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The Theory and Practice of Biomedical Ethics: A Troubled Divide

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Abstract

Biomedical ethics does not lend itself to easy categorisation as either a 'theoretical' or a 'practical' enterprise because inquiry into the quandaries of morality requires both situational and 'translocal' perspectives. These types of investigation bring into question the legitimacy of the theory/practice divide that has dominated intellectual thought since antiquity. This division hinders the development of bioethics by fostering internal dispute within the discipline regarding appropriate methodology and the practice of clinical ethics. In this thesis, I argue that much of these disciplinary disjunctions are due to an undue labeling of bioethics as either 'applied ethics' or 'practical ethics', and a failure to recognise the intricate way in which theory and practice inform each other and are integral and interrelated parts of moral deliberation. I argue for an integration of the theory and practice of bioethics.

Étant donné que les questions de moralité requièrent des perspectifs capables d'être tout à la fois indigène et trans-local, la bioéthique ne se classe aisément ni dans le champ théorique ni dans celui de la pratique. Ce genre d'investigation questionne la légitimité de la scission qui domine la pensée intellectuelle depuis l'antiquité entre la pratique et la théorie. Cette division crée obstacle à l'accroissement de l'éthique en médecine vu qu'elle engendre un désaccord sur la méthodologie voulue et la pratique de l'éthique thérapeutique. Je propose ici que ces disjonctions disciplinaires soient dues à un lapsus fondamental qui voudrait qualifier la bioéthique soi comme 'éthique appliquée' soi comme 'éthique pratiquée', et qui ne permet pas la reconnaissance du fait que la pratique et la théorie se communiquent mutuellement et sont toutes deux parties intégrales de la délibération morale. J'argumente pour l'intégration de la théorie et de la pratique en bioéthique.

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Contents

Introduction

Biomedical ethics is confronted with the difficult quandary of reconciling the immensely diverse personal and social experiences of moral life with the need to apply a universal standard to those fragments of experience that can foster not only comparison and evaluation but also action. Thus bioethics is situated precariously on the theory/practice divide that has dominated intellectual thought since antiquity. When Plato established an irreconcilable division between the Forms and the temporal shadows, he shaped Western philosophical discourse to regard universals and particulars as distinct and unique entities. Aristotle established a distinction between abstract theory and practical wisdom, with ethics defined as a *practical* enterprise. The ethical thought that has followed throughout the centuries has accepted this division between theory and practice and philosophers have argued at length as to *which side* of the theory/practice divide ethics is best situated, without significant challenge to the legitimacy of such a divide.

In this thesis, I will demonstrate that this conceptual commitment to the division between theory and practice hinders the development of the field of bioethics. By upholding this division, bioethics is a fractured discipline encountering numerous internal divisions, such as dispute over what constitutes the 'nature' of bioethics, the methodological debate, and the separation between academic and clinical bioethics. The pressing need for unity within the discipline will be stressed throughout this paper, as the demands being placed on bioethics continues to grow. As medical technology advances and the public grows increasingly alarmed, bioethics will be pushed into the forefront of the ethical, political, and social nexus as the intermediary that makes sense of how

humanity can embrace the prospects of relieving human suffering while properly attending to the astounding dangers and costs associated with biotechnology. Only a strong and unified discipline can adequately address these most difficult questions.

I will argue that bioethics, by nature of its inquiry into the practical resolution of moral problems that arise in biomedicine, requires a blurring of the boundaries between theory and practice. Bioethics entails attention to both universals and particulars, and thus the discipline requires a methodology that integrates both theory and practice rather than holding them apart. On the one hand, bioethics would be of limited use if one were to consider universal ethical formulations in the absence of contextual concerns. For example, informed consent lacks moral significance in international health research if the research subjects are illiterate or lack the knowledge of randomised controlled trials, placebos, or even conceptions of individual autonomy.[1] If taken in abstraction, the concept of autonomy does little to uphold the value of self-determination. At the same time, an examination of ethics and morality requires at least some degree of 'translocality' to critically analyse cultural norms and local practices.

This view of bioethics as encompassing both theory and practice is heavily contested, as many people working in the field try to define bioethics as *either* theoretical *or* practical. This misguided inclination stems from the historically accepted theory/practice divide, which has resulted in the establishment of a huge intellectual gulf between theoretical inquiry and practical work. This situation makes reconciling the two elements a difficult project, and in fact adds to the relentless adherence to the theory/practice divide which I argue is creating many of the internal divisions and difficulties in bioethics.

This paper is divided into three sections, with each one addressing a different area of dispute within bioethics. All three areas attest to a theory/practice divide and in each investigation, the inadequacies of both the theory-based and practice-based approaches are demonstrated. An integrated approach is defended as an appropriate alternative.

In Section I, I will illustrate the difficulty of defining 'bioethics' given the widely accepted division between theory and practice. In fact, the diverse aims and functions of bioethics lends the discipline to both 'theoretical' and 'practical' characterisations, however neither category is sufficient. I demonstrate that it is the theory/practice divide that prompts people working in bioethics to try to define the discipline as *either* theoretical *or* practical. Yet both the applied ethics and the practical ethics conceptions of bioethics prove to be inadequate as they cannot capture the full scope of the discipline in their framework. Instead, the nature of bioethics seems best described as involving an interrelationship of theory *and* practice, a characterisation that challenges the very legitimacy of the theory/practice divide.

In Section II, I will demonstrate that just as the nature of bioethics was difficult to characterise, there is equal difficulty establishing an appropriate method for *doing* bioethics. 'Doing bioethics' involves trying to solve both theoretical and practical moral problems, and thus the appropriate methodology must be far-reaching and multi-faceted. Yet the methodological debate has not escaped the impetus to separate theory and practice and thus the discussions have been dominated by a struggle between theory-based 'applied ethics' and practice-based 'contextualism'. The two methods hold different conceptions of morality and ethical activity which in turn shape different

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[1] I borrow this example from Kleinman (1999).

understandings of how ethical deliberation is engaged as well as how it is justified and applied to particular cases. Applied ethics focuses on generalisability and theoretical clarification as the tools for ethical deliberation, while contextualism regards 'situatedness' or 'locality' as the key factors in moral decision-making. The theory/practice distinction is revealed in the differences between the two methods, as applied ethics provides a theoretical, while contextualism a practical, approach to bioethics.

The nature of bioethics, however, suggests that the discipline requires a methodology that allows for a dialectical relationship between theory and practice. I endorse *reflective equilibrium* as the appropriate bioethics methodology because it allows for such an interchange. Reflective equilibrium incorporates the two incomplete approaches to 'doing bioethics' afforded by the other two methodologies, and by integrating them, provides a more complete picture of morality.

In Section III, I take the discussion into the clinical setting to consider whether my call for the integration of theory and practice extends beyond academic discussion, and by doing so, whether the 'reflective equilibrium' approach can foster a link between academic and clinical bioethics. The conclusions to these questions have severe implications for this investigation, as a negative response would bring into dispute my call for unity given that academic bioethics is largely 'theoretical' in comparison to the 'practice' of clinical ethics. If my conclusion is correct, however, then clinical ethics, which is the practice of moral decision-making in the clinical setting, presumably needs theoretical reference. This seems to suggest a point of convergence between academia and the clinic. By investigating the role of the clinical ethics consultant, I will

demonstrate that moral decision-making in the clinic is far more complex than the methodological theories (discussed in Section II) suggest. In clinical ethics consultation, the required knowledge includes ethical theory, but also medical, legal, and institutional knowledge. Furthermore, numerous organisational and interpersonal skills, as well as specific character traits, also factor into the decision-making process. This fuller account of the 'practice' of clinical ethics consultation demonstrates how 'theory' and 'practice' inform each other and how they are both integral and interrelated parts of moral deliberation. I will argue that this method of clinical ethics consultation, which I refer to as the *ethics facilitation* model, is a reflective process in which theory and practice engage in order to reach 'equilibrium'.

The historical theory/practice divide creates many internal difficulties for bioethics, as the discipline proves to be insufficiently captured under the category of either 'theory' or 'practice'. Recognising the nature of bioethics as encompassing both theory and practice leads to novel conclusions regarding methodology and clinical ethics practice. It also rids bioethics of many of its interior disjunctions, and allows for a stronger and unified discipline.

I. Bioethics: Theory or Practice?

The well-established divide between theory and practice creates difficulty in defining the nature of biomedical ethics. The understanding that conceptual inquiry and practical work can (and often should) exist independently of each other places biomedical ethics in a precarious position, where it experiences troubled coexistence with both philosophical ethics and clinical biomedicine. It will be demonstrated in this thesis that all of the manifestations of the theory/practice divide in biomedical ethics, whether in methodology or between academic and clinical bioethics rest upon the difficulty characterising biomedical ethics. Bioethics is difficult to fit under the rubric of 'theory' or 'practice', as the discipline demands attention to both theoretical and practical considerations. This is evidenced in Samuel Gorovitz's tentative list of the functions of bioethics. They include:

> studying the history of ethical thought, moral reasoning, and theories of ethics and values; studying values empirically especially in health-related contexts; helping people to adhere to the law or to professional codes of conduct; aiding the well-motivated to understand how in general to act with moral conscientiousness; aiding the well-motivated to resolve a particular, morally troubling clinical quandary; imposing tendentious moral indoctrination; explaining and analysing prevailing cultural values; advocating prevailing cultural values; trying to persuade thugs in health care to adopt the pursuit of virtue; and combining the above activities in various ways (360).

These roles of the 'bioethicist'[2] reveal the diverse ends towards which bioethics is aiming. Some of the activities allude to theoretical work, including a need to clarify the general concepts and ethical theories, while others suggest an educational role for

[2] I use this term to denote anyone working in the field of bioethics, regardless of her training or her placement in either an academic or a clinical setting.

bioethicists. Still other activities suggest that bioethics is supposed to provide practical guidance for resolving moral disputes. If one accepts all of the listed functions as being relevant components of bioethics, then it should be apparent that neither 'theory' nor 'practice' can sufficiently encompass all of the aims of bioethics. I will demonstrate in the proceeding sections that the disputes over methodology and approaches to clinical ethics are between proponents of either 'theoretical' or 'practical' models of bioethics, and that these difficulties can be resolved by recognising that bioethics is situated in a theory/practice nexus.

i. <u>The Rise of Biomedical Ethics</u>

The field of bioethics developed in the last forty years as a "response to the moral crisis created by technology" (Winkler 1993, 344). In the second half of the 20th century, unparalleled medical advances created seemingly unlimited possibilities for the health sciences as it pushed medicine into previously untouched domains. These developments changed medicine as it became more able to extend life, cure illness, and give hope to the once destitute. These changes also disturbed traditional values such as sanctity of life and questioned conceptions of personhood, medical futility, life, and death. This brought the goal of medicine into question. While the aim of medicine traditionally had been understood as the promotion of health and life, this position became disputed. Critics started to question what end medicine was working towards, and whether medical capability had surpassed the field's proper function. Accompanying these considerations was a shift in political ideology, where a new focus on human rights and the rise of civil rights movements contributed to shifting the medical parameters by placing an emphasis on patient autonomy. These technological and social factors created what is known in

ethics as an 'is-ought problem,' where just because an act *is* possible, it does not necessarily follow that it *ought* to be done.

ii. Bioethics as Applied Ethics

The moral nature of these new problems in medicine prompted a turn to moral philosophy for guidance in addressing them. Moral philosophy is, after all, the study of the nature of morality and what it requires of us, or to use Socrates' words, 'how we ought to live' and why (Rachels 1999, 1). Bioethics thus was characterised as a form of *applied ethics*, where ethical theories and principles could be systematically *applied* to bioethical issues to resolve these moral problems. Anglo-American moral philosophy has been predominated by deductive models of ethical deliberation, where judgment on specific moral dilemmas could be *deduced* from general principles. Applied ethics involves the subsumption of the facts of the specific problem under a system of moral norms. These moral norms, principles, and general theories are thought to merely systematise common morality, and thus they are applicable to all moral problems, regardless of specific content. Richard Hare held the confident view that

> the problems of medical ethics are so typical of the moral problems that moral philosophy is supposed to be able to help with, that a failure here would be a sign either of the uselessness of the discipline or of the incompetence of the particular practitioner (1977, 49).

In fact, he went so far as to say that "if the moral philosopher *cannot* help with the problems of medical ethics, he ought to shut up shop" (49).

Despite Hare's confidence in the methods of moral philosophy, there is heavy criticism regarding the capability of the discipline to provide the normative guidance that bioethics requires. The critics argue that the emphasis that moral philosophy had placed

in the last century and a half on meta-ethical inquiry rather than normative theory had made its abilities in practical guidance dubious. Even in 1912, G. E. Moore noted that

> ethical philosophers have, in fact, been largely concerned, not with laying down rules to the effect that certain ways of acting are generally or always right, and others generally or always wrong, nor yet with giving lists of things which are good and others which are evil, but with trying to answer more general and fundamental questions....(1944, 8).

Normative ethics concerns guiding agents in making decisions and judgments about what one ought to do, feel, be, or desire in particular situations (Darwall 1998, 5). This investigation is not limited to one's own conduct, however, but includes making judgments about what others should do as well. We are thus not, according to William Frankena, just agents in morality. Instead "we are also spectators, advisers, instructors, judges, and critics" (1963, 11). Still, the primary question remains how it is that we may determine what one ought to do in a certain situation (Frankena 1963, 11).

