ABSTRACT

Title of dissertation:	JUSTIFYING BIOETHICAL CASE DECISIONS: REFLECTIVE EQUILIBRIUM AND MID-LEVEL MORAL PRINCIPLES

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Bioethics is a practical enterprise intended to produce morally acceptable solutions to clinical case problems. Although answers can be derived from deductivist or principle-driven methods of deliberation, these solutions may be too abstract to be accepted as appropriate to the circumstances, clinically effective, or suitable to those stakeholders affected by the decision. Furthermore, it has proven difficult to identify the best moral principle to apply to each case, because of the variation in detail and nuance impacting each situation.

In this dissertation, I exemplify the difficulty in practical bioethics deliberations by presenting in detail the activities of a practicing ethics committee, working at the clinical level of private medical practice in the field of assisted reproductive medicine. In descriptions of over forty cases, I show the difficulty this committee

faced in solving routine cases and even more when attempting to solve the novel cases that arise with some frequency in this unique field.

This research leads me to recommend a more procedural approach, based on the process of reflective equilibrium described by John Rawls, but supplemented by the contractualist version put forth by T. M. Scanlon. In this deliberative process, a wide variety of factors are considered: moral theory, particular details, paradigm cases, information from policy boards or professional organizations, diverse points of view, and public input. From this style of reasoning, useful mid-level principles can emerge, providing justification for bioethical solutions and encouraging consensus, which can also play a legitimizing role in decision-making.

I conclude that this inclusive kind of deliberation is more likely to occur at the level of the professional organization or the national commission, where broad diversity in participation and information, as well as public input, can take place. Decisions or principles achieved from this wider level of discourse will be more legitimate and can then be used to guide ethics committee members functioning at the private level.

JUSTIFYING BIOETHICAL CASE DECISIONS:

REFLECTIVE EQUILIBRIUM AND MID-LEVEL MORAL PRINCIPLES

by

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To Aishe Kader, Mildred Stowe Anderson, and my supporters,
Omar, Tarik, Gabriel, Aron, and Jacob

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INTRODUCTION

Bioethics is more than an abstract investigation of the moral problems arising in medicine and health care; it is also a practical enterprise intended to offer solutions to real cases, and to provide a guide to action in particular situations. Health care professionals, their patients, and those associated with their cases must make considered and acceptable decisions about medical treatments and options in practice settings where value-laden conflicts are involved. Some conflicts can be easily resolved while others may be so difficult as to require legal adjudication, but to be credible each case resolution must be backed up by moral reasoning. It is the duty of bioethicists to offer validation for their decisions and to defend their actions by providing ethical justification.

However, identifying a specific theory, a method, a principle, or a process by which to justify specific bioethical decisions has proven difficult. Some bioethical problems are rare but urgent; that is, they arise out of active circumstances in which the decision-makers must act without taking time for consultation or reflection. Other problems are novel; that is, they present themselves to decision-makers without precedent. Disagreement about the best approach for problem-solving abounds, although it is generally agreed that examining cases through the lens of traditional moral theories has not proven satisfactory, since they often produce conflicting solutions. Over the past twenty-five years, the literature in the field exposes increasing interest in generating and selecting appropriate methods for confronting bioethical decision-making. The proponent of each new method hopes to show that its use might work to better deliver more consistent, thoughtful, supportable and morally acceptable answers. It is thought that the implementation of a correct method can in itself yield justification for the so-

lutions it produces by the way reasons and principles are elicited from its use; however none of the current methods has yet proven reliable in generating acceptable results in practice.

The most supportable bioethical decisions are not necessarily delivered by following an idealized step-by-step method. I believe they are more likely to emerge procedurally, in a process of moral reasoning where more attention to context and detail takes place and where diverse points of view and public input are included. In this dissertation, I show that building support for these judgments is a complex enterprise, assembled upon a mutually supportive set of moral reasons, beliefs, and principles. The specific method used is not as important as the support structure that backs up the decisions and actions.

Certain backing principles stand out as most useful in providing a foundation for this justificatory structure. I call them mid-level principles, because they are specific to problems in biomedicine and are derived from and relate to actual issues that have arisen in the health care arena. Statements such as "always protect the privacy of the patient," "always obtain informed consent," or "do no harm," are examples of such principles. Even more specific situational rules, such as the set of physical criteria for brain death used to validate non-resuscitation policies and the specialty-specific rule that "reproductive medicine may not be used for sex selection" (to choose the sex of one's child) are good examples of mid-level principles. Maxims and rules of this nature, while not necessarily morally explanatory or complete, serve to organize responsive and practical reasons to back up bioethical decisions. These types of mid-level principles have status in biomedicine, because they often carry a scientific basis or be-

cause they are derived from the experiences and deliberations of professional experts and supported by their professional organization. If a judgment violates one of these principles, it is apt to be more controversial and less likely to be taken as valid.

However, in practice it can be difficult to identify and extract the most appropriate and useful principle to apply to the particular case at hand, because several might fit, or seem to apply to certain cases even while conflicting with one another. Sometimes the principle might prove too vague to provide a specific answer or too general to give a meaningful answer for a particular case. Even worse, the citing of a mid-level principle can provide a sense of justification to a decision which is nonetheless wrong. This is why the mid-level principle is useful as a basis, but must be supplemented with moral reasoning to create broader explanation for specific case problems.

The most solid of these principles are those that are developed out of a great deal of experience and put through the public and legal debate generated by controversial cases. For example, the importance of "advance directives" or "living wills" as tools of patient autonomy in matters of fulfilling choices on death and dying evolved out of the now familiar cases of Karen Quinlan in 1976 and Nancy Cruzan in 1983. Over time they became firmly established as basic to bioethical decisions in similar cases, although controversy has not been eliminated.[1]

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[1] See Gregory Pence's *Classic Cases in Medical Ethics (1*995) for a case-oriented text in which the full array of developments in well-known cases leading up to the development of new mid-level principles is presented. In particular, the Quinlan case of 1976 was the first to legally allow the disconnection of life support to a comatose patient as an extension of an implied right to privacy. In the Cruzan case, the Supreme Court in 1990 recognized the right of a dying patient to refuse life-sustaining medical support based on prior intent (3-33).

In this dissertation I review the various methodological approaches and argue that although each has positive features, none are reliable producers of consistently valid results. One possible reason for this is that there is no such thing as a valid answer, fully justifiable, in the arena of practical ethics, because each case displays its own unique set of characteristics, important to different people in different ways. The methods reviewed here are theoretically interesting, but ill-suited for the daily immediacy of problems facing clinicians because sometimes they deliver logically sound, but not necessarily reasonable or practical solutions. For example, if following a deductivist perspective, one might insist on absolute confidentiality at all times, although the public good could sometimes require a breach in that principle. In other words, context and circumstances make a difference. On the other hand, one might follow a less stringent contextual or principle-based method only to find that they can deliver plural answers, often conflicting with one another, making it difficult to assess the overall "validity" of the ethical judgments.

The problem is not inherent in any specific method, but lies in the structure of justification itself. Better results occur when reasoning is built over time, incorporating multiple styles of reasoning, made available for public scrutiny and including diversity in public input. Bioethical decisions are most supportable when built by this sort of procedural structure rather than when deduced or inferred by a specific method, because they garner wider support from more diverse sources. In general, the enterprise is most closely related to the process of reflective equilibrium, developed by John Rawls, where useful mid-level principles are said to emerge from deliberations in which contextual details, paradigm cases, and an array of applicable higher level

moral principles are all taken into consideration in a revisable process.[2] The results are defensible by their inclusion in a framework of mutually supportive reasons, beliefs, and explanations. Many of the current methodologists have recognized how the incorporation of a Rawlsian process can lead to a firmer sense of support for outcomes. However, I argue in this dissertation that the procedure can be augmented by employing ideas from the work of T. M. Scanlon. His model of reflective equilibrium, referred to as "deliberative processes," differs from Rawls's by emphasizing the social and public aspects of the inquiry at stake while relying on practical reasoning based in human cooperation and the need for human interaction.[3] This Scanlonian reflective equilibrium, as I refer to it in the body of the text, is not a method as such, but a style of reasoning that in practice encourages the development of the most defensible judgments, especially when undertaken at the widest levels of discourse, both professional and public. These judgments then filter down to provide the basis for daily decision-making at the clinical level.

It is important to note that using such a broad style of reasoning to examine problems in biomedicine is not practical at the clinical level, in my estimation. When novel questions arise that have not yet been pressed through this process, clinicians find ethical judgments more difficult to make, less useful, and less valid overall. Furthermore, clinicians at the bedside or outpatient level do not normally have much time to consider the problems they confront and generally have no experience in ethical de-

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[2] John Rawls sets out this approach to moral justification in *A Theory of Justice*, 1971.
[3] T. M. Scanlon's *What We Owe Each Other*, 1998, is devoted to showing that moral solutions in general (not only bioethical decisions) are most justifiable when they are backed up by socially shared moral principles, produced by reasonable people motivated by mutual interests.

liberations of the broad nature discussed here. In this dissertation I give many examples of the difficulty in doing ethical deliberation at the clinical level.

