of role responsibilities, individual obligations to institutions, and personal or social moral obligations. The deadline for submissions is Jan. 15, 1990. Contact Stephen E. Kalish, College of Law, University of Nebraska-Lincoln, Lincoln, Nebr. 68583-0902. Telephone: (402) 472-1248.

- George Washington University and the Castello Institute of Stafford, Va., are sponsoring a conference on The Ethics of Genetic Engineering on Oct. 19 and Oct. 20. The keynote speaker will be Dr. James Watson, head of the Office of Genome Research at the National Institutes of Health. For additional information contact Dr. Gary Crum, George Washington University, 600 21st Street, NW, Washington, DC, 20052. Telephone (202) 994-5998.