Metaethics, in contrast, focuses on the more conceptual questions underlying the normative theories and rules of appropriate moral conduct, such as the meaning and justification of judgments of moral obligation and value (Frankena 1963, 10). It thus "consists of *philosophical questions about ethics*" (Darwall 1998, 9). Underlying a normative question such as 'what are our moral obligations?', for example, is the implicit assumption that there are such things as value or right and wrong, which enable us to ask what, if anything, has these properties (Darwall 1998, 8). Metaethical investigation examines such questions as

> what...is it that we mean to say of an action when we say that it is right or ought to be done? And what is it that we mean to say of a state of things when we say that it is good or bad? Can we discover any general characteristic, which belongs in common to absolutely *all* right actions, no matter how different they may be in other respects? And which does not belong to any actions except those which are right? And can we similarly

> discover any characteristic which belongs in common to absolutely all 'good' things, and which does not belong to any thing except what is a good? Or again can we similarly, discover any reason which is *the* reason why a thing is good, when it is good, and which also gives us the reason why any other thing is better than another, when it is better? Or is there, perhaps, no such single reason in either case? (Moore 1944, 8-9).

Metaethics thus investigates the larger conceptual or 'meta' issues that underlie normative theories of appropriate ethical conduct. This more abstract inquiry of course has implications for normative theory, as any reflective person should have some understanding of the meaning of the terms in her ethical judgments in order to justify them. With these fundamental definitions and categories of thought, we also have a basis for judging the plausibility of a normative theory before even commencing application of the theory to practical problems.

The critics question whether these 'meta' investigations can enhance the prescriptive guidance of normative ethics. For one, there has been no consensus on the 'meta' questions, and thus inferred practical 'assistance' to normative ethics seems doubtful. Moore claimed that

> it is true that absolutely every answer which has ever been given to [these questions] by any one philosopher would be denied to be true by many others. There is, at any rate, no such consensus of opinion among experts about these fundamental ethical questions as there is about many fundamental propositions in Mathematics and Natural Sciences (1944, 10-11).

Metaethics appears to be able to do little more than illuminate the underlying assumptions found in the specific normative theory without actually providing concrete reasons to accept one position over another. Furthermore, normative ethics seems to have been influenced by this 'metaethical' phase in moral philosophy and has detracted from the pursuit of establishing principles of right conduct in favour of largely 'meta'

issues. The bulk of the 20th century normative discourse was dedicated to the dispute between deontologists and utilitarians rather than to the development of these or any other prescriptive theories and action-guiding principles.

iii. Bioethics as Practical Ethics (*Phronesis*)

Other critics regard the applied ethics model as failing to provide a sufficiently normative method because it mischaracterises moral deliberation as a top-down or theory-based endeavour.[3] They argue that the resolution of specific moral problems requires a method of practical ethics, and that appeals to 'meta' questions or general theories are simply not going to result in practical judgment.[4] The descriptive nature of metaethics and the abstract generalities of ethical theories make applied ethics insufficient for addressing normative questions. The proponents of this view look toward Aristotelian ethics as the appropriate guide for resolving moral problems.[5] Aristotle distinguished ethics from the abstract theoretical pursuit of knowledge because ethical inquiry requires wisdom, virtuous character, and maturity or life experience. Thus he differentiated ethics from disciplines such as mathematics or physics because insight into the latter is possible with relatively little experience or maturity (1142a20).[6] Ethical knowledge involves practical wisdom and not purely intellectual insight. Furthermore, because ethics reflects on life experience, ethical knowledge and wisdom are impossible

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[3] A more detailed discussion on the nature of moral reasoning, with regards to deductivist and inductivist models, will be undertaken in Section II.

[4] Stephen Toulmin expounded the irrelevance of the moral philosopher to bioethical inquiry where "the philosopher's task was no longer to organise our moral beliefs into comprehensive systems; that would have meant *taking sides* over substantive issues. Rather, it was his duty to stand back from the fray and hold the ring while partisans of different views argued out their differences in accordance with the general rules for the conduct of 'rational debate', or the expression of 'moral attitudes', as defined in *metaethical* terms" (Toulmin 1982, 749).

[5] G. E. M. Anscombe (1958) was the first to express this dissatisfaction with the rigidity of rule-based contemporary moral philosophy and to look toward Aristotelian ethics as an appropriate alternative model of ethics.

if one has not lived through such experiences and learned from them. Ethical truths could only come from the judgments of mature, experienced human beings, and not systematic analysis.

Aristotle believed that even the best efforts in formulating general ethical ideals and principles are likely to be relatively unhelpful in providing specific practical guidance, especially to those who have not yet developed mature character and judgment. Stephen Darwall argues that according to Aristotle,

> the role of the philosopher thinking about ethics is not to formulate and ground abstract rules that anyone can apply, but, rather to draw virtuous people into a process of reflection, much of the basis for which is their own experience and judgment, in order to further shape and develop their judgment (1998, 201).

Ethical knowledge could not be formulated in rules and principles that people are able to understand more or less independent of their own ethical development.

In Aristotle's *Nicomachean Ethics*, we find an action-based[7] ethics that sharply contrasts the rule-based deductive model of ethics briefly described above. Supporters of Aristotelian ethics argue that Aristotle proposes a subtler, richer, and even more realistic picture of the ethical life than has been provided by rule-based 'moralists', such as Mill or Kant. The ethical theories, they argue, are unrealistically abstract. They agree with Aristotle's view that ethical knowledge involves a kind of wisdom or judgment that cannot be codified. Many supporters also concur with Aristotle's emphasis on social

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[6] To exhibit excellence in mathematics or physics, one must exhibit *intellectual virtues*, while proper ethical conduct requires *practical virtue*.

[7] Some would argue that Aristotle's ethics is more appropriately regarded as an 'ideal-based' ethics because the agent aims at virtuous character and disposition rather than 'right' action. However, Aristotle regarded virtue and right action to be closely connected. A virtuous character develops out of a certain type of action (which is why Aristotle placed so much emphasis on the proper education of the young. It was only through education that one learns correct action and develops virtuous character). Once one develops a virtuous character, one's actions will be reflective of that character.

connection and commonality over the themes of individual separation and conflict found in most of the traditional theories.

Aristotle regarded ethics as a practical discipline in that it aims at action and not abstract knowledge (1104a1-10). The capacity for ethical deliberation thus required practical wisdom, or *phronesis*. Practical wisdom is a virtue, however it differs from the excellence[8] involving scientific theorising in that it entails excellence in practical thinking and deliberation (1140b40). Excellence in deliberation, according to Aristotle, requires that one deliberate well with respect to actions that are worth choosing for their own sake. Practical wisdom is the quality of mind concerned with things that are "just ," "fine," and "good for a human being" (1143b21). Thus ethical deliberation does not entail wisdom in examining particular subjects but in living well or human flourishing in general (1140a25).[9] This deliberative capacity involves not only "cleverness", which is the ability to work out the means to the required end, but also the sensitivity to particulars that would enable one to see how an act would play out in a specific context. The specific act must be able to realise the virtuous end of acting nobly on a given occasion. The 'practically' wise person deliberates well with respect to the just and noble in the sense that she is able to see what justice, temperance, and courage specifically *call for*. Thus practical wisdom is further differentiated from scientific knowledge because it concerns particulars (1140a25).

According to Aristotle and his followers, only an upbringing that nurtures maturation and growth and develops the right habits can get one inside the circle of

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[8] 'Virtue' and 'excellence' are equivalent interpretations of *arete*.

[9] Aristotle regards 'flourishing' or *eudaimonia* as the chief good for which all human action aims. Ethical action is determined by whether it furthers human flourishing.

ethical ideas and thought in the first place (1142a12-20). Such an education is necessary to develop the full affective and cognitive capacities that are necessary to acquire ethical knowledge and to understand ethical ideas and principles. Ethical knowledge is therefore not equally available to all and it certainly cannot be formulated as universal ethical principles that are accessible to and understood by all those to whom they apply. In the end, there is no substitute for judgment and wisdom that can be acquired only by a process of human maturation and growth that is nurtured by the wisdom of the preceding generation (Darwall 1998, 214).[10]

Stephen Toulmin, an outspoken supporter of 'practical' bioethics, argues that contemporary moral philosophy has ignored all of Aristotle's cautions about the differences between the practical modes of reasoning appropriate to ethics and the formal modes appropriate to mathematics (1982, 748).[11] Because bioethics aims at the resolution of specific moral problems, it is in fact a practical enterprise that requires a context-specific and rational deliberative approach. Bioethics requires *phronesis*.[12]

Practical judgment,[13] according to Toulmin, was regarded by Aristotle as fundamental to both ethics and medicine. In medicine, the first indispensable step to treating a medical problem is assembling a rich 'case history'. Until that has been done,

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[10] Aristotle thus founded his ethical model on the wisdom and virtuous character of the *phronimos*, a person who 'lives well', rather than a set of rules or criteria for right action.

[11] Both Anscombe and Toulmin regard the systematisation of ethics that they find so unsatisfactory to have commenced with Henry Sidgwick's *The Methods of Ethics* (London: Macmillan, 1901).

[12] While Toulmin (1982), and similarly Jonsen (1986) and MacIntyre (1978), expound practice-based models of ethical decision-making that do not adequately appreciate other aspects of Aristotle's ethics, such as wisdom, maturity, and good character, their emphasis on context-specific ethical deliberation is still reflective of Aristotelian virtue ethics. After all, deliberation and action are reflections of one's character. Thus when a clinical ethics consultant makes a decision or recommends a course of action, presumably that decision and action will reflect a character that is virtuous in the sense that it manifests wisdom, maturity, and patience, to name a few. If anything the authors are underappreciating the role of *phronesis* in influencing one's practical reasoning in the clinical context. A closer application of Aristotelian ethics to contemporary moral issues has been undertaken by proponents of *virtue ethics*. For a good elaboration, see Rosalind Hursthouse (1997), "Virtue Ethics and Abortion." (consult bibliography)

> the wise physician will suspend judgment. If she is too quick to let theoretical considerations influence her clinical analysis, she may prejudice the collection of a full and accurate case record and so distract her from what later turn out to have been crucial clues (1982, 742).

Practical judgment strives for *reasonableness* rather than insisting on a kind of exactness that theoretical reasoning pursues (1094b12). Thus medicine, like ethics, does not aim for universal truths. Ethical theory, in particular, "indicate[s] the truth roughly in outline; since...we argue from and about what holds good usually (but not universally), it will be satisfactory if we can draw conclusions of the same sort" (1094b20). Clinical medicine and the problems of ethics, in Toulmin's reading of Aristotle, are "two varieties of a common species" (1982, 743). He argues that ethical categories, such as 'kindness', 'conscientiousness', and 'cruelty', need to acquire specific context, such as identifying some *actual* person or piece of conduct as 'kind', 'conscientious', and 'cruel' in order to be ethically relevant. Similarly in medicine, if described in general terms alone, diseases are abstract entities, and they acquire a practical relevance only for those who have learned the diagnostic art of identifying real-life cases as being cases of one disease rather than another (1982, 743). It was by turning philosophical attention back to the 'particulars' of the case that medicine is argued to have 'saved the life of medical ethics'.[14]

Thus Toulmin concludes that the art of ethical deliberation resembles the art of clinical diagnosis and prescription. In both fields, theoretical generalities are helpful to us only up to a point, and their actual application to particular cases demands a human

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[13] By this I mean the deliberative component of *phronesis*.

[14] Alasdair MacIntyre makes a similar claim that medical ethics demanded moral philosophy to turn attention back to the 'particulars' in "What Has Ethics to Learn from Medical Ethics?" (see bibliographic reference).

capacity to recognise the slight but significant features that mark off, for example, a 'case' of minor muscular strain from a life-threatening disease (Toulmin 1982, 743). Once brought to the bedside, ethics and clinical medicine both use Aristotelian 'practical reasoning' (743).

iv. <u>The Division of Theory and Practice in Ethics</u>

What is apparent in both rule-based and action-based ethics is a presumed theory/practice divide, where the former rests on the 'theory' side and the latter on the 'practice' side of ethical inquiry. Both modes of ethics uphold this divide by situating their ethical model on *either* the theory *or* the practical side, which of course presumes that ethical inquiry can in fact be divided. Western philosophical thought typically has organised ethical activity such that conceptual and practical activities are treated as distinct and separate tasks. *The Encyclopedia of Philosophy* begins the 'History of Ethics' article by "separating purely philosophical thought from practical advice, moral preaching and social engineering which it illuminates and from which it receives its sustenance" (in Sherwin 1996, 207). The conceptual category of ethics includes such matters as the pursuit of questions aimed at developing systems for investigating moral claims and also efforts to clarify the nature of the terms, principles, and arguments that are used in moral discussions. The practical category is thought to encompass the explorations of questions that arise out of the human experience of trying to live as a moral agent, including efforts to solve identified moral problems. Although few would deny a connection between these two tasks, the precise nature and strength of these connections are somewhat ambiguous (Sherwin 1996, 187).

Both modes of ethics make a claim regarding which realm is the legitimate sphere

for ethical thought. The majority of philosophers has long favoured the view that the philosopher's role is exclusively in the abstract conceptual realm, though there is a small but vocal group that argues for the prominence of practical reasoning free of the restrictive constraints of theory. Some even question the usefulness of abstract ethics altogether. Despite these ongoing disagreements about which element is primary, few philosophers have challenged the general view that they are separate and distinct activities.