In general, I argue that better deliberations at the level of national commissions, professional organizations, and public bodies will promote better problem-solving to pass down to the more modest level of the practical decision-maker. Those higher-level deliberations ought to follow a model of Scanlonian reflective equilibrium that I present here.

I set out my case in three sections. First, in Part One, I evaluate the well-known methodological approaches, pointing out their strengths and weaknesses, while documenting the benefits of the coherentist approach, where moral answers emerge and justification for them is forged by a process-driven system of reasoning.

In Part Two, I present in detail the activities of an ethics committee, at the level of the doctor's office, or inpatient clinic, as it works to resolve problems presenting in the practice setting of assisted reproductive medicine. My research is unique in documenting how ethics deliberations actually transpire in this basic level of a clinical setting, and in noting the techniques used by untrained clinicians in decision-making.

The practice of assisted reproductive medicine (referred to here as ARM) exists in a climate of highly technical and innovative privacy, unregulated by the federal government. The treatments and techniques in this specialty are generally unpublicized unless some new practice makes news. Because this work occurs at the level of the private outpatient clinic, it carries no formal duty to be ethically reviewed; physicians engaged in private practice are expected to comply with basic professional standards, but are not required to subject their professional decisions to the review of

others. It is unusual to find a private practice that voluntarily subjects its internal decisions to an ethical case review mechanism. Thus I was lucky to participate in and observe the activities of one such ethics committee at a private suburban ARM clinic for several years, documenting the methods, principles, and rules by which it generated decisions. My primary goal in this section is to describe and analyze the committee's processes of clinical deliberation, illustrating its dependence upon mid-level principles passed down from higher level decision-making bodies, usually the professional organization or the expert commission. Although the clinical participants of the committee worked diligently to establish their own internal rules, apply ideas taken from paradigm cases, and elicit professional policies to ground their decisions, they faced difficulty in setting out consistently defensible decisions, especially in novel situations. Specific actions in similar cases were not always internally consistent; furthermore, they also sometimes varied from the recommendations of the professional organization. This, of course, does not mean they were wrong decisions, but it serves to illustrate the difficulty in finding principled reasons for moral judgments in real cases with practical implications. The lack of a larger context for case evaluation and comparison caused the group to look outside itself for useful principles and policies, rather than to seek a formal method or system of discussion internally. Citing appropriate mid-level principles to back up a decision or action was sometimes impossible at this level of deliberation; the participants needed more ready-made, previously worked out guiding principles to structure their discourse.

The most common problem in this ethics committee was to formulate explanations or defenses for rejecting treatment to a client. Members of the committee fre-

quently resorted to a barely articulated emotion, expressed as the "yuck factor." This led me to add in this section an analysis of the work of one of the foremost critics of the science and practice of fertility medicine, Leon Kass. His arguments against common ARM practices (such as in vitro fertilization (IVF) and embryo manipulations in general) have rarely been accepted by the public, or at least have had little effect on curbing the practices, but continue to force extensive public debate as to their overall value. His writings give voice to the "yuck factor" and provide an example of how negative public input and dissent is important in shaping the basis for effective justification, whether accepting or rejecting specific treatments or practices.

Finally, in Part Three, I set out in more detail how my account of Scanlonian reflective equilibrium can best allow for a model of the deliberative process that can expose unjustified decisions or build and deliver a fuller, more complex, and more coherent structure of justification. Here I show how certain background assumptions and styles of decision-making can serve to cloud the larger moral issues. In the activities of the clinical bioethics committee (examples presented in Part Two), certain worries about negative publicity, personal reputation, and a desire to avoid grappling with moral abstractions outside of their medical expertise caused inconsistencies in decisions and difficulty in stating defensible reasons for their actions, although to be sure most of the decisions were fair and thoughtful. I show that their reliance on expert advice from higher level ethics commissions and policy boards exemplify the value in having access to a body of general decisions worked up in a broadly based public and expert framework, so as to provide better policies for the lower level private practitioners to rely upon.

I conclude that Scanlonian reflective equilibrium is the most effective way to secure morally justified results because it can obtain the fullest base of support. It works from the case-specific level up to a more general, principle-based response by taking into consideration the larger moral principles at stake, the social goods, and the opposing viewpoints that might affect overall reasoning. Furthermore, it allows for local judgments and a great deal of range in admitting pertinent information, with flexibility in determining the scope of the problem at hand, so that the correct mid-level principle can emerge from discussion and not be applied by rote. Here I emphasize the value of publicity in making the content and scope of the debate open to all points of view. It is within the full process of reasoning that a moral account is created that can buttress the associated ethical decision or action.

The overall approach is procedural, emphasizing a plural, rather than individual, structure of justification and insisting that a broad range of theories, principles, practices, viewpoints, and experiences work together to create majority viewpoints on important moral issues (although rarely can full consensus be expected), while incorporating concerns for human rights and goods and discouraging human harms.

However, expecting this complexity in deliberation is more than can be usually provided by a localized, clinic-based ethics committee; it is more plausible at the professional or national commission level where more diversity in views and backgrounds can be included.

PART ONE

PROBLEMS IN DERIVING MID-LEVEL PRINCIPLES

CHAPTER ONE

THE RANGE OF BIOETHICAL METHODS

As bioethics has emerged as a field over the last thirty years, various practice

models have been introduced, each attempting to provide a method by which to pro-

ceed in the actual problem-solving activities demanded by the increasingly technical

and difficult biomedical cases emerging in our scientific age. However, these models

are usually discussed in the abstract, but rarely observed in practice. The cases they

purport to solve are usually after the fact discussions of well-known incidents. And yet

most bioethical decisions are made at the ground level: the hospital bedside or the doc-

tor's office. Only when controversies develop within the health-care system are some

cases elevated to higher-level discussion, either at the hospital ethics committee re-

view or legal review. Only rarely do cases in the private physician's office become

subject to public controversy; and yet, this is where many novel cases are seen and

where the first steps in moral adjudication are taken. Clinicians are rarely trained in

ethical methodology and no specific approach to problem-solving is taught, even

though hospitals in the U.S. are now mandated by their accrediting organization to

conduct ethical reviews of difficult cases. In any event, no clear method has emerged

as the most effective way to proceed.

In a very general way, the various methods, and the techniques supporting

them, are often categorized by philosophers in the field into three types: deductivist,

contextualist, or principlist.[4] However each method, whatever the type, depends on

the use of tailored mid-level principles, sometimes employed deductively as a starting

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[4] See Norman Daniels "Wide Reflection Equilibrium in Practice" (1996) for an overview of the types of
approaches and how they compete for priority in the field.

position for working out a solution, or after the fact as a means of justification for the results.[5] In theory, each type of method provides defensible ways to deliver ethically based medical decisions, but in practice, each has proven difficult to employ. When a mid-level principle is applicable to a case and simply needs to be brought to bear, then any method might appropriately be used. But in more novel cases, or cases with unusual circumstances, in which a group finds itself unable to generate an appropriate principle, the use of a method, in and of itself, doesn't seem to offer much assistance in moving forward, and without locating a principle, deliberators feel unsure that their decisions are ethically sound. In this chapter I describe the prominent methods and their advantages and disadvantages.

Deductivism

The first category, deductivism, relies on the notion that justified moral judgments are derived from applying a theoretical moral framework in a "top-down" sort of way. Proponents believe that a localized moral problem can't be solved in isolation from the larger, more universal moral framework under which the case ought to be subsumed. Here the moral principle precedes the case. Traditional moral theories (such as consequentialist, deontological or virtue approaches) are emphasized, because

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[5] In this dissertation, the term "mid-level principles" is meant to apply to the specific rules and maxims that are used to defend practical decisions in bioethics, as opposed to grand principles in ethics like the utility principle. Examples range from broad statements like, "Do no harm," "Don't deceive," and "Respect the autonomy of others," to more detailed and scientifically developed "standards for brain death" used to make medical decisions about withdrawing feedings or transplanting organs or the rules for obtaining "informed consent" so as to prevent violation of human autonomy in medical actions. These mid-level principles are basically formulized reasons set out to defend decisions. These precise formulations carry great weight in justifying bioethical decisions, because they are taken as akin to statements of fact about medical justification or as providing proven ethical reasoning for treatment decisions.

it is assumed that the maxims and rules that make up a complete moral system are applicable to bioethics, just as they are to any other moral endeavor.[6]

As David De Grazia put it in an often cited 1992 paper (well known for its analysis of the various bioethical methods), the use of a comprehensive moral framework can produce the best-supported outcomes (not necessarily best outcomes for those involved but best supported analytically) because the applicable principles, as derived from the theory, are applied to specific cases in a logical way.[7] Such a framework is successful when it is complete enough so that no reliance on moral intuition is necessary, because critics emphasize that intuitions are often in conflict on important social matters and can produce no firm basis for their inferences (512).