This vision of a bifurcated ethics landscape[15] causes constant difficulty for bioethics because bioethics in fact blurs the boundaries between theory and practice by demanding attention to both theory and practice. Gorovitz's list of the aims of bioethics illustrated both theoretical and practical functions, yet instead of rising up to these challenges, bioethics seems to be locked in dispute over the nature of bioethics in the belief that the discipline must be either a theoretical or a practical enterprise. In Section II the dispute over bioethics methodology will be demonstrated to be a disagreement over whether bioethics is paradigmatically theoretical or practical. In Section III, the ethics consultant will be shown to hold an uncertain position in the clinical setting, as she is meant to bridge the gap between theory and practice by bringing academic bioethics into the hospital for practical application. The diverse and often disparate demands on biomedical ethics may result from the discipline's precarious position as situated in the clinical setting, the academic arena, and in the public and political spectrum. On the one hand, bioethics needs to provide practical guidance and solutions for clinicians, yet on the other hand, it must also provide moral grounding to satisfy academics, as well as clear

[15] I borrow this phrase from Sherwin (1996).

and strong justification responding to an often reactionary public. I have tried to suggest that the seeming irreconcilability of theory and practice is so well established in ethics that those engaged in bioethics either have been unwilling or have never considered challenging the divide. I will argue throughout this thesis that not only is a unification of theory and practice possible but it is necessary for undertaking bioethical inquiry. Thus bioethics is best defined as both a theoretical and a practical enterprise.

As a new and developing field, bioethics faces no single greater challenge than to stop and reflect on itself and ask the question: what are we doing when we do bioethics? This 'taking stock' of the nature and function of bioethics is critical as the discipline continues to be pushed hard and fast by rapidly developing technology, increased public interest and media attention, as well as severe criticism discrediting the field at all levels. In academic circles, for example, bioethics is regarded by many as dubious for often straying from its original grounding in traditional ethics, and incorporating pluralistic methodologies that are seen as theoretically weak, and thus insufficiently accountable or justifiable. Clinical ethics consultants, on the other hand, are often criticised by clinicians for invoking irrelevant philosophical considerations that at best provide no practical benefit, and at times even make matters worse by confusing health care providers, heightening the anxiety of patients, complicating the work of policymakers, and promoting regulations that impede clinical practice (Gorovitz 1986, 357).

It will be demonstrated in Section III that the response to these demands has been a division of labour between academic and clinical ethics, where the former attends to theoretical bioethics and the latter to practice. While the subdividing of a discipline can be a sign of its maturation or evolution, I suspect that the division between theory and

practice in academic and clinical ethics represents a weakness in biomedical ethics at a crucial point when unity is needed. While many disciplines, including medicine and philosophy, have evolved into sub-specialisation, there is reason to think that biomedical ethics is not following this process of maturation. Unlike the other disciplines, biomedical ethics is a very new field that has evolved rapidly by difficult and diverse demands. In fact, the discipline has not stopped to take account of its current position, status, goals and methods. Without such self-reflection, it becomes uncertain whether the discipline will be able to respond to further challenges, and whether it will continue to be regarded as legitimate by the public, political, and institutional views.

II. Methodology in Bioethics: Theoretical and Practical Approaches

Just as the nature of bioethics was hard to define, there is equal difficulty establishing an appropriate methodology for *doing* bioethics. As the list of tasks provided in the previous section should have indicated, 'doing bioethics' involves trying to solve very different kinds of problems, some quite practical and others more theoretical. Bioethics at times entails resolving a particular case or developing a specific policy. At other times, the problem is in understanding the relationship between this case or policy and others and in adopting an approach that is consistent with all of them. Bioethics also engages in theoretical inquiry into such matters as the nature of rights, virtues, or consequences, as moral decision-making requires the proper understanding of the terms of ethical judgment. Norman Daniels is correct in his belief that "*there is no one thing we do that is always central to solving an ethical problem, for there is no one paradigmatic ethical problem*" (1996, 102). Thus establishing an appropriate methodology for bioethics proves to be challenging, as it must be able to assist in the diverse array of functions that comprise bioethics. This diversity may prompt some to suggest that different methods might be needed for different tasks. Perhaps the conceptual work needs a theory-based methodology while the practical judgement requires phronetic activity. However, in following with the discussion in the previous section, such a view allows for a theory/practice divide within bioethics, a division that impedes bioethical inquiry by failing to recognise the nature of bioethics. It is only by properly reflecting what bioethics is that a method can adequately resolve its ethical questions and prescribe morally appropriate action. To prescribe how the moral agent ought to live, a good methodology tries to provide a plausible perspective on the making

of moral judgements, the fashioning of rules and principles, and the devising of a virtuous life (Callahan 1996, 10).

In the previous section, I illustrated the misguided impetus to try to define bioethics as either a theoretical or a practical discipline that stems from an accepted division of theory and practice that dates back to antiquity. The methodological debates have not escaped this inclination and have been largely dominated by the struggle between 'applied ethics' and 'contextualism'. The two methodologies illustrate opposing pictures of morality, which entail different visions of the nature of moral reasoning and how ethical deliberation is to be justified and applied to particular cases. From here I will introduce *reflective equilibrium* and argue that it is the most appropriate methodology for bioethics. Reflective equilibrium incorporates certain aspects of the other two approaches to provide a more complete account of 'doing bioethics'. It does this by holding 'theory' and 'practice' in a dialectic relation rather than regarding them as mutually exclusive. I endorse this model because it best reflects the nature of bioethics.

i. <u>The Applied Ethics v. Contextualism Debate: Theory or Practice as the Foundation of Bioethics Methodology?</u>

As was discussed in the previous section, when ethical problems in medicine first arose, moral philosophy was seen as the appropriate discipline to respond to these problems, and thus its approach to moral decision-making[16] was adopted and applied. In due time, however, these methods began to be challenged. Applied ethics was charged with failing on a practical level, as it did not resolve clinical disputes, and in fact often

[16] I refer to the deductivist approach, which is not confined to any particular moral theory. Rather it is a way of conceiving the relation between moral judgement and moral theory, and it suggests a particular method of doing biomedical ethics--proceeding from general theories down to judgements about cases (Murray 1994, 92). This approach will be discussed in depth in this section.

contributed to confusing the issues by evoking complex conceptual investigation (Gorovitz 1986, 367). Critics also argued that 'applied' bioethics had no legitimate *methodology* or foundation, as there are no universally accepted theories or standards in moral philosophy (Green 1990, 180). These criticisms prompted an alternate school of thought advocating a contextual or practical approach to doing bioethics. The contextualists advocate various means of *practical ethics*, and although many of the methods such as narrative ethics, the ethic of care, and feminist ethics do not have the grounding in Aristotelian ethics discussed in the previous section, they still share the emphasis on practical deliberation and sensitivity to context that Aristotle advocated. I refer to this 'practical' approach as 'contextualism' rather than 'practical ethics', however, to emphasise its origins as reaction against the *generalism* found in contemporary moral philosophy. Instead of subscribing to grand ethical theories and deducing practical judgement from general rules and principles, contextualists regard the case as the starting point for ethical analysis and advocate decision-making that is sensitive to context. It is only from rigorous case analysis that more general rules and principles can be derived to inform, guide, and justify future case-resolutions.

The methodology of moral philosophy was not regarded by all, however, as incompatible with the demands of medical ethics. Hare, for example, saw no problem with the philosopher's role as "technical and morally neutral [and] centered in methods of conceptual analysis and the assessment of argument rather than in any special moral insight or wisdom" (Hare 1977, 52). Advocates of the applied ethics model hold that the knowledge and analytical skills can help to order our understanding of practical issues and to overcome various confusions and fallacies. In his belief that this methodology

could assist in resolving specific moral problems, Hare stated that

> once the issues are thoroughly clarified in this way, the problems will not seem so perplexing as they did at first and, the philosophical difficulties having been removed, we can get on with discussing the practical difficulties (Hare 1977, 59).

The analytic techniques and systematic methods of moral philosophy were thus seen by many as a useful method for addressing the moral problems in medicine.

This dispute over methodology between applied ethics and contextualism highlights unresolved issues regarding the philosophical foundations of bioethics. These issues, which include the nature of bioethics and moral reasoning, and how ethical deliberation is applied to particular cases, will be further examined in this section. First, however, a more thorough account of applied ethics and contextualism will be provided.

Applied Ethics

As the name suggests, applied ethics involves, although it is not confined to, the application of general ethical theories to the specific problems raised by medicine and biological research (Green 1990, 181). The basic method of applied ethics is deriving applicable principles from general ethical theory. Winkler describes "the holy grail of moral philosophy" as

> a single, comprehensive and coherent theory that is based in universal, basic principles, which, in their turn, yield more particular principles and rules that are capable of deciding on concrete issues of practice. Accordingly, the ideal of moral justification is essentially deductivist, involving different levels of generalisations (1993, 350).

The deductivist, or 'top-down', model of moral reasoning emphasises general norms and ethical theory as the proper basis for reaching correct moral judgements. Justified moral judgements are deduced from a preexisting valid theoretical structure of normative precepts (DeGrazia 1992, 512). This model is said to have been inspired by justification

in disciplines such as mathematics, in which a claim is shown to follow logically and deductively from a credible set of premises. Moral judgement is seen as the application of a rule (principle, ideal, right, etc.) to a clear case falling under the rule, thus making the deductive model 'top-down' in application of general precepts (Beauchamp and Childress 1994, 14).

Contextualism

The contextualist methodology involves both examining the individual case in order to be sensitive to the context or particulars and case comparison for moral judgement. It is from these experiences with cases that we derive our principles. Contextual, or 'bottom-up', perspectives emphasise moral tradition, experience, and judgement as the bases of both general norms and theory (Beauchamp and Childress 1994, 14). Contextualists, or inductivists, maintain that we must use existing social agreements and practices as a starting point from which to generalise norms such as principles and rules rather than deducing particular judgements from previously established theories and rules.[17]

Inductivists argue that *induction*, or reasoning from particular instances to general statements about the instances, is central to moral deliberation. Beauchamp and Childress explain that

> a society's moral views are not justified by an ahistorical examination of the logic of moral discourse or by some theory of rationality, but rather by an embedded moral tradition and a set of procedures that permit new developments. A static or morally conservative conception of morality

[17] In After Virtue (1981), MacIntyre argues that traditional ethics ignores the way in which *community* creates obligations for us. For example, professional commitments dictate specific ethical demands associated with certain professions or jobs. The wide-acceptance of these ethical and legal dictates suggests some kind of a foundation on which to begin reconstructing ethical values. It also brings into question the individualism endorsed by contemporary moral philosophy by demonstrating that we cannot self-create codes of ethics. Instead we find ourselves born into communities in which the available ways of acting are largely dictated in advance.

> does not follow from this account...New experiences and innovations in the pattern of collective life lead to modifications in beliefs and the institution of morality cannot be separated from a cultural matrix of beliefs that has grown up and been tested over time (1994, 18).

Alasdair MacIntyre suggests that the deductivist account of moral reasoning does not reflect how people actually make moral judgements. He explains that the fundamental appeal in moral deliberation is not to rules, but to cases (1984, 501). Furthermore,

> no rule exists apart from its applications and if as we approach [for example] the question of whether a physician on a particular type of occasion ought to answer a question by a patient or not it must be in the light of previous applications of the rule (MacIntyre 1984, 502).

It is only in the specific context, for example in the physician-patient relationship, that the rules of truthfulness are first learned, and not in reference to abstract imperatives. Thus "all or most of the real work in actual moral reasoning and decision-making is case-driven rather than theory driven" (Winkler 1993, 355). Winkler argues that other models leave out of account the very complex processes of interpretation that constitute our moral understanding both of cases and of principles. He claims that "within the complex realities of practice, it is dominantly the interpretation of cases that informs our understanding of principles rather than principles guiding the resolution of difficult cases" (1993, 355).

The Nature of Moral Reasoning

The debate between applied ethicists and contextualists is illustrative of a dispute regarding the nature of moral reasoning. Both sides claim to capture in their methods the way people actually deliberate over moral issues. Yet their accounts of moral deliberation are diametrically different, as seen below:

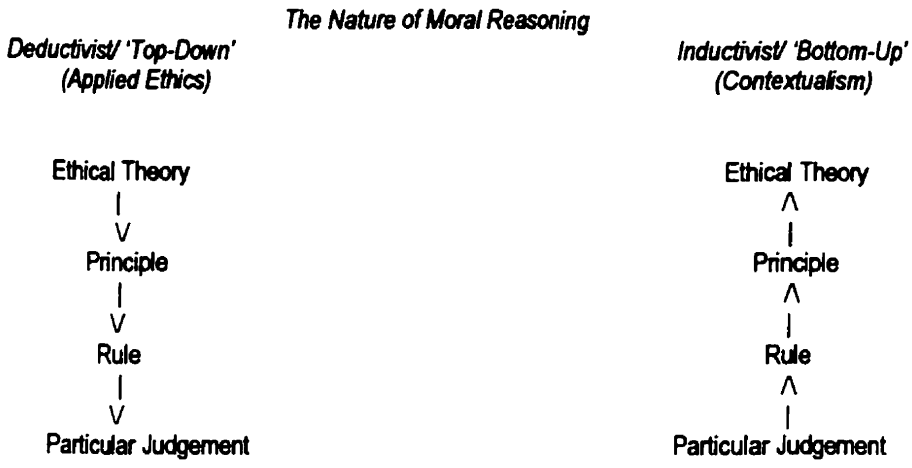

Figure 1. Applied ethics and contextualist accounts of the nature of moral reasoning.

Applied ethicists hold that moral agents deduce particular judgements from higher level principles or theories that the agent has rationally accepted and follows. An ethical theory is understood to merely organise our moral beliefs into a systematic and applicable method. According to Beauchamp and Childress, it "provides a framework into which agents can reflect on the acceptability of actions and can evaluate moral judgements and moral character" (1994, 44). Ethical theory not only reflects our conceptions of correct moral action, but also serves as a test for our particular judgements. If a decision or action does not conform to higher-level rules or principles, then the decision is seen as unethical and should be disregarded.

Contextualists reject the deductivist model of moral reasoning. They argue that applicable moral principles are derived from comparative case analysis, taking into account relevant historical and cultural traditions and norms, rather than from ethical theory on the grand scale. This method is thus *inductivist* because general rules and principles are *induced* from particular judgements and comparative case analysis.

Moral decision-making is thus seen by contextualists to centre on the

interpretation of individual cases and kinds of cases, with little attention to principles or to processes of applying principles. Winkler explains that in order to understand the moral dimensions of a situation, we need to understand the context of the situation, and it is only then that we can relate cases to principles. However, principles also need interpretation in order to derive applicable prescriptions from them. He argues that within the process of moral reasoning, resolution of case analysis informs our understanding of principles, rather than principles serving in the resolution of cases (Winkler 1993, 357).

Contrary to the applied ethics model, contextualists hold that moral reasoning entails a considerable amount of interpretation and the lateral comparison of cases. Even when principles do come into the picture, they come from the *bottom-up*, rather than top-down resolution of cases by principles. These principles are commonly referred to as 'middle-level' principles because they do not propose to be as uncompromisable and absolute as higher-level deductivist principles. They are derived from lateral case comparison, reference to paradigm cases, and local customs and institutions, and are regarded as mutable or 'imperfect' obligations.

Justification

Any discussion of moral reasoning must include consideration of how these reasons are justified. In situations of moral perplexity or uncertainty, we often need to justify our moral claims. For an action to be morally justified, it must have strong moral reasons endorsing it. To justify is to show something is right or warranted, or at least that one has sufficient reason for one's claim. The reasons we finally accept express the conditions under which we believe some course of action is morally justified

(Beauchamp and Childress 1994, 13). Peter Singer explains that not any justification will do. For example, self-interest is not regarded as a sufficient justification. Ethical conduct has historically required some form of universality in order to be justified. This position is apparent in the biblical 'Golden Rule', the Stoical adherence to natural law, Kant's Categorical Imperative, 18th century British philosophy's 'impartial spectator' and the more modern 'Ideal Observer' theory, Utilitarian theory, and so on (Singer 1995, 13).

Proponents of applied ethics often argue that a major strength of their system of moral reasoning is its justifiability. The deductivist approach grounds all decisions in an overarching ethical theory or a deduced principle. The established ethical theories are assumed by its adherents to be "rational reconstruction[s] of the basic principles informing the whole of the moral life" (Winkler 1993, 360). Furthermore, moral philosophy and applied ethics adhere to the Kantian imperative of *universalisability*. The ability of rules and principles to transcend the local context attests to its justifiability by appealing to universal values. The translocal perspective rids the proclamation of individual bias and irrational belief. Therefore subsuming a particular judgement under a principle or theory is thought to fully justify that decision.

Because justifiability is so commonly equated with universalisability, contextualism, in its emphasis on particulars, is criticised for failing to justify its claims. Even the middle-level principles that contextualists appeal to are merely derived from comparative case analysis. Some critics argue that contextualist particular judgements rely on mere intuitions about 'right and 'wrong', which is ultimately an inadequate foundation and justification for ethical decisions. Without theoretical rigour, they question what limits a decision from merely reflecting personal bias or self-interest

(Lustig 1992, 489).

Contextualism, however, holds that in the real encounter with genuine moral problems, considered moral judgements are justified by defending themselves against objections and rivals. Justification is understood by contextualists to be "essentially continuous with the case-driven, inductive process of seeking the most reasonable solution to a problem, carried out within a framework of central cultural values and guiding norms, professional functions, obligations... and so forth" (Winkler 1993, 360). Contextualists are deeply skeptical about applied ethicists' method of justification as they question the possibility of a universally valid ethical theory that adequately dictates moral action (Winkler 1993, 360). Justification is not seen as *ex post facto* or retrospective, but in fact is a *process* involving interpretation and comparison for arriving at a considered moral judgement and defending it as a fully reasonable alternative within the full context of the problem (Winkler 1993, 363).

While this account of justification is not systematic, and thus may seem less capable of limiting nonuniversalisable judgements, DeGrazia argues that it is mistaken to believe that applied ethics is in fact more 'justified' in its moral claims than contextualist theories (1992, 514). In applied ethics, specific moral judgements and rules are said to be justified by appeal to the theory's supreme principles. Yet ethics has yet to agree on a theoretical foundation and without a universally accepted theoretical foundation, appeal to theory fails to legitimise a moral claim. Appeal to another theory that could possibly derive an opposing judgement would not be considered any less legitimate (Strong 1988, 193). Thus it is disputed whether ethical theory has greater moral certainty than contextualist appeals to specific norms or middle-level principles (DeGrazia 1992, 514).

Some contextualists in fact see no difficulty with the justifiability of contextualist moral decisions. Strong, for example, claims that the 'middle-level principles' that are derived from case analysis and comparison are constitutive of common morality,[18] and are therefore ultimately justified (1988, 208). He sees appeal to ethical theories as an unnecessary step because they too are justified by middle-level principles. Any higher-level theory of ethics which turned out to be inconsistent with the middle-level principles would be considered inadequate. For example, theory that upheld a judgement that was inconsistent with common morality, such as the principle 'killing is wrong', would be rejected for allowing unacceptable conclusions (Strong 1988, 208).

Thus the search for a foundation for the middle-level principles would not be to determine whether it is a requirement of morality to accept those principles, but rather to illuminate further why it is reasonable and moral to act in ways that respect them. Strong concludes that "one need not answer this question about ultimate foundations in order to arrive at justifiable conclusions about what ought to be done in specific cases" (1988, 208). Furthermore, "the case comparison method appears to provide an acceptable way of justifying normative statements" (Strong 1988, 209).

Applicability

Applied ethics is criticised by contextualists for being excessively theoretical and therefore unable to yield solutions to many moral problems. Applied ethics is seen as too abstract and "unrelated to problems outside the ivory tower" (Gorovitz 1986, 357). Thus "it engages the intellectually curious but is useless in the arena of practical affairs" (Gorovitz 1986, 357). In the clinical setting, applied ethics has been further charged with creating rather than resolving conflict. Applied bioethics arguably

[18] He situates our common morality within the Judeo-Christian tradition.

> confuses health care providers, heightens the anxiety of patients, complicates the work of planners and policymakers, and promotes regulations that impede clinical practice – such as excessively demanding requirements of informed consent; and medical research – such as unwarranted prohibitions on the use of certain classes of research subjects, for example, prisoners or early stage embryos (Gorovitz 1986, 357-8).

Even some moral philosophers working in clinical ethics contend that use of this method of tracing norms back to theories is irresponsible in the practical setting because it risks unnecessary complication of the issue and dogmatic adherence to a theory when pluralism is more appropriate (DeGrazia 1992, 514).

Upon investigating how ethical problems are actually resolved, contextualists have concluded that deductivism is simply not used in practical situations. DeGrazia argues that moral philosophers working in clinical settings are often surprised to learn how infrequently it seems necessary to refer to theories (1992, 514). MacIntyre similarly argues that in moral disputes "the various parties involved in the disagreements at one level and the agreements at another are not in fact applying the moral principles or rules about which they disagree" (1984, 501). He cites the experience of Toulmin working on the National Commission of the Protection of Human Subjects to emphasise this point. Toulmin reported that there was a remarkable amount of agreement among the members of the Commission on policy issues and practical application, and that disagreement only arose when theoretical justification was invoked (MacIntyre 1984, 510).[19] While this experience is not antithetical to principles and rules, it suggests that reference to rules is often not necessary and in fact may be gratuitous at the practical level of problem-solving.

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[19] For a first-hand account of the events, see Toulmin (1981), pp. 31-2.

However, applied ethicists defend the practical ability and value of their methodology. Hare believes that further clarification of the problems through philosophical inquiry leads to practical resolution (Hare 1977, 51). Similarly, Graham Oddie argues that philosophy can help us organise our ideas in more straightforward ways, bringing method and order to the analysis of complex issues. He explains that moral dilemmas can arise from uncertainty, including uncertainty of the real values involved. In "Moral Uncertainty and Human Embryo Experimentation", he demonstrates how game theory and decision analysis can lead to novel conclusions in the ethics of human embryo experimentation (1994, 144). Furthermore, Hare (1996) argues that moral dilemmas, which are primarily conflicts between the beliefs or intuitions that comprise our 'everyday' moral thinking, are resolved by principles derived from our higher-level or critical moral thinking (29). Thus not only do the contextualists err in disregarding the critical level of moral thinking, but they also mischaracterise applied ethics as utilising only the abstract level and attending to particular cases by way of a mechanical application of general principles.

Furthermore, while contextualism is argued to be a better method for resolving moral conflict because case-based moral reasoning necessarily results in case-based resolution, it can have problems with applicability too. Strong argues that in the case comparison method, ethical disagreements may arise at various points (1988, 209). There can be disagreement concerning which principles are pertinent to a particular case and how these principles are to be formulated, as well as dispute over whether the factors in a given case are sufficient to override a principle. Similarly, there may be disputes as to whether the case at hand is closer to one paradigm case or another. Strong indicates

that these disagreements may not always be resolvable (209).

Much of the criticism launched by contextualists against applied ethics has involved a mischaracterisation of applied ethics as the mechanical application of general principles to particular cases. Green (1990), Sherwin (1996), and Bosk (1999) all attest to bioethicists who approach the field from disciplines other than moral philosophy "treating the four principles[20] as an adequate summary of all necessary conceptual effort when they engage in practical ethical problem solving" (Sherwin 1996, 188). Green laments this mechanical application that "avoid[s] penetrating theoretical analysis, even when such analysis is unavoidably required" (1990, 179). Furthermore, he argues that "the interdisciplinary nature of [bioethics]...contributes to this relative lack of theoretical sophistication" (192). In the practical setting,

> physicians, scientific researchers, and even lawyers are impatient with the kind of fine-grained analysis (or 'logic chopping') to which philosophers are prone. Hence a pressure has always existed to 'get to the point'. Frequently, the 'point' has been a set of readily understandable moral 'principles' that ethicists could reasonably explicate and apply (Green 1990, 192).[21]

No moral philosopher, however, has ever claimed that ethical theory is readily applicable to a particular context. Green notes that "on most theoretical accounts, the application of moral theories or basic principles to real problems in life, even the simplest of these, almost always requires attention to factual matters" (1990, 182). All principles are abstract and generalisable rules of conduct that require *specification*. Theories, rules, and principles aim at universalisability, such that they can prescribe conduct rather than simply describe right action in a specific situation. The universal is the *essential*

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[20] Beauchamp and Childress (1994) Principles of Biomedical Ethics. See bibliographic reference.

[21] In the next section, I discuss how philosophers actually contribute to this 'mechanical' bioethics, which is widely used in clinical ethics, by trying to situate themselves on the theoretical side of ethical deliberation.

component that transcends the local context to relate particulars to each other, and thus it requires a certain degree of abstractness and generalisability. To be 'brought down' to particular application, the universal principles must be furnished with the specifics of the particular context.

Specification refers to the act of "specifying a more detailed content of abstract principles in the form of more specific behaviour norms" (Veatch 1995, 215). Abstract principles must be developed conceptually and shaped normatively to connect with concrete action-guides and practical judgements. Beauchamp and Childress, the creators of *principlism*, a deductive theory of *prima facie* principles, argue that "to tighten our principles, we must take into account various factors such as efficiency, institutional rules, law, and clientele acceptance" (1994, 28). They follow Henry Richardson's (1990) argument that specification of our principles is essential for determining what counts as an instance of that principle and for overcoming moral conflicts. Specification lessens the dilemmas and circumstances of conflict that the abstract principle has insufficient content to resolve. Beauchamp and Childress give the example of the principle of nonmaleficence, which *prima facie* obliges a moral agent not to inflict evil or harm on others. This principle provides only a rough starting point for guidance about the conditions under which harmful actions are prohibited. Normally we regard causing someone's death as a harm, yet must assisted suicide and voluntary active euthanasia be deemed harmful actions that are absolutely prohibited in light of the principle of nonmaleficence? Are acts of mercy killing themselves sometimes acts of nonmaleficence, or even beneficence? If we ask whether a physician who helps a patient commit suicide thereby harms or benefits the patient, the principle of nonmaleficence

offers little guidance. Without further specification, nonmaleficence is a bare starting point for resolving such problems as assisted suicide and euthanasia (Beauchamp and Childress 1994, 28). Specification is seen as a necessary complement to the principles in order to direct moral action. Beauchamp and Childress state that

> abstract principles...often must be developed conceptually and shaped normatively to connect with concrete action-guides and practical judgements. In tightening our principles, we must take into account various factors such as efficiency, institutional rules, law, and clientele acceptance (1994, 28).