However, deductivism, in this strong form, has been claimed to be irrelevant to bioethics because it has not shown itself able to provide unifying answers, either in specific case problems, or for larger social debates, for three reasons. First, squeezing the details of cases into a fit with the larger theory is inherently difficult. Abortion debates, for example, might take the most important feature to be the problem of "killing" an infant, or they might take a different feature as most important: the presumed right for an expectant mother to make decisions over her own body. Second, different moral theories can offer different answers to the same problem; for example, one theory might consider goods more important than rights.[8] A third and more basic reason

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[6] This is often described as a 'top-down' approach, because an overriding principle, such as "maximizing utility," is applied to a problem. See more on the distinctions between top-down and bottom-up methods in Daniels: "Wide Reflective Equilibrium" (96-100). Also, on the ambitious nature of attempting this approach as public policy, see Kymlicka (245-250).

[7] See De Grazia's 1992 "Moving Forward" (511-539) where he promoted the use of mid-level principles in an overall coherentist scheme.

[8] For example, in the well known problem of paternalism in medicine, a consequentialist approach might support lying or misleading a patient about her prognosis for the sake of protecting her, hoping to

for the failure of deductivism in bioethics is that general theory is thought to be too remote from actual cases, where specific facts lend particular details to situations, so that the use of an overriding or general principle cannot be adequate to cover any group of similar cases even if such a general principle could be developed, because of the way slightly different features, or a peculiar emphasis on some features, tend to vary in individual cases. Nevertheless, some versions of top-down, or deductivist, approaches retain a place in the current debates over the merit of the various bioethical methods.

The best-known proponents of deductivism are the team of K. Danner Clouser and Bernard Gert, whose approach is tempered by an attempt to integrate moral theory with common sense morality. They insist that less deductive methods are apt to ignore a moral imperative that calls for ethical decision-makers to be impartial, rational agents who accept universal moral rules if they are to be taken seriously. Clouser argues that bioethics is not a special arena of morality in which the provisions of universality and impartiality can be rescinded. Of his and Gert's standpoint he says:

> Ours is a general ethical theory rather than one that is articulated specifically for biomedical ethics. We regard this as a strength of our approach since it shows the unity of all of morality and does not involve questionable ad hoc constructions specifically created for biomedical ethics (Clouser 1995, 226).

While stressing universalizability, they anticipate exceptions, although those must follow the rule of being logically extractible from a generalizable public system. Clouser

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promote the overall good, while a deontological approach might focus more on the right of the patient to know the truth even if immediate suffering is caused. See Jecker (113-124) for a discussion on the advantages and disadvantages of deductivism and foundational theories in bioethics.

describes morality as a system where violations of the rules are only permissible when exceptions are publicly and consistently applied.

The benefit of such a firm system is that the answers are justifiable by its foundationalist supporting framework; in other words, ethical decisions are justified by the basic structure of the moral system from which they are derived. Foundationalist accounts of morality provide the strongest support for moral judgments in a logical sense, but at the cost of individual suffering, when a specific case is forced into an unsatisfactory decision as a result of the "one size fits all" requirement. As a theoretical method, the answers seem to ensure certainty, but as a practical method it does not offer necessarily correct solutions to real problems, because the structure itself can vary so widely – not only from consequentialist to deontological, but perhaps even to some version of natural law – all of which produce various results. Benjamin Levi pointed out in 1996 that deductivist approaches in bioethics are "easy to dismiss" because "even the most simplistic theory can generate answers. What we are looking for are reasons to believe that a particular deductive theory is valid" (11).

Furthermore, the judgments derived from deductivism are not always as clear, specific and useful as advertised because, as De Grazia puts it, "deductivist theories (including those limited to some specified domain) are indeterminate. That is, even with knowledge of relevant facts, deductivist theories cannot determine an answer for each moral problem" (1992, 514). It is not always possible to achieve consensus, even within groups who share similar deductivist belief systems.

When discussing deductivist theories in the abstract, it is easy to miss another reason for their lack of success: the difficulty in producing or arriving at a useful and

specific mid-level principle to apply to a specific case, presumably deducible from the general theory. Clouser and Gert have attempted to actualize their project by providing a list of rules as stand-ins for their whole system, presumably to be used by actual committee problem-solvers. These rules are meant to finesse the problem of deriving mid-level principles, but it is unclear how they break down into specific and helpful maxims for solving particular cases. Each rule is a general directive derived from one large overriding principle of avoiding harm against human beings in general, such as "Don't kill, "Don't deceive," "Don't cause pain," "Don't break promises," (Clouser 1995, 230). However, it is not set out clearly how one should decide whether "Don't kill" precludes abortion, or whether "Don't deceive" determines how much information to give a patient in terminal episodes of illness. It is simply not clear how Clouser and Gert's rules can lead to an appropriate principle or maxim by which to solve this problem, especially if the maxim is intended to satisfy the particular needs of the patient or her extended family, or more universal expectations of the medical staff, on to the public at large. As Andrew Lustig said in his 1992 critique of Clouser and Gert's approach, "Any judgment Gert renders is likely to be ad hoc at worst, merely empirical at best, and thus hardly compelling to all rational impartial observers" (509). This explains why deductivism in general is thought to be impractical. Instead, bioethicists have shown more interest in the other end of the spectrum: taking the particular details of cases more seriously and assessing cases individually. This approach is referred to as casuistry.

Casuistry

Casuistry, in the generic sense, is supposed to be a means of developing the reasoning for a case decision over time, by immersion into the particular circumstances of a case. Pertinent principles are thought to be disclosed as they emerge out of deliberating in context about specific and particular details. Here, instead of beginning with an ethical theory, principle, or set of rules and applying them top-down, the proper starting position is to sort out the relevant aspects of the case at hand, identify the moral issues at stake, and then reason upwards toward capturing an appropriate principle or value that might back up, or justify, the decision. As the factual details are filled out and amplified, the most accurate maxim or mid-level principle takes on weight, so that in the best case scenario, conflicts between principles are overcome. Defenders compare the process to that employed in the legal system where precedent and paradigm cases assist in deriving the most accurate way to support decisions for specific cases.

Leaders of this approach are Albert R. Jonsen and Stephen Toulmin, who published their main defense of casuistry in 1988.[9] Jonsen argued more recently (in 2000), that they had "hoped to 'resuscitate' casuistry from the disrepute and neglect that had almost deprived it of a living place in moral reasoning." The two were opposed to what they called "the tyranny of principles," particularly the popularization of the set developed by Beauchamp and Childress (which will be presented here shortly). But more recently (in 2000), Jonsen had come to realize that the two had left the im-

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[9] Besides Jonsen and Toulmin's *Abuse of Casuistry* in 1988, see Toulmin's historical overview adapted for Jecker, Jonsen and Pearlman in 1997 (101-109), and Jonsen's condensation of his 1986 overview in the same volume (158-161).

pression that they "rejected principles as an integral part of moral reasoning." This impression was wrong, he said, because the two had, in fact, intended to "restore" a fuller picture of moral reasoning, while emphasizing the importance of particular circumstances as the "foreground" of the total picture, but not totally displacing the "relevant maxims and principles in the midground and ethical theory and cultural ethos in the background" (Jonsen 2000, 349-350). The reason for the priority of context and circumstance was to ensure that appropriate backing principles were developed, but not forced onto situations.

Casuists complain that the advocates of principle-driven approaches to cases cannot explain why certain principles should or should not apply or have or have not emerged as the prevailing explanation for various results. They have further pointed out that the leaders of principled methods, specifically Beauchamp and Childress, have problems in defending how ethical principles are supposed to give authority to case decisions. In the prominent 1989 text written by Beauchamp and Childress, the door was opened to admit various weighting schemes as an answer to the questions that had been raised by the more contextualist proponents of casuistry. The two admitted that various interpretations, definitions, weighting schemes, and the level of stringency applied to the "relevant moral terms" would affect the choice of moral principles used for decision-making (5). Jonsen complains that this uniqueness of circumstance is too often overlooked by those who should know better, since philosophers ought to take circumstances seriously and refrain from collapsing similar cases into exactly the same categories. To be similar does not mean to be exactly alike according to Jonsen al-

though it isn't clear how similar contexts must be related to one another to forge a unifying relationship to any specific moral principle (1996, 38).[10]

For casuists, principles are important in the abstract, but they do not stand alone in providing substance or direction to moral decision-making. As Jonsen explained, "Circumstances are not, as the etymology of the word suggests, things that 'stand around'; they are as integral to the moral analysis as are the principles" (40). Instead of assuming that consistency requires that similar cases should have similar solutions, Jonsen noted that even in the soundest of reasoning, multiple conclusions are possible, necessitating more complex reasoning in order to attain the best outcome in each particular case. A particular case could be so singular as to require its own applicable maxim rather than be subsumed under a more general principle.