Specification is the method that takes the principles from the abstract to the contextual. Principles were never intended to be applied directly or mechanically to a specific case.

This clarification is meant to rid applied ethics of misguided criticism such that the methodology can be evaluated based on its actual merits. Having denied mechanical application, the questions that remain are whether specification is sufficient for bridging theory with practical judgement and whether applied ethics is correct to think that a moral problem can be solved by correctly analysing the values at stake.

ii. <u>Doing Bioethics: Applied Ethics and Contextualist Accounts</u>

Thus far we have seen two very different pictures of morality illustrated in the two competing bioethics methodologies. Applied ethics depicts ethical activity as a process of *rational reconstruction*, which entails identifying and integrating valid moral norms, rules, or principles, into a coherent and consistent theoretical system (Hoffmaster 1991, 215). Moral philosophy and applied ethics function to produce rational reconstructions of the vague, tumultuous, and unconnected moral opinions of ordinary life by identifying the logical relationships between them and then integrating them into overarching principles and ethical theories. A well-constructed moral system is thought to yield new moral knowledge. Once the disparate and disaggregated norms implicit in

unreflective moral experience are refined and attuned by rational systematisation, they will presumably be epistemologically transformed from mere moral opinion to moral knowledge (Hoffmaster 1991, 215).

To succeed at rational reconstruction, the norms lurking in these often confused and unintelligible beliefs need to be extracted and stated precisely so that the logical relationships among the norms can be delineated clearly. Logical relationships between norms can be established only if the elements to be connected by these relationships are fixed and determinate. The expertise that analytic philosophers possess in logic and conceptual analysis naturally renders them well suited to accomplish these tasks (Hoffmaster 1991, 217).

However this emphasis on logical and semantic rigour is not a neutral process of clarification, as applied ethics appears to suggest. In deductive reasoning, all moral problems must be stated clearly and precisely. If there were any vagueness or ambiguity in the formulation of a moral issue, there would be slippage between the presentation of that issue and the rigourously crafted norms that are to be applied to it. Uncertainty about which norms might apply or what results they might entail would of course jeopardise the objectivity of morality. This demand for rigour is troubling not because of applied ethics' aim at clarifying concepts is unwarranted, but because complex moral problems rarely lend themselves to such categorisation. Ethical problems are usually complicated and multi-layered, in that they incorporate the legitimate interests and claims of various parties, and require the considerations of many non-moral issues, such as religious beliefs, political context, and scientific evidence. It is questionable whether a pre-established clear moral directive can be sufficiently 'flexible' to allow for proper

attention to all of these factors *even with specification.* Although we aim for clarification and resolution, the pre-set categories provided by moral philosophy risk losing important aspects of the case in its search for internal coherence. In rule-based ethics, the norms of the system determine how moral problems are formulated. They do this by providing the criteria for ascertaining what is morally relevant.

With this objection to the primacy of logical and semantic rigour, contextualists emphasise *situatedness* and *particularity* as key factors in moral thinking. In defiance of contemporary moral philosophy's focus on *internal coherence* as the primary category of ethical action; contextualists try to make sense of the confusion, idiosyncrasies, and social obligations that actually factor into the moral agent's deliberative process. From here they advocate a practical ethics that pays attention to the context of the case and engages in lateral case comparison (or analogical reasoning) in order to render judgement rather than relying on abstract ideals.

With these different pictures of morality, we find different conceptions of justification. Applied ethics aims at systematic generalisability, while contextualism searches for comparative justification, where the resolution of a particular case is tested against like cases, cultural values, norms, and obligations. The methods differ in that the former provides a static, ahistorical, and *a priori* reference for justification, while the latter regards justification as a *process* involving localised justification. Thus instead of searching for timeless generalisations, which some argue to be impossible if one respects cultural diversity and pluralism, contextualists localise their 'universals'. I borrow Hare's distinction between *generality* and *universality* at this point. By his account, even a considered judgement can be a universal statement in that it applies to all situations *in*

that type of context. It is not a generality, however, because it is confined to the local context. Although 'generality' and 'universality' are often used interchangeably, they differ in that generality necessarily requires abstractness and acontextuality. Universality, on the other hand, allows for consistency within a localised context. Contextualism thus aims for *universality* but differs from applied ethics by not seeking *generality* (Hare 1996, 20).

Regarding the application of moral judgements to actual moral problems, contextualists assume that sensitive attention to context will result in the practical resolution of moral problems. Thus ethical inquiry is largely defined by the collection and analysis of empirical data. Hoffmaster (1991), for example, investigates the nature of moral decision-making and moral relevance or valuing by examining social scientific research on reproductive decision-making by women after genetic counselling. The proper understanding of how people actually make moral decisions and assign moral relevance are, of course, necessary for creating an appropriate bioethics methodology. From his findings, he launches a critique of deductivism for characterising decision-making as *static* and *context-independent*, where the agent refers only to general pre-established principles that are not sensitive to the idiosyncrasies of persons and their circumstances (1991, 218). Instead he observes actual decision-making to be idiosyncratic and constrained, and decision-makers do not follow the deliberative processes dictated by formal accounts of rational decision-making (1991, 219-224). Contextualists regard the applied ethics methodology as irrelevant to bioethics because deductive deliberation is nothing more than a theoretical ideal. Without properly understanding how moral agents make decisions, a methodology cannot assist in problem

solving.

Applied ethicists, however, argue that philosophy and general theories in fact help clarify the problems that impede case resolution. Hare (1996), for example, argues that theories serve to resolve moral conflict by assisting in moral deliberation. He provides a two-tier normative theory that separates moral thinking into two categories. First there is the day-to-day level at which most moral thinking takes place. This moral knowledge includes intuitions of right and wrong that frame initial reactions to moral situations. He claims that most of the difficult problems in moral philosophy arise because intuitions conflict, and thus a higher level of moral thinking is needed to settle these conflicts. This critical level of moral thinking settles intuitive conflict by undertaking abstract theorising. Our everyday moral thinking is informed by the results of such theorising (Hare 1996, 29). Hare's theory suggests that the contextualists are too quick to argue that moral deliberation does not entail consideration of higher-level principles. We in fact refer to them when conflict arises at the intuitive level. He further proposes that contextualists are wrong to think that *other* intuitive beliefs or middle-level principles can resolve conflict, because they provide no authority or means for adjudication.

iii. <u>An Alternate Methodology: Theory and Practice in Equilibrium</u>

Deductivism and inductivism are characterised and differentiated from each other by the former's emphasis on ethical theory and the latter's commitment to context. Because of these allegiances, deductivism is criticised for not being easily or readily applicable to practical situations while inductivism is accused of having no foundation on which to justify particular judgement and to safeguard against immoral conclusions. However, the prior discussion emphasised different conceptions of morality and ethical

activity held by each methodology, which in turn shaped a different account of justification and applicability. Applied ethics regards justification as *generalisability* and application to derive from theoretical clarification. Contextualism, in contrast finds justification in local institutions, and demands practical methods to resolve practical problems. The theory/practice distinction is thus revealed in the differences between applied ethics and contextualism, as the former provides a theoretical and the latter a practical approach to bioethics. Rational reconstruction entails theoretical rigour and conceptual analysis, while practical ethics emphasises sensitivity to context and human experience.

Both methodologies uphold a theory/practice divide by situating themselves on either the theory or the practice side of ethical deliberation. Applied ethics characterises bioethics as a largely theoretical enterprise best served by theory-based methodology. Problem-solving is best engaged through conceptual clarification and value-analysis. The specifics of the particular moral context are accounted for by merely supplementing the pre-established principles with 'the facts'. Contextualism provides a practical approach to bioethics where context-sensitivity and case-comparison are key to moral deliberation rather than overarching principles. Even the principles that may guide ethical conduct are derived from comparison of like cases. Both approaches hold conceptions of what bioethics is and how moral deliberation and case-resolution are engaged in order to derive a methodology that meets the needs of the discipline.

It has already been discussed in the previous section that bioethics seems to blur the boundaries between theory and practice that are so well-established in ethical discourse. In contrast to Plato's regard of irreconcilable division between universals and

particulars, bioethics is argued to bring the two together on a par in an interchange of 'checks and balances' that not only tests theory and practice against each other but also informs and illuminates theoretical and practical considerations. This places bioethics in an ambivalent position, where it is somehow related to, yet not contained by, either category.

This position on the nature of bioethics suggests that the discipline requires a methodology that allows for a dialectical relationship between theory and practice, thus rendering both applied ethics and contextualism inadequate because they maintain a dualism between the two categories. We have seen that to subscribe to applied ethics is to assume that bioethics is an 'applied' ethics, and thus its methods should not differ from the theory-based methods of traditional ethics. However, bioethics is widely regarded as an 'interdisciplinary' field. Contextualists have argued that since so much of bioethical inquiry involves other disciplinary specialties, such as medicine, law, and politics, it does not follow to assume that bioethics is an off-shoot of moral philosophy. Furthermore, the issues with which bioethics deals are regarded by many as so novel that ethics as it traditionally has been conceived is unable to adequately address these problems. Because of these difficult and unprecedented questions, they argue that bioethics is best thought of as a new and unique discipline with problems and methods of its own (Green 1990, 181).

Applied ethicists respond to this contextualist critique by downplaying the uniqueness and novelty of bioethical problems, stating that moral philosophy has always been able to deal with these sorts of problems. They stand by their conception of bioethics as a form of applied ethics because bioethics ultimately deals with moral deliberation, which has always been the specialty of moral philosophers (Green 1990,

182). They argue that specification allows for the interdisciplinary considerations to factor into moral decision-making. Furthermore, the new challenges that bioethics brings to ethical deliberation are seen as not out of the realm of traditional ethics. K. Danner Clouser argues that "these new developments merely stretch, rather than break, existing capabilities within standard moral theory" (Green 1990, 185). For example, moral philosophers have always needed to determine the boundaries of moral community and human life, and thus current bioethical questions regarding the moral status of frozen embryos are not beyond the scope of traditional ethical theories. Clouser defines bioethics as "the response of traditional ethics to particular stresses and urgencies that have emerged by virtue of new discoveries and technology" (in Green 1990, 185). Applied ethicists do not recognise the different conceptions of application and justification proposed by practical ethics as legitimate, and instead focus on defending their methodology against criticisms of excessive abstractness.

For the remainder of this section, I will argue that both methods have legitimate claims regarding the nature of moral deliberation, justification, and applicability. I will further the claim that bioethics seems to require *both* theory and practice in the attention it pays to universalisability and particularity to include the need for both generalisable and particular methods of *doing* bioethics. Thus neither methodology provides a sufficient picture of the bioethical moral ground, even with such attempts to bridge theory and practice as specification and middle-level principles. I will propose *reflective equilibrium* as the methodology that most appropriately characterises and provides the means for doing bioethics. I will demonstrate that only reflective equilibrium allows for the necessary dialectical interchange between theory and practice.

Reflective Equilibrium

Reflective equilibrium entails a process of dialectical interchange between our considered judgements, our background theories, and our principles of conduct. This method is often referred to as the 'in-between' approach to bioethics because it brings the strengths of both contextualism and applied ethics into one integrated approach.[22] The argument is that by incorporating both the applicability and sensitivity to context found in contextualism as well as the justifiability of ethical theory into one methodology, reflective equilibrium captures the dialectical nature of bioethics and contributes to the various ends that the discipline hopes to achieve. However, I have attempted to demonstrate that it is not the case that applied ethics or contextualism are more capable in some respects and less in others, but instead that they simply hold different conceptions of applicability and justifiability. I will further argue that both methodologies depict an incomplete account of 'doing bioethics', and that it is only by uniting the two in a process of reflective equilibrium that we derive a more complete picture of morality.

Proponents of reflective equilibrium notably decry the division between 'practical ethics' and 'ethical theory'. They rightly argue that in fact cases test and develop moral theory, while theory guides the ethical resolution of cases. Applied ethics errs in assuming that theory development occurs prior to case-resolution, while contextualists fail to recognise how theory guides practical resolution. Neither approach appreciates how *both* theory and practice coexist and benefit from each other in a dynamic interchange, rather than a one-way beneficiary where theory develops practice or practice

[22] For an example, see Sumner and Boyle's (1996) introduction to Philosophical Foundation of Bioethics (see bibliographic reference). They observe a near consistent favouring by the contributors to the anthology of various versions of *reflective equilibrium*, which they characterise as a 'middle ground' along the continuum defined by the extreme positions of 'hard-line' generalism and particularism (pp. 7-8)

creates theory. This sentiment is shared by Sherwin, who argues that

> we should reject all models of ethics that envision practitioners engaged in a deductive exercise of developing and then applying settled concepts to practical dilemmas. We ought also to reject models of bioethical reasoning that suppose we can resolve specific questions merely by gathering particular sorts of data without reflecting on the concepts and principles that guide our deliberations (1996, 189).

This is further endorsed by Daniels, who correctly suggest that "ideally, people who do ethics should have rigorous training in both areas of problem solving" (1996, 103).

The weaknesses of both the applied ethics and contextualist methodologies seem to lie in the *exclusive* use of either method. I have just suggested that each methodology provides an incomplete account of how moral deliberation is engaged and how practical decisions should be applied and justified. I will now attempt to provide a more complete picture of morality by demonstrating how moral deliberation is actually done and how justification and application follow. Reflective equilibrium, by holding 'theory' and 'practice' in relationship, allows for this more comprehensive account of 'doing bioethics'.