In casuistry, maxims are developed out of the specifics of contextual details, in other words, from the bottom up. Although all bioethicists rely on "cases" to define and refine their approaches, casuists like Jonsen take each case and associated maxim as distinctly individual:

> [Maxims are] expressions of moral or prudential advice; the circumstances were the existential facts being addressed in the case at hand. Out of these two materials the minor arguments were constructed…I am certain that ethical evaluation of cases very often, if not always, dwells upon these minor arguments rather than on the grand arguments of principle. (43).

Defenders of casuistry believe that it offers a more realistic method of how cases are decided in real-life situations, with an added benefit of modesty. It does not claim status as a theory but remains grounded as an inductive method, enabling it to remain

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[10] See Jonsen's defense of moral circumstances in the 1996 collection *Philosophical Perspectives on Bioethics* edited by L.W. Sumner and Joseph Boyle.

somewhat exempt from debates about "grounding," whether and how its results can be justified. At the same time, it can join with most of the other methods in claiming to be a sort of coherentist project. Jonsen suggests coherentism is the basis for defending his work:

> Moral judgment is a patterned whole into which principles, values, circumstances, and consequences must be fitted. The particular judgment itself must be fitted into a larger set of judgments about moral suitability of behavior and practices. Fittingness suggests how we 'morally appreciate' the circumstances of a case…Principles, values, circumstances and consequences must be seen as a whole. The judgment about them comprises all of them (45).

Carson Strong, a supporter of casuistry, states that a primary benefit of casuistry is its ability to detect the morally important features of specific cases as it works to form comparisons with more general paradigm cases. As an essential technique of casuistry, this allows for a thoughtful process of locating the most useful backing principles from among a variety of conflicting possibilities, all of which might apply to the case, until a degree of resolution has been reached. Resolution occurs when a comfortable fit with a paradigm case and an assessment of the level of any related harms and suffering that may be applicable to *this* specific case has been accomplished. The problem is that more than one justificatory principle is available in many cases, and different scenarios can produce conflicting decisions, although the correct path is said to emerge from deliberating over these sorts of details. However, as Strong admits, the justification for each decision is bound to its particular case, and cannot necessarily be generalized to other similar cases, making for a weak foundation. Casuists intend that their solutions gain validity by the reasoning used and the analogies to paradigm cases, but not be held accountable to absolute consistency. Strong describes the process as

one in which argument makes it "reasonably clear what course of action should be taken" (2000, 331).

However, the problem for Strong, and for casuistry in general, is that there are many cases in which, as he admits that casuistic factors "can vary from case to case" so that "casuistry simply does not provide an answer" (331). One reason for the possible variance in outcomes is that morally defensible reasons vary among fair-minded individuals and weighting facts differently can as easily lead to moral deadlock as to moral agreement.

A second, more technical problem for casuistry is that paradigm cases don't always exist to enable the procedure to take shape. It is much easier to work out a moral decision when it can be based on history, both legal and social. However, novel cases underpin the study of bioethics; new technology and research create new types of cases over time, necessitating the creation of new paradigms. How is one to begin the deliberations toward applicable moral principles in a contemporary case in which a woman became pregnant years after the death of her husband by use of his saved and frozen sperm, or where a divorced couple cannot reconcile the ownership of their created and frozen embryos? The reason these new cases make headlines and are difficult to solve is that they haven't previously been put through a private or public process of moral examination so that some reasonable paradigm stance can be established.

A third problem for casuistry, one mentioned by De Grazia, is that by its dependence on paradigms and previous moral reasoning on issues, it may be too accepting of current beliefs and practices, thus uncritical of the status quo. If casuistry

depends on practical wisdom, a sort of intuitionism, to determine which ethical norm applies to which specific case, it is weakly grounded to be sure, although, in fairness, that problem can be said to apply to deductivist methods also. However, according to De Grazia, casuistry is particularly "rooted in traditions and practices, not in pure reason or a special faculty of moral intuition (516). Associated with this concern is that the focus on specific cases encourages the casuist to miss the more global aspect of bioethical problems, such as organ selling in the undeveloped world, or environmental concerns worldwide as they relate to health policy, or the moral status of under-represented minority groups, as in ensuring the representation of women in research medicine.

Strong accedes to the need for stronger justification in casuistic ethical decisions through an appeal to moral principles as well as through analogy to paradigm cases, and also by ensuring that the judgments are upheld by discursive argument. He insists that,

> No casuist in bioethics has argued for ethical reasoning that fails to consider principles, rules, and the plurality of ethical concerns relevant to biomedicine...There is no need to assign an epistemic priority either to judgments about cases or to principles (2000, 337).

However, it can be said that the role of principles, as well as the means of locating correct principles for individual cases, is underdetermined by this method.

Principlism

The lack of acceptance of both the overly deductivist theoretical approach and the inductive casuistic approach helps to explain the popularity of "principlism," wherein specific mid-level principles are thought to enable practical, but well sup-

ported, case-solving.[11] Principlism usually refers to a set of four mid-level, but general, principles: autonomy, beneficence, non-maleficence, and justice. These were disseminated by Tom L. Beauchamp and James F. Childress as tools for identifying and solving bioethical problems, although the term has grown to be used more or less expansively to encompass all principled, but less deductivist means of bioethical problem-solving. Principlism is the best-known method, due to its brevity, clarity and ease of use, and perhaps more theoretically, because it is the main proponent of coherentist justificatory standards for verifying its results.

Continued interest in principlism derives from the likelihood that mid-level moral principles, extracted from common sense morality, are more useful for decision-making than the deductive attempt to apply theoretical principles. The specific set of four mid-level principles are thought to provide a comprehensive and universally acceptable set of tools for grounding decisions while avoiding the inconclusiveness and the abstract nature of deductivist theories. The principles are not only supposed to lead to correct decisions, but to provide an ethical justification for the decisions, although admittedly not as strong a justification as might be possible if moral answers were derived from traditional theory. Nevertheless, when a good reason for action is backed up by one or more of the principles, it is thought to provide validity to practical solutions, especially in the everyday, pressure-filled necessity to resolve biomedical cases.

The original proponents of principlism, Tom L. Beauchamp and James F. Childress, first published their method in the well-known *Principles of Biomedical*

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[11] The term "principlism" is intended to apply to a principle-based approach to bioethics (usually the four principles defined by Beauchamp and Childress) and was claimed to be coined by Clouser and Gert in their 1990: "A Critique of Principlism" (219-236).

Ethics, in 1979.[12] The basis for the selection of their list of four overriding principles had emerged from a federal conference on moral issues in human experimentation in which Beauchamp had participated. The group's discussions were held at the Smithsonian Institution's Belmont Center, inspiring their 1979 report known as the "Belmont Report."[13] In the report, respect for persons (or autonomy), beneficence, and justice were set out as three foremost standards of reference for the solution of the bioethical problems at stake, specifically in the arena of research involving human subjects.

Later, as Beauchamp and Childress developed their more general version of these principles, they augmented the framework to add non-maleficence as a separate principle in itself (not just as the flip side of beneficence), because the notion of "do no harm" holds such a venerable position in medicine and consists of a demanding obligation in itself. They also expanded on the principle of respect for persons to elevate individual autonomy as a paramount ethical principle. Thus their well-known list of principles - autonomy, beneficence, non-maleficence and justice - have become the basic guidelines considered in practical bioethics, taught to health care professionals, and cited as justification for decisions. They have become such successful tools that they are often referred to as the "Georgetown mantra,"[14] to be recited whenever an ethical problem is up for debate.

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[12] The authors introduced their ideas in the first edition of *Principles of Biomedical Ethics,* in 1979, but their updated and expanded third edition, published in 1989, secured the place of principlism to the health-care community. Recently (in 2001), their fifth edition was published.

[13] See the discussion in Moreno's *Deciding Together* (86) about the activities of "The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research.

[14] Barry Hoffmaster said in 1991: "The influence of Beauchamp and Childress's view of what medical ethics is has been so great that those working in the field now talk about 'the applied ethics mantra,' i.e., the reverential intoning of their four principles" (231). For other references to the "Georgetown" man-

One reason for the popularity of the four principles is that they appear to not only offer justification for ethical decisions, but to support them in a practical way by encouraging group consensus more successfully than has been achieved by the advocates of more top-down or bottom-up practitioners, although it has been duly noted by critics that the consensus and the validation obtained by the reference to the principles is often shallow, as opposed to deeper commitments supposed to be obtained when ethical decisions are justified by principles derived from abstract ethical theories. Nevertheless, a decision that is backed up by one of the well-known principles, and then further supported by group consensus, is certainly more supportable than one having no justificatory back-up at all, especially when practical decision-makers, in the heat of medical practice, are generally unprepared to cite ethical theory or sit through a drawn-out, casuistic type process.

Beauchamp and Childress suggested that even as the mid-level principles work to justify a moral decision, they are themselves justified by higher-level ethical theories, adding another layer of justificatory support. The authors introduced their principles as general enough so that both rights-oriented, deontological perspectives and goods-oriented consequentialist perspectives could be encompassed by the overall method; neither approach is considered superior to the other, but neither is totally ignored. In fact, they stated in their book that one of the authors considered himself to be a rule-utilitarian, while the other claimed to be a rule-deontologist, causing no problems in application of the principles (1989, 44). One supporter, Robert Veatch, argues

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tra, see Jecker et al (147); De Grazia, "Moving Forward" (518); Hoffmaster (4); and Moreno, "Deciding Together" (76).

that the principles can be thought of as means of bringing both of the predominant

ethical theories to bear on problems:

> Some principles, such as *beneficence* and *non-maleficence*, identify the maximizing of good consequences and/or the minimizing of bad ones as right-making characteristics of actions. . . . [Other principles] focus instead on the formal structure of the action or rule…these nonconsequentialist principles are related to formalism or deontological ethics (1995, 200).

Beauchamp and Childress's intent was to offer a "composite theory," in which the

four principles were to be each taken as binding but none would have priority over the

others, so that they would serve as surrogates for consequentialist or deontological

theorizing. The authors' reasoning seemed to be that the principles were general

enough to be flexible and yet comprehensive enough to stand in for broader theory, al-

lowing deliberative outcomes to take support from the idea they were backed-up by

this composite theory, even though no specifics were cited and no method given abso-

lute authority. Thus they avoided the sense of requiring any deductivist application of

theory and didn't have to take a stand on the major ethical theoretical standpoints.

Besides this somewhat obscure justificatory appeal, the principles were popu-

lar because their intuitionist basis appeared to allow experience and common sense to

be used as modifiers in interpreting how they were to be applied. Supporters have

taken the intuitionist basis as offering a non-deductive but relatively clear basis for

moral reasoning, because of its reference to a sort of dialectic between moral experi-

ence and moral theory, while critics see the same intuitionist foundation as a weakness

since it suggests, in the words of Andrew Lustig, "principles and rules themselves are

somehow 'obvious' at the moment of moral insight and decision" (49). If moral deci-

sion-making were 'obvious,' then the moral differences noticeable in the various solutions to so many bioethical cases would disappear. However, the intuitionist project has deep appeal to critics of foundationalist projects, particularly relativists who doubt the human ability to step outside their culture in order to take an objective moral standpoint. As Benjamin Levi points out, human moral capacities to identify and deliberate about moral problems vary and may be therefore founded in our social lives. He sees this as a benefit of principlism:

> It is in part this very recognition of incompleteness that distinguishes principlist theories from deductivist theories. Most principlists recognize that we must rely on intuitions at some point and freely admit that in a secular pluralistic society it is important to subject how ethical principles are interpreted and applied to a dialectical process of emendation (18).

Of course, this positive benefit of the intuitionist basis for principlism is also its weakness when one questions why the four principles are the only ones that have emerged as important to bioethical decision-making. Levi points out that certain other widely known principles, for example, the principle of "care," have been excluded from the mantra, causing criticism by proponents of such views.[15]

Some supporters promote principlism by pointing out that it is not deductivist in its application, in spite of its elevation of four predominant principles, allowing contextual (casuist) decision-making into the process. Although theoretical underpinnings are cited as justificatory support, they do not seem to be required as basic to the actual use of the method. As De Grazia said, "It [the principlist method] acknowledges the lack of a supreme moral principle or set of explicitly-related principles from which all

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[15] See Levi 1996, pp. 16-19, for mention of these criticisms, for example, the exclusion of virtue and other ethical approaches from the principlist list.

correct moral judgments can be *derived*" (1992, 523). To Beauchamp and Childress, each principle was set out as a prima facie duty, and yet they acknowledge the necessity for one or more to be overridden on occasion due to circumstances, to be taken as action-guides rather than rules. As they said:

> A composite theory permits each basic principle to have weight without assigning a priority weighting or ranking. Which principle overrides in a case of conflict will depend on the particular context, which always has unique features (51, 52).

The advantage of this approach rests in the flexibility and allowance for those casuistic, case-specific details to take their place in the process. But the flexible, free-floating nature of the principles also has a cost: how can one determine the weighting scheme for the principles, or determine which one should override the other, in cases where they conflict? Beauchamp and Childress tried to solve this problem by providing a list of conditions meant to assist in comprehending how their procedure worked, although the conditions do not necessarily provide the clarity required for actual practice.

The main criticism of principlism is that it is ineffective in situations where the various principles collide, offering different possible outcomes for the same problem or arguments about which principles should supersede the others. This can produce a classic dilemma: often the application of beneficence clashes with autonomy causing contradictory resolutions to a case. Furthermore, principlism's defenders have not shown how more specific, mid-level principles or rules can be derived from their abstract initial "first" principles, especially in novel bioethical cases and situations. Conflicting solutions can be developed without violating any of their conditions, espe-

cially by variances in how much weight to give each principle at any one time or for any one case.

Richard Davis states that the principles cannot be effective surrogates for moral theory if each stands alone; instead, they must function in an inter-related system, or they cannot offer clear direction for moral action (89).[16] It appears that if the principles allow enough context, so that details count, they are not strong enough to be useful; if they are meant to be strictly applied, they conflict with one another. And if they stand as individual rules, they don't make sense as to why one is applicable and not another. Thus the strongest criticism directed towards the principlist approach is that the lack of a system for determining the weight of each of the four principles makes it impossible to determine how they should be applied consistently, allowing for the generation of several, possibly contradictory, moral conclusions about an individual case. Figuring out how the principles can be used to produce more specific mid-level principles, or how to use them to "specify norms" requires more explanation.

Specification of Norms

By 2001, Beauchamp and Childress recognized the need to "reduce the amount of intuition involved" in using their method (19). They also suggested that their "dialectical process" was backed up by an inferred use of "Rawlsian reflective equilibrium to add requirements of coherence" to the overall project (200, 15-21).[17] Admitting that their principles were light on content and might not satisfactorily re-

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[16] See Davis' article "The Principlism Debate: A Critical Overview" (94-95) for a discussion of the usefulness, or lack thereof, of these conditions in achieving clarity and direction for the overall method.
[17] See David De Grazia's assertion that reflective equilibrium underpinned the work of Beauchamp and Childress in his aforementioned 1992 article, p. 520. Also Norman Daniels discussed its use in detail in his 1996, "Wide Reflective Equilibrium in Practice" (96-114).

solve hard cases, they adopted suggestions presented both by De Grazia and Henry

Richardson, which attempted to define the weight and scope of the principles and tai-

lor them for use in individual cases.

Henry Richardson had shown concern in 1990 about how the abstract nature of

the four principles (or any general principles) could be narrowed into solving the re-

quirements of a specific problem. He agreed with De Grazia,[18]

> The idea is to think of principles and specification united. That would
> mean roughly, that a small number of principles – perhaps Beauchamp
> and Childress' four – would, through specification, branch into more
> and more specific norms, reaching down into judgments about specific
> cases (1992, 528).

Richardson's goal included the idea of moving beyond the top-down, deductive rule

application, or the alternative, bottom-up, balancing of principles schemes, and instead

consider how general norms could deliver guides to action by becoming more specific

to situations. He was opposed to the popular notions of "balancing" or "lexical order-

ing" of the basic mid-level principles as if one could find moral trade-offs among

them; instead he suggested narrowing the initial norm down into a more specific, but

closely related extension of the more general starting principle, to see how, for exam-

ple, autonomy could be detailed into helping to solve a specific case problem. For ex-

ample, if one assumes that it is wrong to withdraw hydration from a badly deformed

infant on the grounds of beneficence, a conflict arises if the parents believe they have

a right to make a decision to withdraw hydration. Following Richardson's style, one

could begin a specifying process which would lay out alternative thinking and add de-

tails about the child's suffering, chances of recovery and so on until a more specific

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[18] See Henry S. Richardson, "Specifying Norms as a Way to Resolve Concrete Ethical Problems," *Philosophy and Public Affairs,* Vol. 19 (Fall 1990): (279-310).

norm develops. Perhaps it would be wrong to withdraw hydration when suffering is apparent, but in *this* case due to an unconscious state, it could be permissible.

To Richarson, a specified norm adds such information as "where, when, why, how, by what means, to whom, or by whom the action is to be done or avoided," in a way so that the initial principle would not be lost, and the connection between it and the more specified maxim would be made transparent (1990, 289). This process seems to provide more clarity as to why one principle is used and another neglected, besides functioning as a "bridge between a general precept and a concrete case," according to Richardson. Specification allows for making concrete decisions without "generating unacceptable implications," or losing the "underlying motivation" and retaining consistency among a set of similar problems (283-284).

However, Richardson asserts that conflicting principles cannot be balanced in many cases, as if some middle ground exists (say between providing or withholding nutrition. for example), nor can weighting them offer a solution because each choice has opposite results. Here, one principle must be chosen over the other. In these tough cases, Richardson supposes that the ethical agent will be able to move progressively toward a reflective and specific action-guide by narrowing the more generic principles for each particular set of circumstances. In this way, Richardson hopes to have pushed the reader to consider the fact that most moral rules are non-absolute and not taken as binding until the context is understood.