Proponents of reflective equilibrium recognise that moral reasoning neither is nor should be a unidirectional process, where the agent either deduces practical judgement or induces general principles. Instead, moral decision-making is regarded as a reflective process where consideration of the specific case and context is balanced against established principles and theory. When deliberating, we adjust and revise our considered judgements and challenge our principles and theories in an effort to achieve overall congruence or 'reflective equilibrium'. In contrast to the applied ethics and contextualism models of moral deliberation, reflective equilibrium characterises moral deliberation as follows:

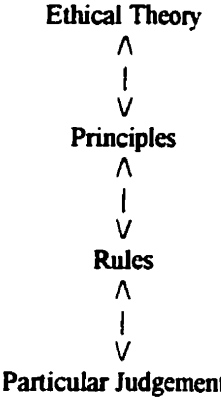

Figure 2. The reflective equilibrium account of the nature of moral reasoning.

This model suggests that the depictions of moral reasoning proposed by the deductivists and the inductivists are not opposing and exclusionary, but in fact compatible and complementary. Furthermore, it is only in unison that they properly describe moral deliberation. We in fact partake in both deductive and inductive moral reasoning when we engage in ethical activity. Our preconceived rules of conduct inform our particular judgements, however particular judgements and lateral case comparison at the same time create and revise higher-level principles.

Reflective equilibrium rejects the positions held by applied ethics and contextualism, where ethical decisions are grounded in or justified by *either* generality *or* the community; instead justification entails both. In the traditional approaches' disagreement regarding whether justification is situated in the universal or the particular, they fail to recognise that justification in fact entails both local and translocal contexts. This is because moral agents are largely situated in but not confined to their local contexts. While the contextualists are correct in suggesting that our moral intuitions are largely shaped by our social and cultural environment, they fail to recognise that ethical inquiry also entails transcending the local and critically reflecting on one's own moral

sphere.[23] This latter part is captured in the applied ethics search for *generalisability*, although whether there is such a thing as *absolute* universal value is heavily contested. Furthermore, moral philosophy inadequately accounts for how we are shaped by our surroundings and thus what it entails to 'step out' of that context in order to engage in critical reflection. Justification for action is thus found in both local and universal contexts. Our local institutions create and govern our moral conduct, but the reflective agent constantly tests her moral sphere against overarching principles. The process of justification cannot be confined to either theoretical ideals of generality nor practical accounts of local situatedness.

Reflective equilibrium methodology proposes that case resolution requires attention to particulars as well as conceptual inquiry. Contextualists advocate attention to particulars to resolve cases yet they fail to demonstrate *how* sensitivity to context actually results in resolution. Is contextuality a directive methodology or is it merely something *to keep in mind* when engaging in ethical deliberation? Furthermore, contextualism does not indicate how the moral agent should respond to competing institutional norms. This seems like a glaring oversight, given Frankena's admission that most moral problems entail a conflict between competing legitimate claims, duties, or principles (1962, 3). Contextualism also does not provide a means for critically reflecting upon norms and customs. A higher-level understanding of morality is necessary in order to deem a cultural practice to be *unethical*. Now applied ethicists, while advocating conceptual

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[23] To illustrate this, I borrow a passage from Kleinman (1999), in which he asks:

> And yet can there be an understanding of ethics--in the sense of, and the very least, an imagination of and struggle to develop universal values--that does not seek to transcend the local? After all, local worlds--as in the recent examples of Bosnia, Kosovo, and Rwanda--can be utterly unethical. How could we make the case for human rights and against genocide in such terrible instances based on something called ethics--unless ethics provides translocal values that can criticise local practices from the outside? (1999, 73).

inquiry to guide the resolution of moral problems, ignore how 'everyday' thinking informs 'critical' thinking. Even Hare's two-level model of moral thinking is guilty of this oversight. Unlike most applied ethicists, he identifies that moral thinking occurs at not only the 'theoretical' or 'critical' level, but also at the 'practical' or 'everyday' level. He even adequately accounts for how the theoretical level informs practical moral judgement. However, he proposes a unidirectional interaction between theoretical and practical thinking by failing to recognise that 'everyday' thinking informs 'critical' thinking, and not only the other way around. Furthermore, conflict resolution can take place in certain circumstances by means of lateral case-comparison. Reference to 'higher' morality is not *always* necessary. Although case-based ethics seems more readily applicable to case-resolution, there is merit in the applied ethicists' claim that theory can help clarify moral problems and assist in resolution. Again, a convergence between theory and practice seems warranted. Similar to my conclusions regarding justification, case-resolution relies on both attention to the 'facts' as well as theoretical clarification.

Even attempts to bridge the gap between theory and practice by specification and middle-level principles fails to achieve the necessary dialectical interaction between theory and practice for which only reflective equilibrium allows. Applied ethicists such as Green have argued that specification corrects the problem of the inapplicability of ethical theory because of its abstractness by allowing for particulars to be integrated into theoretical investigation. In some respects, specification creates an 'equilibrium' between principles and cases. Richardson goes so far as to suggest that the real work of practical ethics lies in specifying norms (1980, 280). However, specification does not

capture the full scope of the interrelationship between theory and practice. Specification serves to refine our principles by establishing an interchange between cases and principles. We get proper specification when we arrive at an equilibrium between the 'facts' of the case, our moral beliefs about it, and the qualifications on the principles that apply. Daniels regards specification of norms as a '*narrow* reflective equilibrium', and while recognising its merits, he rightly suggests that we need a 'very *wide* reflective equilibrium' that erodes many of the distinctions of theory and practice in bioethics (1996, 101).

Daniels argues that justification in ethics or bioethics requires a *broad* coherentist approach, which involves consistency between not only one's set of moral beliefs, but beliefs at many levels, including individual, shared, social, political, and institutional beliefs. Unlike the *narrow* equilibrium achieved by specification, *wide* reflective equilibrium allows for no beliefs to be beyond revision.[24] Instead of confining the process of critical reflection to narrow principles of action, equilibrium must be reached on a larger scale, where the social, political, particular, and universal are balanced against each other.

Contextualists propose that the inductive formation of middle-level principles resolves the criticism launched against practical ethics that moral judgements are not sufficiently justified. They argue that these principles, which are *induced* from case

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[24] Daniels' list of beliefs include beliefs

> about particular cases; about rules and principles and virtues and how to apply to act on them; about the right-making properties of actions, policies and institutions; about the conflict between consequentialist and deontological views; about partiality and impartiality and the moral point of view; about motivation, moral development, strains of moral commitment, and the limits of ethics; about the nature of persons; about the role or function of ethics in our lives; about the implications of game theory, decision theory and accounts of rationality for morality; about the way we should reply to moral scepticism and moral disagreement' and about moral justification itself (1996, 101).

comparison and local norms, can adequately justify our moral judgements and thus bring the strength of 'theory'--namely principles of right conduct on which to test particular judgement--into their practical approach. What they fail to incorporate, however, is how theory in fact assists *in* practical judgement, rather than merely providing justification *after the fact*. Thus theory is not integrated into contextualism, but instead merely supplements it.

In my account of how moral deliberation, justification, and applicability entail attention to both universals and particulars, I hope to have demonstrated that reflective equilibrium is the most appropriate methodology for bioethics. The attention to both 'theory' and 'practice' entailed in the nature of bioethics, and subsequently, the methods in which we *do* bioethics, has been demonstrated to be insufficiently accounted for by applied ethics' specification of norms or contextualists' middle-level principles. Instead bioethics requires a methodology that assigns "privileged epistemological place" to both general principles and particular judgement (Sumner and Boyle 1996, 8). This criterion is only captured in the dialectical interchange between theory and practice found in reflective equilibrium.

In the next section, the scope of my methodological claim will be put to the test, as clinical ethics consultation will be examined. My investigation into the theory and practice of bioethics had been prompted by my recent exposure to clinical ethics as a philosophically trained graduate student in bioethics, and my immediate realisation that there is very little congruency between academic and clinical bioethics. Thus although academic discussions on the nature of bioethics has illustrated a need for a methodology that actively engages both theory and practice, it still remains to be seen whether such a

conclusion holds in the clinical setting. It will be demonstrated that clinical moral decision-making is a far more complicated and multi-faceted task than proposed by the competing methodologies' stark characterisations of the nature of moral reasoning. I will argue, however, that despite the practical demands of the clinic, theory and practice both need not and should not be separated.

III. Clinical Bioethics: Theory and Practice

There is a noticeable division between academic and clinical biomedical ethics, as the two areas exist almost independently of each other. Were it not for the common practice of joint appointments of academics working in bioethics as clinical ethics consultants in the teaching hospitals, it is not clear that there would be any convergence whatsoever. Academic and clinical bioethics have their own bodies of literature, journals, and conferences. Clinical ethics also has its own methodologies, which is hardly surprising, given that ethics and academic bioethics[25] have yet to come to agreement on how to resolve moral dilemmas. It is clinical ethics methodology that will be the focus of this section, as an investigation into the relationship of theory and practice is also an examination of methodology. Furthermore, I have already argued my position that the disciplinary nature of biomedical ethics demands a methodological interrelationship between theory and practice. Thus clinical ethics, which is the practice of moral decision-making in the clinical setting, presumably needs theoretical reference, which seems to suggest a point of unification between academia and the clinic.

However, my investigation into how moral deliberation is done in the clinical setting resulted in some surprising observations. Upon entering the clinic, I soon discovered that the theory/practice separation was even more pronounced than I had first imagined. Not only does clinical ethics not engage with the academic discourse, but it upholds the theory/practice divide in its practice. I encountered two widely used models

[25] By 'academic bioethics', I refer to the work in bioethics being done by academics in the university setting. Academic bioethicists primarily consist of philosophers, however, there is also a large amount of bioethics scholarship coming out of law faculties and religious studies, anthropology, and sociology departments. 'Ethics' on the other hand, refers to traditional moral philosophy. Although all philosopher-bioethicists have training in moral philosophy, many moral philosophers choose not to engage in bioethics.

of ethics consultation, one that situated the ethics consultant on the 'theory' side of ethical deliberation in an exclusively 'clarificatory' role, and another that defined the ethics consultant as an ethics 'practitioner', a role which was engaged with minimal theoretical consideration.

This observation was surprising considering the move in academia to unify theory and practice. In this section I investigate why clinical ethics has upheld the theory/practice divide. Is it a flaw in clinical ethics practice or are the academic theories and discussions simply not relevant to the clinical setting? Can we therefore conclude that the divide between theory and practice both *within* clinical ethics and *between* academic and clinical ethics is justified? I will argue for a unification of theory and practice in clinical ethics, which will suggest the relevance of academic bioethics to clinical ethics. To do this, I endorse the *ethics facilitation* model of ethics consultation because it holds theory and practice in equilibrium.

i. <u>The Clinical Ethics Consultant</u>

Ethics consultants,[26] because of the ethical training that they bring into the clinical setting, serve as the link between academia and the clinic. The hospital serves a *practical* function, namely to treat illness, whether through patient care or medical research. This is in stark contrast to the university setting, which serves primarily to foster theoretical investigation. Clinical ethics was introduced into the hospital setting not to tackle theoretical questions but to assist the hospital in its aims of patient care and medical

[26] In this section, I will limit my discussion on ethics consultation to independent on-site consultants who engage in bedside case consultations. Other formats, such as ethics teams and committees will not be discussed, however many of the general suggestions will still be relevant to those models of ethics consultation. Lastly, I refer to ethics consultants from a variety of backgrounds -- philosophy, law, theology, and medicine. It is assumed that they have undertaken some clinical ethics training, such as the one-year clinical ethics program at the University of Chicago.

research. Thus 'ethics' was brought into the hospital with a practical goal in mind. The ethics consultant focuses primarily on individual cases or research protocols as well as hospital policy proposals, with the aim of putting her ethical work to practice. And just as theory and practice have exhibited troubled coexistence in defining the nature of bioethics as well as in the methodological debate in academic bioethics, there is also uncertainty as to how clinical ethics relates and is relevant to hospital practice.

Academic bioethics has provided little guidance for the ethics consultant regarding how to integrate ethics into clinical practice. The clinical setting places unique demands on the ethics consultant that are not faced by the academic partaking in moral deliberation. Time constraints, impatient clinicians, difficult patients and/or family members, as well as legal and institutional demands, add to the difficulty of moral deliberation. The extent to which moral deliberation is different in the clinical context needs further investigation and recognition.

The tie between the academy and the clinic cannot be made by the mere presence of an on-site ethics consultant. The link between theory and practice, as we have seen, is far more complex. Perhaps due to the ill-defined way that the ethics consultant is supposed to make that link, many appear to be upholding the theory/practice divide in their clinical work by defining their roles in the clinical setting as *either* theoretical *or* practical, when in fact, as I will be arguing, clinical ethics should entail both.

ii. <u>Two Models of Ethics Consultation: 'Theory' and 'Practice'</u>

The theory/practice divide manifests not only between academic and clinical bioethics but also *within* clinical ethics in two popular models of health care consultation: the *clarificatory* and the *practitioner* models. Many clinical consultants appear to mirror

the divide between academic and clinical bioethics by allying themselves with either the university or the clinic. I will argue that both models are flawed because they place the ethics consultant on either the 'theory' side or the 'practice' side of ethical deliberation, and assume that moral judgements can endure this division of moral labour.