Richardson further admits that very restrictive uses of moral rules are not reasonable because real life conflicts among moral rules are common, explaining why the qualifiers "most of the time" or "generally speaking" are so often used in prescribing

moral conduct so as to allow for exceptions." However, he believes the need for exceptions is lessened when "specifying" is adequately done because then "it will be sufficiently obvious what ought to be done" (294). He looks to reflective equilibrium as the basis for justifying these moral decisions because it allows flexibility in the application of his scheme of specification. He believes that his process of specifying is simply reflective equilibrium brought "down to the level of concrete cases" (300).

In the following chapter, I provide a broader explanation of coherentism, and more specifically reflective equilibrium, in this context to show how it offers a basis for justifying non-deductive moral decisions, whether casuistic or principlist, as in Beauchamp and Childress's and Richardson's styles of principle-based methodologies.

CHAPTER TWO

COHERENTISM

For a method of bioethics to be successful, we have now seen that it need not deductively produce moral absolutes. Instead it must achieve something more like reasonable moral accuracy along with public consensus or acceptance, because, like public policies in other fields, the results must be supported by good reasons and judgments and must be accepted by those individuals who are most affected if they are seen as valid over time. As Ana Smith Iltis stated in her recent (2000) introduction to a discussion of method in bioethics,[19] the attainment of "useful" judgments, not technically "true" or "right" judgments, is the primary goal, because the judgments not only impact real people in an immediate way, but also occur in real public settings, rather than in academically abstract arenas. She calls for a "step away from theory" and toward "choices, decisions and actions" because to many participants, "bioethics is about resolving cases in ways which can be justified to those involved but not in ways that are necessarily right." (272-273).

It is this practical approach that has encouraged interest in coherentism as a basis for justifying the approaches of most methodologists in the field, whether contextualist or principlist. Deductivist methods are supported by a foundationalist structure in which their rules and maxims are derived from some core, foundational principles or beliefs giving justification, if not certainty, to their solutions to moral problems. The advantage is that the suggested action is supported by the citing of a more basic

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[19] Iltis was promoting a special issue of *The Journal of Medicine and Philosophy* that was devoted to this subject in June 2000. The participants referred to by Iltis in this citation include Tom L. Beauchamp, Albert R. Jonsen, Carson Strong, Bernard Gert, C. Culver, K. Danner Clouser, and Henry Richardson.

and general principle. However, as I have already shown, even deductivist solutions can be thought wrong when different perspectives toward basic principles are at stake, or when the impact of the application of the principles on the afflicted person and family cause contradictory responses.

Coherentism is a distinctive and acceptable alternative to foundationalism in bioethics, because the justification for a moral decision is based upon a wider array of reasons. In coherentism, a belief (or an action) is justified by assessing how it fits into a whole system or web of beliefs and how they interrelate. Features such as consistency with other held beliefs, connections to broader theoretical concerns, supporting links to the reality of known good or virtuous outcomes all work to add support to one another in a justificatory circle. In coherentism, the work to justify moral judgments does not only go from top-down (principle to application) but also bottom-up (from context-driven case to principle). The agent analyzes the principles and rules at hand, the larger available theories, and his or her own "considered" judgments, so that the outcome is defensible by its inclusion in a framework of mutually supportive beliefs and explanations. Practically speaking, the process of justification becomes more than a matter for an individual agent or committee to deliver by working through a problem; instead a more complex point of view, one that includes the standpoint of the afflicted party, is given credibility when it is supported by all those involved—the patient, family, the medical community and the greater public.

The problem for foundationalism is that an answer might seem logically correct (as when the clinicans refused to withdraw hydration from the previously mentioned sick infant due to beneficence), but be nevertheless unacceptable to those who

face and must live with the consequences. Coherentism can surmount that problem by including the desired end result into the moral calculations (in this case a peaceful and painless death). If patients and their families, as those most directly affected by bio-medical technologies, are not a willing part of the process, or if public objections are aroused, then even judgments deemed "right" from a moral perspective will be disregarded, since most people are unwilling to accept moral principles imposed upon them from above.

Of course, coherentism has weaknesses as a form of justification for moral decisions since there is no way to dismiss the possibility that culturally bound internal beliefs have not biased the outcome. If a group begins a deliberation with a point of view (say that abortion is murder), then coherentism provides very little reasoning power to include alternative positions. However, because it insists on investigating a whole set of possibilities, it is not necessarily restricted to narrow viewpoints. The best known coherentist method in ethics is reflective equilibrium, articulated by John Rawls in his *A Theory of Justice*, 1971. I describe it greater detail in the next chapter, especially its advantages in bioethical methodology.

Principlism is a coherentist project because of the way it seeks support from a wide variety of theories and principles. Beauchamp and Childress correctly recognized that if their principles were to be successful, they must be used in a dialectical process, one "consistent with both a rule-utilitarian and a rule-deontological theory," and not as an applied set of rules (62). They were trying to avoid obligatory rule-applications, because they realized that such rules, by their nature, must occasionally conflict, requiring arbitration by some unnamed "derivative" rules, in a vague "process." How could

such a vague process lead to justifiable moral judgments?   Critics were quick to pro-

claim their original set of rules to be too free-floating, essentially based in intuition,

omitting the reasoning that might fully support their ideas.[20]

The weak justificatory basis for their method did not initially trouble the au-

thors, although it has continued to trouble their critics. To Beauchamp and Childress

such theoretical squabbles weren't important. They underestimated the importance of

moral justifications on a practical level, calling the use of competing moral theories "a

trivial difference in specifying the material action-guides that must be followed in

making particular moral judgments" (45). And yet they grasped that citing some rea-

son or principle to back up judgments was valuable to their methods, offering dialecti-

cal discourse as a preferred way to locate good reasons for actions. However, the way

they described dialectical reasoning sounded like they were seeking something like a

coherentist scheme. They wrote:

> Moral experience and moral theories are dialectically related: We de-
> velop theories to illuminate experience and to determine what we ought
> to do, but we also use experience to test, corroborate, and revise theo-
> ries. If a theory yields conclusions at odds with our ordinary judgments
> – for example, if it allows human subjects to be used merely as means
> to the ends of scientific research – we have reason to be suspicious of
> the theory and to modify or seek an alternative theory…cases provide
> data for theory and are theory's testing ground as well. Cases lead us to
> modify and refine embryonic theoretical claims, especially by pointing
> to inadequacies in or limitations of theories (15-16).

Not only does this description sound coherentist, it was, perhaps, as David De Grazia

later argued (and as I will explain later on), a sort of Rawlsian reflective equilibrium

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[20] Beauchamp and Childress adopted the notion of "self-evident" basic duties of common morality
taken from the work of W.D. Ross, but they glossed quickly over the details of how to figure out which
duties were binding in which situations. See p. 52 of the 1989 edition of Beauchamp and Childress for
their discussion on the role of intuition in their work.

they sought although the two authors did not seem particularly aware of the process in their 1989 edition.

By 1990, when Henry Richardson introduced his ideas on how to "specify norms," as a way to handle the conflicts inherent in applying any given list of principles, duties, or rules, he had mentioned "bridging principles" as the "mid-level norms" that allowed for deriving a "specified" principle from a more general principle, but he also noted that such a step seemed to depend on intuition, making the process "beyond the pale of justification unless something more was added" (1990, 284, 286-288). He was the first to point out that it was Rawlsian reflective equilibrium that had provided the means by which to move beyond the overly intuitionist structure advanced by Beauchamp and Childress for the use of their four "first" principles.[21]

Later, in 1992, David De Grazia went further in linking Beauchamp and Childress's procedure to a process of reflective equilibrium, albeit in an unclear and undeveloped fashion. He complained of the vagueness in Beauchamp and Childress's endorsement by saying, "At the same time, principlism, as presented by Beauchamp and Childress, has weaknesses, one of which is…that to the extent that reflective equilibrium (which does allow for discursive justification) is to be used, it is not clear in what ways and at what levels" (1992, 524). De Grazia has since promoted Richardson's proposals on principle specification as a way of achieving coherence in the overall set where mid-level principles, background theory, moral reflection, and judgment-making all have a place, while avoiding the inherent weakness of reliance on intuition

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[21] Richardson proposed a "coherence standard for the rationality of specification" which he claimed carried the "Rawlsian idea of wide reflective equilibrium down to the level of concrete cases." He felt that this provided the "argumentative support" for his linkage between general principles and specifications (1990, 300).

as a moral foundation. He recognized that intuition could not determine a correct moral solution, nor could it determine whether a "specification" of a principle was correct. Rather, he promoted the idea that intuitive notions were "testable" by their overall coherence with a plausible "set of norms" and that when norms and notions conflict, one or the other must be revised to increase coherence and defuse contradictions (528-529). This was basically a description of reflective equilibrium.

In their most recent fifth edition, published in 2001, Beauchamp and Childress took the criticisms of their method to heart and began to openly adopt a "coherence theory," specifically reflective equilibrium as a basis for their project. In their explanation, they say,

> Method in ethics properly begins with our "considered judgments," the moral convictions in which we have the highest confidence and believe to have the lowest level of bias…Whenever some feature in a moral theory that we hold conflicts with one or more of our considered judgments, we must modify one or the other in order to achieve equilibrium (398).