The Clarificatory Model (Theory)

The first model places the ethics consultant in a *clarificatory* role, where she distances herself from the practical resolution of cases and instead serves to guide the appropriate decision-makers through moral deliberation by clarifying important concepts, bringing up ethical considerations, and highlighting the competing interests and values involved. In this exercise, the ethics consultant clarifies what is 'really' at issue in ethically problematic cases. For example, if confronted with an end-of-life case, the ethics consultant will stress the conceptual issues underlying the particular case, such as definitions of life, death, and personhood, as well as fitting the particular ethical question into a larger moral structure, where questions of justice or the duties of the clinician can be addressed. She may also analyse the component features of the case in order to make clear which factor should dominate in final decision-making. Armed with a clearer understanding of the issue, the clinicians, patient, and/or family members, can come to the appropriate resolution. Ruth Macklin endorsed this model in a 1984 interview with the *New York Times* on the role of ethics consultants in the hospital setting.

> Doctors come to her with questions, and she gives them questions back. They come with gut reactions and she hacks away at the reactions with analytic cleavers. It is not her role, she said, to decide matters but rather to place them in a moral context..."They're not expecting answers from me," said Dr. Macklin..., "They're looking for guidance. Legal precedents. How to think about a problem. I give them arguments on both sides" (in Gorovitz 1986, 370).

In this model, the ethics consultant's role is situated on the 'theory' side of ethical inquiry, where she provides the conceptual groundwork and the practical work is left to the parties directly involved with the case.

The Practitioner Model (Practice)

In the *practitioner* model, the ethics consultant confines herself to a 'practical' role, where she participates as an active member of the decision-making team. The ethics consultant acts as a mediator of conflicting needs, invoking such considerations as competing demands, intuitions, and legal precedents, with little mention of ethical theory and conceptual inquiry. This practical role is understood to require very little theoretical consideration. 'Practical' consultants may sum up the ethical 'work' by applying the 'Georgetown' principles[27] to the case.

Why 'Theory' or 'Practice' Models?

Along with the ethics consultant's ambivalent position as the link between the university and the clinic, the demands of the clinic may motivate the ethics consultant to narrow the scope of her work. She may choose to skip over much of the conceptual work because it can be time-consuming and even frustrating in that instead of resolving questions it often brings up new ones. The consultant that recognises the importance of the conceptual work may decide to limit herself to a 'clarificatory' role, and leave actual resolution to the involved parties. One's background training may motivate which role one chooses to undertake as an ethics consultant. Philosophers may be more inclined toward the theoretical role, while clinicians are more likely to embrace the practical model.

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[27] I refer to Beauchamp and Childress' Principles of Biomedical Ethics (1994). The four principles--autonomy, beneficence, nonmaleficence, and justice--are often referred to as the 'Georgetown mantra'.

Problems with These Models

Both the theoretical and practical models of health care consultation wrongly assume practical ethics to be distinct from theoretical activity, where each one can be engaged independently from the other. In these models, the 'theory' is provided *prior to* the commencement of practical resolution.

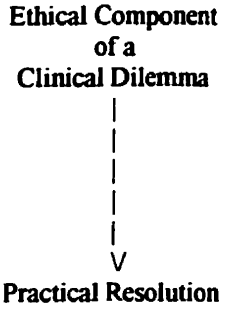

Figure 3. The relationship of theory and practice in the *clarificatory* and *practitioner* models of ethics consultation.

The above diagram demonstrates the assumption that theoretical input *ends* when practical resolution begins, a supposition that allows for the ethics consultant to engage in *either* theory *or* practice. In fact theoretical considerations constantly inform practice throughout the deliberative process, and also undergoes refinement as conflict arises. 'Theory' and 'practice' inform each other and are both integral and interrelated parts of moral deliberation that work in unison. This is the reflective process in which theory and practice engage to reach 'equilibrium'. Theory does not merely inform practice unidirectionally *or* a priori--instead they reflect on each other in a constant exchange and dialogue.

Both models uphold the popular assumption found in ethics that the study of practical moral problems may not need significant theoretical input. The abstract conceptual questions are seen as the more truly philosophical, while practical problems,

because they arise out of human experience, are thought to represent questions that confront all moral agents and therefore do not demand a high level of philosophical inclination and experience. Since identifying and exploring practical questions is an activity demanded of all moral agents, and since philosophers do not stand apart as actually living more ethical lives, it is not clear that practical ethics even requires any special philosophical acumen or theoretical investigation (Sherwin 1996, 187). It is following these assumptions that clinical ethics can endorse models of ethics consultation where the practical work is removed from conceptual considerations, in which the ethics consultant engages in either theory or practice, but not both. Yet insofar as theory and practice inform each other, this assumption is flawed.

The *practitioner* model also errs in its assumption about what the conceptual part of ethical deliberation entails and therefore lacks the necessary theoretical effort that must go into ethical resolution of moral problems. The ethics 'practitioner' either disregards the conceptual work and focuses on the many other considerations, such as the competing claims and the legal and institutional demands, or she sums up the 'ethical work' in the Georgetown principles. In fact a 'mechanical' application of the principles to specific cases does not cover the necessary theoretical work. The principles limit the way we can frame a moral problem by defining it as a conflict between no more than four competing principles. Certain aspects of the case may not be adequately addressed under such a framework.[28] In fact, even Beauchamp and Childress argue that the principles were not

[28] For example, cases where patients are not fully competent to make personal or medical decisions are defined as a conflict between autonomy and beneficence. While this framework allows for discussion on patient rights and the duty to care for those who cannot care for themselves, other problems, such as the conceptual divide between legal notions and psychological understandings of competency are excluded. Legally, a patient is or is not competent, while competency is recognised by clinicians to often be intermittent, specific to certain tasks, and exist in degrees. These cases are limited by a framework of conflict between principles, as such a characterisation excludes other difficulties, such as the ambiguity of

meant to be the only components considered in the framing of moral question. Furthermore, the 'mechanical' application is a misuse of the principlist method, as the principles need specification (Beauchamp and Childress 1994, 28-32). This naïve use (or misuse) of the principles resonates with the earlier discussion on the unfair characterisation of applied ethics.

The conceptual work required for case resolution is in fact captured in the *clarificatory* model, however two errors follow. One is the assumption that 'theory' need not reflect on and be refined by practical events as they arise, and the second is that the 'practice' will not require any further theoretical input beyond what has been supplied in the initial clarification consult.

iii. The Irreconcilability of Academic and Clinical Bioethics?

Before continuing, it must be established whether it is appropriate to invoke an 'academic' argument for the need to unite theory and practice when discussing clinical ethics. In fact, we have seen that the clinical setting is radically different from the university setting in which these theories are derived, and that the ethics consultant faces challenges in moral deliberation over cases that are not encountered by the academic philosopher. This may lead one to make three false conclusions:

(1) Academic and clinical bioethics are so different that while the unification of theory and practice may be possible (and even preferable) in academia by means of *reflective equilibrium*, there is no reason to think that the same holds for clinical ethics.

(2) The theory/practice divide is upheld in clinical ethics because this partitioning is an appropriate division of ethical labour in the clinical setting.

(3) The methodological theories, because they are created by academics, are inadequate for the clinical context.

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the term 'competency'. It may also lead to excessively rigid standards of competency and misdiagnoses of patients.

To these objections I respond that clinical ethics can and should unite theory and practice because clinical ethics requires ethical deliberation, and ethical deliberation demands both theoretical and practical input. This argument holds true in both academia and the clinic. In specific response to each objection:

(1) Despite the many differences between academic and clinical bioethics, the differences are in the *context* in which moral deliberation is undertaken. The *nature* of moral deliberation does not change--only *how* moral deliberation is implemented in practice.

(2) For the clinical consultant to 'divide the ethical labour' by undertaking *either* theoretical consideration *or* practice (and leaving the other to another party) is to misunderstand the relationship between theory and practice. Conceptual claims and practical conclusions must constantly be tested against each other in search for inconsistency or contradiction. Both the theory and the practice must come to coexist in equilibrium.

(3) Theories are general guidelines that need specification in order to be applicable to particular moral contexts. Thus while the theories may *seem* inadequate, because they do not capture the context in which clinical ethics functions, they cannot be rejected until appropriate specification can be made.

To support my position that academic theories are relevant to clinical ethics and thus convergence between academia and the clinical setting *is* possible, I will now endorse a third model of ethics consultation--the *ethics facilitation* model--as an alternative to the *clarificatory* and the *practitioner* models and demonstrate that it functions as a *specified* model of *reflective equilibrium*. Thus the division of 'ethical labour' will also be demonstrated to be an unnecessary consequence of the clinical context.

iv. <u>An Alternative Model: Ethics Facilitation</u>

The *ethics facilitation* model defines the ethics consultant as a facilitator of moral decision-making. This model is endorsed by the American Society for Bioethics and

Humanities' (ASBH) Task Force on Standards for Bioethics Consultation,[29] who argue that this approach is "the most appropriate for health care ethics consultants in contemporary society" because it is "consistent with the rights of individuals to live by their own moral values and the fact of pluralism" (ASBH 1998, 6-8). While they limit their analysis and praise to the decision-making involvement that the consultant takes in relation to the involved parties (patient, family, clinicians),[30] I further support this model because it best illustrates both where the ethics consultant fits into the clinical context and the necessary knowledge and skills needed for clinical ethics.

This model serves to unite the theory/practice divide in clinical ethics by providing a fuller conception of what 'practice' entails for the clinical ethicist, and where 'theory' fits into that role. 'Practice', as defined in biomedical ethics as the resolution of actual moral problems, needs further specification when considering the clinical context. It is only with a fuller conception of 'practice' that we can understand if and how 'theory' relates to it.

The *ethics facilitation* approach entails identifying and analysing the nature of the conflict and facilitating the building of consensus, while recognising the societal, legal, and institutional context in which ethics consultation is done. To identify and analyse the nature of the conflict, the consultant must gather relevant data through discussions with

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[29] The ASBH Task Force produced Core Competencies for Health Care Ethics Consultation (1998). See bibliographic reference.

[30] The ASBH regards the *ethics facilitation* approach as the happy medium between the two extreme polar approaches to ethics consultation: the *authoritarian* approach and the *pure facilitation* approach. The former places the ethics consultant as the primary moral decision-maker at the expense of the patient or surrogate decision-maker. The latter aims at forging consensus among involved parties, which is problematic because the consensus may fall outside acceptable moral boundaries. The *ethics facilitation* model, in contrast, upholds the importance of inclusion and consensus in decision-making while still recognising the boundaries for morally acceptable solutions normally set by the context in which ethics consultation is done. Unlike the *authoritarian* approach, ethics facilitation emphasises an inclusive consensus-building process. In contrast to the *pure facilitation* approach, ethics facilitation recognises that societal values, law, and institutional policy have implications for a morally acceptable consensus.

the involved parties and the examination of medical records and other relevant documents, as well as clarify relevant concepts and issues, and help to identify a range of morally acceptable options within the context. From here, she can facilitate the building of consensus among involved parties. To do this, she must ensure that involved parties have their voices heard, assist the decision-makers in clarifying their own values, and finally help facilitate the building of morally acceptable shared commitments or understandings (ASBH 1998, 6-7).

This brief account of ethics facilitation should highlight the fact that the 'practice' of clinical moral decision-making is a rich and complicated endeavour involving multiple steps, many types of knowledge, and numerous skills. From the two core features of ethics facilitation identified above, namely conflict analysis and consensus building, a rudimentary account of the multiple types of knowledge and skill of the ethics consultant can be posited. Data collection requires good communication and interpersonal skills in order to engage in discussion with the involved parties. Some basic medical knowledge, at minimum enough to read and understand a medical record is also necessary. The clarifying of relevant concepts requires some familiarity with the bioethics literature pertaining to issues such as confidentiality, autonomy, or informed consent. Clarifying normative issues, such as the implications of societal values, law, ethics, and institutional policy, requires some knowledge of moral theory, civil and case law, as well as relevant institutional policy. To facilitate the building of consensus among involved parties, the ethics consultant must have facilitation skills and be able to build a trust and rapport with the involved parties so that everyone feels confident that their voices will be heard. She must be able to assist in discussion without dominating or shutting certain people out. To

do this she must exhibit patience, tolerance, and integrity.

This examination demonstrates that moral deliberation is a much more complex and multi-task endeavour than the methodological theories seem to suggest. It is a far cry from the lone philosopher pondering an ethical dilemma guided only by clear and rational thought. Instead it involves communication and rapport with all involved parties, working knowledge of philosophy, medicine, the law, and institutional policy, organisational skills, and even certain character traits. Furthermore, the practice involves active engagement with moral theory and principles. Theory is not examined and considered prior to deliberation (as the clarificatory model indicates), but instead it is used to foster discussion and test competing positions. Principles are also subject to refinement and augmentation when contradictions arise. Thus clinical moral deliberation is comprised of both theoretical and practical ethical 'work'.

The view that ethics consultation is not confined to a specific practical skill or theoretical knowledge[31] is in fact endorsed by the ASBH as well as the Strategic Research Network on Health Care Ethics Consultation.[32] The Network's profile of a health care ethics consultant,[33] which serves as a functional description of the ethics consultant active in the clinical setting outlines the requisite *knowledge*, *abilities*, and *traits of character* for case consultation in clinical care or research, consultation to ethics committees or research ethics boards, or policy formulation committees(31-40). In Core Competencies, the ASBH Task Force similarly outlines 'Core Knowledge' (section 2.3),

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[31] The *practitioner* model emphasises interpersonal skills while the *clarificatory* model stresses philosophical knowledge.