They go on to explain the importance of "paradigm judgments and the need to construct "action guides" that are coherent with the whole context of the problem at hand.

This approach goes a long way toward saving the project of principlism from being nothing more than a checklist by which to assess biomedical activities or judgments. However, Beauchamp and Childress have still not shown why their four principles should be the basis of the process, nor how to go on when "paradigm judgments" are not available. How does one move from a core concept like "autonomy," or "beneficence," to make a specific decision such on the correctness of experimenting with stem cells for Parkinson's Disease for example? While reflective equilibrium provides a means to justify a decision, it is not clear which specific princi-

ples are to be made part of the process in the first place, or how one is to "specify" down from the general to the specific. Before we turn to these questions, something more needs to be said about reflective equilibrium, especially how to be sure that one's "paradigm judgments" or "set of norms" are accurate to begin with.

Reflective Equilibrium

In describing reflective equilibrium in his 1971 book, *A Theory of Justice*, Rawls took it as the end result of a process of moral deliberation in which one's personal views are contrasted with alternative views and compared to greater moral theories opening the door to reasonable revisions to be brought into the system until finally, one's viewpoint is no longer revisable. He put it this way:

> This state is one reached after a person has weighed various proposed conceptions and has either revised his judgments to accord with one of them or held fast to his initial convictions (and the corresponding conceptions)…One is to be presented with all possible descriptions to which one might plausibly conform one's judgments together with all relevant philosophical arguments for them (Rawls 1971 48-49).

The equilibrium reached by this process was said to offer a reasonably good basis, or at least a modest justification for moral judgments, which is a considerable claim since any hope for isolating absolute foundations was not seen to be plausible by Rawls.

In practice, reflective equilibrium is said to be obtained when one's personal moral convictions are held up to certain *selected* moral principles for comparison and moved through a revision process until stability is gained. The selected principles are acquired by testing various conditions to see what principles are yielded; assessing the sorts of judgments that might be produced by applying the principles; considering how specific cases and situations might impact the judgment at stake; then revising either

one's personal opinions or revising the principles applicable to the case until some kind of balance is obtained in which the principles and judgments coincide (1971, 18-20). Rawls avoided either a "top-down" or a "bottom-up" approach, saying of his method: "we work from both ends." The outcome can be taken as dependable because he said, "we know to what principles our judgments conform and the premises of their derivation" (20).

In trying to make this system of reflective equilibrium work to solve problems in bioethics, it is important to remember that Rawls was working in a different sphere: creating a theory of justice. Here he "selected" his overriding moral principles from his well-known thought experiment, wherein he advocated imagining oneself in an "original position" behind a "veil of ignorance" choosing the principles of justice to govern society. The special principles derived from this experiment were said to take precedence over other moral principles if the goal of justice was to be achieved, and so they supersede everyday moral maxims. Furthermore, in order to work on a specific moral problem, it seemed to Rawls that the moral agent must be rational, have "considered" moral convictions, must be able to compare her moral convictions to whatever larger principle is at stake, take into consideration the salient details of the situation, and note any discrepancies or gaps between her personal conviction and the principle. The agent must then examine these discrepancies, thereby altering either her previously formed conviction or revising the principle to make it more closely related to the particular situation. If the principles and convictions match up then moral decision-making is successful; if not, one must return to checking one's interpretations, as-

sessing the capacity of the principles, and/or assessing the strength of one's convictions. As Rawls said:

> By going back and forth, sometimes altering the conditions of the contractual circumstances, at others withdrawing our judgments and conforming them to principle, I assume that eventually we shall find a description of the initial situation that both expresses reasonable conditions and yields principles which match our considered judgments duly pruned and adjusted. This state of affairs I refer to as reflective equilibrium (1971, 20).

This particular description of reflective equilibrium has been called "narrow" by those critics who believe that Rawls intended something more defensible than a simple fit between one's personal moral judgments and more abstract principles. Norman Daniels, for example, pointed out that the method actually depended upon implicit background theories; in particular Rawls's conception of personhood, society, and rationality. To Daniels, these background assumptions needed to be made explicit, so that it would be apparent how their role insured diversity in ideas and elevated the process of reflective equilibrium beyond banal circularity. He sought a requirement that background theories be more than "reformulations of the same set of considered moral judgments" already in play (1996, 22-23). One way to broaden the scope of reasoning would be to widen Rawls's original scope into "wide" reflective equilibrium where the inclusion of *many* moral points of view are brought into play, in order to achieve a fuller account of morality, not just a circular local equilibrium. One way to do this, according to Rawls, is to insist upon a "condition of rationality" by the agent. Not any argument or set of considerations can be considered rational; some are more "feasible" or "reasonable' than others (1974, 289). By ensuring that an inquiry has taken into consideration viewpoints outside the customary, and a variety of standard

moral theories, Rawls' wide reflective equilibrium can surmount local and habitual moral customs, and avoid accusations of relativism. He believes that reflective equilibrium is a means of elevating moral reflection beyond bias and traditional thinking, by insisting that "no judgments are immune to revision" (1974, 288).

Practically speaking, reflective equilibrium, as a means to solving moral problems is supported by the fact that individuals can hold within themselves a variety of contrary and dissenting moral positions at any one time, necessitating some internal give and take similar to reflective equilibrium if one is to attempt internal consistency. Group opinions enlarge upon the number of possible outcomes, illustrating a reason one can doubt the possibility that an individual can establish objective moral first principles for her or himself, let alone provide such principles, or moral truths, for others, giving support to the requirement in reflective equilibrium that many perspectives must be considered to reach a valid conclusion. Rawls disavowed any attempt in his project to assert epistemological assumptions about the existence (or lack) of objective moral truths, but he did assert that the adoption of reflective equilibrium as a justificatory method could provide the most satisfactory foundation for morality while holding metaphysical claims in abeyance.

This fuller picture of reflective equilibrium, in the wide rather than the narrow sense, shows that it can provide satisfactory justification for the sort of "useful" judgments required in bioethics, in spite of the complexity of the process taken perhaps too simply by its followers in bioethics methodology. The disadvantages in using reflective equilibrium as a practical tool for decision-making have been alluded to: specifically that it is too subjective, too dependent on intuition, too mired in relativism,

supported by an unrealistic conception of rationality, and that its underlying motivational principle is non-moral. The responses to these objections are similar in that reflective equilibrium (and coherentism in general) gain accuracy depending on the wideness and variety of moral input taken into consideration. More specific responses to these objections follow.

Critique of Reflective Equilibrium

Some critics argue that reflective equilibrium is too subjective. The intent in reflective equilibrium is to ensure that biased, selfish or parochial moral judgments must be discarded when faced with the consideration of broader and more universal principles; however, the procedure does not necessitate such an outcome, since there is no external fixed principle, such as the categorical imperative or the principle of utility, no ideal observer, nor an Archimedean point by which to test the result. As Rawls said, "there is no point at which an appeal is made to self-evidence in the traditional sense either of general conceptions or particular convictions. I do not claim for the principles of justice proposed that they are necessary truths or derivable from such truths" (1971 21). Thus, the possibility always exists that either the principles at stake, the moral judgments being compared, or even the background rationality constraints might rest on faulty premises—specifically, the subjective beliefs of the agent—so that even though a comfortable coherence is attained, allowing for a firm judgment, it might nevertheless be morally wrong. R. M. Hare criticized Rawls as "advocating a kind of subjectivism, in the narrowest and most old fashioned sense… He is making the answer to the question 'Am I right in what I say about moral questions?' depend on the answer to the question 'Do you, the reader and I agree in what we say?" (82).

Norman Daniels thinks this problem is overcome because the process can be compared to scientific inquiry, where the amount of scientific convergence for an idea is taken to be tantamount to knowledge itself, while questions of truth are put off for future exploration. Convergence on the outcome of a moral process can be considered strong evidence of its acceptability and usefulness, while not constitutive of moral truth. To Daniels, challenges can always be made on the substance of a problem, but otherwise, he argues: "Do we really have moral truth, given convergence in wide reflective equilibrium?' is an *idle* worry in the absence of any *specific* research capable of destabilizing the equilibrium. In the absence of some particular, plausible way to challenge the convergence, the questions is tantamount to strong and unfruitful skepticism" (1996, 37).

Rawls does concede however that it is difficult to presume that his theory and its results can necessarily be extended into "non-liberal" or "non well-ordered societies," different from our own, perhaps thereby relinquishing the possibility of achieving objectivity by this method. [22]

A second criticism of reflective equilibrium is that it is too dependent on intuition for moral reasoning. It is said to be too dependent on subjective moral beliefs for its starting place, and even more for privileging the place of moral intuition. Rawls does not take intuitive moral beliefs to be foundational, in the sense of Sidgwick, Ross or Moore,[23] where self-evident propositions play a role, but neither does he totally discount their place in formulating moral principles: "There is no reason to suppose that

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[22] See also the discussion in Rawls's "The Law of Peoples," written in 1993, and republished in 1999 in *The Collected Papers*, edited by Samuel Freeman (529-564).