[32] The Network, which functioned from 1991-1993 with funding from the Social Sciences and Humanities Research Council of Canada (SSHRC), consisted of philosophers, theologians, clinicians, and lawyers from across Canada. The Network produced a final report that has been adapted into a compilation entitled A Profile of a Health Care Ethics Consultant, ed. Francoise Baylis (Totowa, NJ: Humana Press Inc, 1994).

[33] In A Profile..., pp. 25-44.

'Core Skills' (s. 2.2), and 'Character' (s. 2.4) in its outline of the core competencies for health care ethics consultation (1998, 12-23).

Upon reviewing the requisite knowledge listed in both texts, the multidisciplinary nature of clinical ethics becomes apparent, as knowledge is not limited to ethical theory and moral reasoning, but instead includes legal, medical, social, and institutional knowledge. In fact, both the Task Force and the Network accept the diverse professional backgrounds that ethics consultants come from as properly reflecting the multidisciplinary nature of ethics consultation. They do not support one discipline as most suited for clinical consultation, but instead take measures to point out the knowledge and skills that each of these professions bring in and suggest areas where abilities may need to be supplemented.[34]

Along with the knowledge requirements, there are important skills needed for ethics consultation. The Task Force identifies three categories of skills: (1) ethical assessment skills, (2) process skills, and (3) interpersonal skills. The first category includes such skills as data collection, identifying the assumptions and values of the parties involved, clarifying relevant concepts, and critically evaluating bioethics literature, law, institutional policy and professional codes relevant to the case (1998, 13). Process skills consist of the abilities needed to resolve conflict, such as the ability to facilitate discussion, identify key decision-makers, create an atmosphere of trust that respects privacy and confidentiality and encourages open discussion among involved parties, as well as the ability to build moral consensus (1998, 14). Finally, interpersonal skills include the ability to listen well and to communicate interest, respect, support, and

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[34] See Core Competencies..., p. 11, and M. Burgess et al. 1994. "Feeder Disciplines: The Education and Training of Health Care Ethics Consultants" in A Profile..., pp. 63-108.

empathy to involved parties, educate involved parties regarding the ethical dimensions of the case, elicit the moral views of involved parties, and represent the views of involved parties to others. Furthermore, the consultant must enable involved parties to communicate effectively, and to recognise and attend to various relational barriers to communication (1998, 14). In A Profile..., Abyann Lynch argues that interpersonal facilitation (mediation, negotiation, and arbitration) is more essential than the consultant's other forms of knowledge and abilities. Lacking this ability, the ethics consultant would be unable to initiate or conclude suitable discussion or consultation concerning resolution of ethical dilemmas (1994, 56-7).[35]

Character is also seen as a necessary part of ethics consultation. The 'Profile' indicates that "knowledge and abilities are not sufficient, particularly since the abilities listed in the Profile presume certain virtues" (1994, 40). For example, the ability to make and defend sound ethical judgements requires wisdom (40). Similarly the Task Force views "good character [as] important for optimal ethics consultation" (1998, 21). They provide a list of character traits that they see as either necessary for or incidental to the acquisition of certain kinds of skills or knowledge in clinical ethics. For example, tolerance, patience, and compassion are traits that would enable the consultant to listen well and communicate interest, respect, support and empathy. Honesty, forthrightness, and self-knowledge would help prevent the manipulative use of information and help create an atmosphere of trust necessary to facilitate discussion.

Thus not only are knowledge, skills, and character required, but they are thought

[35] In fact, many argue that the majority of the issues that arise on a daily basis and "end up as 'ethical conundrums' originate more in interpersonal communication problems and inappropriate attitudes than in

to interrelate in a non-reducible exchange that enables clinical ethics consultation. The diagram below captures the relationship of the 'core competencies' of ethics consultation.

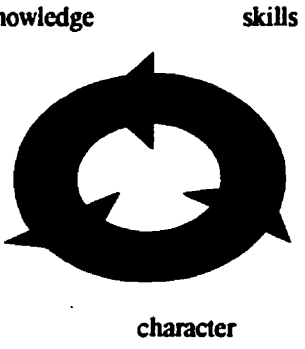

Figure 4. The ASBH 'core competencies' of a health care ethics consultant.

v. The Ethics Facilitation Model and the Coexistence of Theory and Practice in Clinical Ethics

With this more comprehensive account of the 'practice' of clinical ethics, we see how theory and practice coexist in clinical ethics. Ethics consultation is undoubtedly a practical endeavour, however the *ethics facilitation* model demonstrates that the practice is largely informed by academic work, such as ethical theory, philosophical concepts, and even the methodological theories. The theoretical work cannot, however, be merely supplied by the 'clarificatory' consultant or pulled out of Beauchamp and Childress' Principles of Biomedical Ethics, as if 'theory' was a separate category of ethical deliberation. Instead the theory must integrate with the practice of clinical ethics, engaging in dialogue for every step of moral deliberation. Clinical moral deliberation thus looks more like:

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purely philosophical or intellectual dilemmas (Bereza 1999, 27).

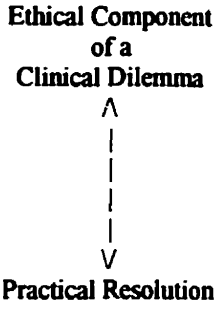

Figure 5. The relationship of theory and practice in the *ethics facilitation* model of ethics consultation.

Philosophy and moral theory *are* useful in practical exercises because they fit problems into larger moral structures and therefore highlight further considerations, questions, and alternatives. The criticisms expounded by contextualists that theories are too abstract and principles are too rigid only hold when 'theory' is held separate from practice. When engaged with practice, theory assists in giving direction to discussion by revealing the broader implications of the case or position, organising our ideas in more straightforward ways, and bringing method and order to the analysis of complex issues. It is only when theory is treated as separate and distinct from practice that principles become 'tyrannical' and context gets ignored.

vi. Ethics Facilitation Model: Specified Reflective Equilibrium

While the *ethics facilitation* model may appear to be of a different species than the theory of reflective equilibrium provided in the previous chapter, I will demonstrate that the model is in fact a *specified* account of reflective equilibrium. As was discussed in Section II, specification is the process of fitting general principles and theories into a *specific* moral context. Thus the description of reflective equilibrium previously given was only a 'theory', or a general outline, and *ethics facilitation* is the contextualised or specified account of the theory of reflective equilibrium.

The *ethics facilitation* model provides specification by supplying a thorough description of 'practice'. The 'practice' of moral deliberation in the clinical setting was illustrated to entail multiple steps, such as data collection and interpersonal facilitation. These tasks required multidisciplinary knowledge and a variety of skills and character traits. The relationship of knowledge, skills, and character revealed a dialectical interchange between theory and practice, where they could not be separated in a tidy division of ethical labour. The ethics consultant could not be *either* theoretical *or* practical, as the two were demonstrated to rely on each other in moral deliberation. This illustration that moral deliberation does not allow for such a divide where the 'theory' comes in *prior to* deliberation and resolution captures the schema of moral deliberation expounded by proponents of reflective equilibrium. In the *ethics facilitation* model, theory and practice constantly intermingle to test and refine each other until 'equilibrium', or a morally justified consensus, is reached.

vii. <u>The Relationship between Academic and Clinical Bioethics</u>

Thus the relationship of academic and clinical ethics becomes apparent. Not only is academic bioethics relevant in that it supplies the necessary knowledge to ethics consultation, and in turn should be informed by its application to practice, but the methodological theories are also relevant to the clinical setting. Any model of ethics consultation makes assumptions about the nature of moral deliberation, and thus the theories regarding moral deliberation must be considered. It has already been argued that the *clarificatory* and *practitioner* models of ethics consultation both presume the acceptability of a theory/practice divide in moral deliberation. In fact all of the methodological theories except for reflective equilibrium see bioethics as either 'applied

ethics' or a practical enterprise, and thus presume that ethical deliberation can be divided into theory and practice components and handled separately. My contention that an appropriate model of ethics consultation must be a form of specified reflective equilibrium presumes that the nature of moral deliberation entails a reflective and irreducible relationship between theory and practice. The *ethics facilitation* model demonstrated that 'reflective equilibrium' could be enacted in the clinical setting, and thus the method is not a merely theoretical ideal, but an appropriate underpinning for clinical ethics. The current division between academic and clinical bioethics should not be accepted as a logical separation between two disparate areas of bioethics. Instead, the two areas have much to gain from a closer and integrated association.

Conclusion

The theory and practice of biomedical ethics are interrelated entities that must resist conceptual separation. I have demonstrated that attempts to hold theory and practice apart have produced problematic results for bioethics. With these internal difficulties, bioethics may be unable to adequately respond to the increasing demands being placed on the discipline by public and political interest in the complex moral issues surfacing in biomedicine. The current response to these demands has included a fracturing of the discipline into theoretical and practical factions comprised of academics working in the former and clinicians in the latter. This approach, while appearing to be an efficient division of moral labour, has proved to be an inadequate means of addressing the difficult moral problems that arise in bioethics.

While it has already been suggested that the subdividing of a discipline often demonstrates disciplinary maturation, such as in the cases of medicine and philosophy, the fracturing of bioethics is not following that same course. For one, the division in bioethics appears to be a largely unreflective response to the barrage of demands being placed on this very new discipline, rather than a slow progression of sub-specialisation. Furthermore, medicine and philosophy did not subdivide along theory/practice lines, where the medical researcher, for example, ignores the social dimension of her work. The theory and practice of bioethics have been demonstrated to be limited without interchange with each other. Bioethics by its very nature demands the integration of theory and practice. The proponents of either theory-based or practice-based bioethics only 'legitimise' their views by upholding a limited view of the discipline.

It was demonstrated in Section I that bioethics does not allow for easy categorisation as either a theoretical or a practical enterprise. By being located in the academic, clinical, political, and public spheres, bioethics is situated precariously on the theory/practice nexus. The discipline simply cannot be captured by traditional categories of ethics either, as bioethics suggests to be distinct yet not completely removed from moral philosophy and practical ethics. The abstract theorising of moral philosophy, while helpful in clarifying concepts and weighing alternatives, is limited in its ability to truly appreciate the circumstances of the particular problems that arise in the clinical context. Practical ethics, on the other hand, does not allow for the questioning of local customs and institutions that is so important to critical ethical investigation. Bioethics thus seems best characterised as *both* theoretical and practical.

The investigation into methodology undertaken in Section II illustrated two different conceptions of morality held by the dominant theory-based and practice-based approaches to bioethics. Applied ethics grounds moral decisions in generalisable principles and resolves cases by means of theoretical clarification. Contextualists, in contrast, justify their claims by reference to local institutions and endorse practical methods for the resolution of practical problems. Thus applied ethics depicts ethical activity as a process of 'rational reconstruction', where valid ethical rules and principles are integrated into a coherent theoretical system, while contextualists regard situatedness and particularity as essential components of moral thinking. It is case-analysis and lateral case comparison that renders moral judgment.

The discussion in Section I on the nature of bioethics, however, contrasted the depictions of moral deliberation presupposed by both methodological camps. The

theoretical *and* practical investigations undertaken by bioethics suggests a need for a methodology that is neither entirely theoretical nor exclusively practical. Applied ethicists and contextualists do not deny this position, however, their attempts to reconcile theory and practice are demonstrably inadequate for bioethics inquiry, as they do not sufficiently appreciate the intricate interrelationship of theory and practice in their methods of specifying deductive principles and inducing middle-level principles. Instead they attempt to bridge the theory/practice gap by supplementing theory-based methodology with practical 'facts' or deriving principles by case-comparison and examination of local norms and practices. Neither methods bring theory and practice into the necessary *wide reflective equilibrium.*

The division between theory and practice appeared on two levels in the clinical setting, where a disjunction was revealed between academic and clinical ethics, and a further divide was discovered in the methods of clinical ethics consultation. The first model situated itself on the 'theory' side of ethical deliberation, and gave the ethics consultant an exclusively 'clarificatory' role, while the second model defined the ethics consultant as an ethics 'practitioner', a role which was engaged with minimal theoretical consideration. This observation of how clinical ethics consultation is conducted had been somewhat surprising, given the move in academia to integrate theory and practice. It was demonstrated, however, to be incorrect to conclude that the differences between the clinical setting and the academic setting legitimised the division of moral labour in the clinical setting.

What both models failed to recognise is that 'theory' and 'practice' inform each other and are both integral and interrelated parts of moral deliberation that work in

unison. This reflective process in which theory and practice engage to reach 'equilibrium' holds true regardless of the moral setting. The nature of moral deliberation does not change. The *ethics facilitation* model not only reconciled theory and practice in clinical ethics consultation, but by doing so, revealed the link between academia and the clinic. The model was demonstrated to be a method of *specified* Reflective Equilibrium.

With this more comprehensive account of clinical ethics consultation provided by this alternative model, we saw how theory and practice coexist in the 'practice' of clinical ethics. The 'ethical component' of clinical moral deliberation cannot be provided *prior to* the practical decision-making, as the 'clarificatory' and 'practitioner' models suggest, but instead work in reflective interaction.

The theory and practice of biomedical ethics can only work and develop in unison. Any separation of these two components of ethical inquiry severely diminishes the ability of the discipline to engage in both theoretical and practical moral investigations. Thus bioethics is neither a theoretical or practical enterprise, but a discipline encompassing both factions and fostering exchange.

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