[23] See his exploration of the role of intuition in his essay "Kantian Constructivism in Moral Theory," written in 1980, republished in *The Collected Papers* as above, (343-346).

we can avoid all appeals to intuition, of whatever kind, or that we should try to. The

practical aim is to reach a reasonable reliable agreement in judgment in order to pro-

vide a common conception (1971, 44-45).

David Lyons (in his 1972 response to Rawls's theory) criticized coherence

schemes in general, noting their reliance on arbitrary intuitions as moral convictions:

> The justificatory force of coherence arguments is unclear. Suppose one
> assumes that there are such things as valid principles of justice which
> can be justified in some way; suppose one believes moreover, that a
> coherence argument explicates our shared sense of justice, giving pre-
> cise expression to our basic moral convictions: one may still doubt
> whether a coherence argument says anything about the validity of such
> principles. For pure coherence arguments seem to move us in a circle,
> between our current attitudes and the principles they supposedly mani-
> fest…To regard such an argument as *justifying* moral principles thus
> seems to assume either a complacent moral conventionalism or else a
> mysterious 'intuitionism' about basic moral 'data' (146-147).

The Rawls defender, Norman Daniels, noted the force of the intuition objection when

he worried that "Once the foundational claim about moral judgments is removed,

however, we have nothing more than a person's moral opinion, however considered

(1996, 83).

The best answer Rawls has for this line of attack (as well as for the criticism of

subjectivity) is to depend upon the wideness of the reflective equilibrium; in other

words, the insistence on a variety of alternative viewpoints enlisted to encourage the

examination and possible revision of initial judgments. His further defense is that no

one begins moral inquiry from outside their belief system; prior moral judgments are

always influential in the development of any moral theory, so that there is no point in

ignoring them or pretending not to have them. However, wide reflective equilibrium is

intended to provide a check on these basic intuitions so that neither the end result, nor

the overall theory, is dependent upon them. An additional constraint imposed by Rawls is to insist that primary moral intuitions, when taken into account, must be "considered," "reflected upon," or "reasonable," because they may not be accurate or defensible from the outset (1971, 19-20).

The third criticism of reflective equilibrium comes from the challenge of relativism. Since a certain degree of subjectivity and intuition are inherent in the process, how can reflective equilibrium surmount the idea that its solutions are accurate only for certain cultures or specified groups? To Rawls universality is not necessarily the highest goal for moral judgments, because that would presume that all human goods are similar or can fit into a small set, or that all similar human dilemmas can be answered by single moral formulations. Rawls is not monistic in this way, but instead takes a pluralistic view of individual and societal goals, so for him it is impossible to reduce the many goods that humans need and desire into one or even several common aims that can take precedence over the others (1971, 5). Although he accepts that human needs are rooted in an expression of plural moral goals and he acknowledges personal differences in individual goals, desires, conceptions and life plans, he denies total skepticism about the possibility of achieving broadly general terms of moral consensus, as long as they do remain general and applicable to all.

In 1990, R.B. Brandt criticized coherence theories for their relativism, especially the inescapable influence of society in the moral codes developed from them, and asked how such theories could possibly adjudicate among conflicts. He asked whether people would not choose to be led by specific moral codes for themselves and their own society (264). Presumably, groups would tend to formulate quite specific

moral rules to oversee their own happiness and well-being. To Brandt, Rawls's moral

pluralism is a serious shortcoming because "what we know about variations of moral

beliefs around the world and their probable causes" should urge us to seek generally

applicable answers (273).

But such general answers might be too restrictive. Because it is a fact that even

one's "considered" judgments can be strongly influenced by the norms of society, care

must be taken to override those that are wrong or harmful to others. Brandt concedes

that a useful moral theory "will not ignore 'considered opinions' and indeed will wel-

come them as reasons for further reflection, without holding that agreement with them

is decisive for a normative theory" (277). Because of the variation among human aims,

the goal of coherentist theories is not to reduce multiple goals into a single common

good, like happiness, but to formulate procedures where overlapping forms of consen-

sus can occur without restricting their diversity. Even that broad definition of diver-

sity, however, may show the process to be confined only to liberal societies, which

include a certain liberal conception of the person as a moral agent. As Daniels admits,

> He [Rawls] says that justice as fairness rests on acceptance of a particu-
> lar ideal of the person and on a conception of the function of justice in a
> heterogeneous nation-state in which there may be disagreement about
> conceptions of the good…Whether or not justice as fairness would
> emerge in a wide reflective equilibrium involving people from dis-
> tinctly different moral and political tradition is not something Rawls is
> ready to comment on, at least until the ideals of the person and other
> 'background theories" of the other tradition are made explicit. In princi-
> ple, however, the door is open to some form of relativism with regard
> to justice (1996, 116).

Jurgen Habermas, in his 1995 exchange with Rawls, asserted that even if the

Rawlsian approach were taken by other societies to be a natural means of assessing

morality, that would not indicate any proof of a more general and universal moral basis for it, because, he argues, the approach has a *functional* foundation, not a *moral* one. Presumably, a theory is less relativistic when consensus occurs, but neither consensus nor majority agreement entails that a universal moral truth has been obtained (121-122). Of course, Rawls believes that one of the positive features of his "selected" principles for justice is that they are universal, and that the universality was produced by the special standpoint, the veil of ignorance, from which they were obtained. He asserts that anybody who can imagine a similar scenario would accept the same ideas. But the principles in bioethics weren't devised from such a stringent standpoint, laying them open to even more skepticism than one might identify in the Rawlsian project (1971, 132). Can universal bioethical principles be formulated? Many critics from other countries claim that autonomy, as one example, is too Western, too American, to be given the status we might want for such principles.

This is a serious problem, ignored by the supporters in bioethics of the use of reflective equilibrium: whether the procedure can be removed from its original context, where the main claim that lifts it above relativism is its dependence upon the specially derived principles suitable for providing an interpretation of justice. It is the use of those special principles that provides substance to the judgments that are derived from the process, and it is not clear that without such substantively defended prior principles, the process can deliver the necessary coherence.

A fourth criticism of reflective equilibrium is that Rawls depends too much upon a notion of rationality that might not be reflected in the considerations of the average agent engaging in moral thinking. Rawls distinguishes between "reasonable-

ness" and "rationality," where both are necessary as background conditions for his theory. To be rational was to take "effective means to achieve one's ends" (1971, 401) and to "rank options according to how well they further purposes" (143). But to be reasonable is put forth as conceptually prior to rationality because making and offering reasons is an activity that necessitates social cooperation:

> Fair terms of cooperation articulate an idea of reciprocity and mutual- ity: all who cooperate must benefit, or share in common burdens, in some appropriate fashion as judged by a suitable benchmark of com- parison. This element in social cooperation I call the *Reasonable*. The other element corresponds to the *Rational:* it expresses a conception of each participant's rational advantage, what, as individuals, they are try- ing to advance...Familiar examples of such principles are: the adoption of effective means to ends; the balancing of final ends by their signifi- cance for our plan of life as a whole and by the extent to which these ends cohere with and support each other; and finally, the assigning of a greater weight to the more likely consequences; and so on (1980, 316).

This explanation is broader than many ascribe to Rawls, which is that his definition of rationality is limited to narrow self-interest. He goes to great lengths to make this dis- tinction in his later work, because he understood that rational behavior can sometimes include non-moral acts when they are seen to promote one's individual goals and aims, whereas reasonableness requires a moral component, because other persons must be persuaded through dialogue to share the point of view. Agents must have the ability to exercise these faculties in order to deliberate in reflective equilibrium. But a problem lies when attempting to link this definition of rationality to reflective equilibrium: that of motivation. If moral behavior is motivated by the basically individualistic goal of achieving one's personal ends, it seems to preclude altruism.

The fifth and final criticism of reflective equilibrium to be considered here is the problem of non-moral motivation. Rawls believes that his "original position"

thought experiment spins off certain desirable principles because of his associated be-

lief that humans will always try to maximize their own access to goods or interests.

While this desire may be thought to be selfish at heart, the realization that one must al-

low access to others in order to maintain one's personal access to goods encourages

fair play. Overall, it is supposed to be the desire to pursue one's own goals that moti-

vates moral behavior because a rational person ranks "options according to how well

they further his purposes; he follows the plan which will satisfy more of his desires

rather than less, and which has the greater chance of being successfully executed"

(1971, 143).

Individuals in this Rawlsian type of social contract are thought to be motivated

to behave fairly only because their own goals might be blocked if fair access isn't of-

fered to everybody; the ethical content of the goals is not deliberated (11-12). Morality

is a by-product of social cooperation. The plethora of goals can't be narrowed or adju-

dicated by any specific ethical principle or code of conduct, because of the danger that

to reduce the multiplicity of goals into one, or even a few, means an inherent loss of

freedom for some participants. Thus the principles at stake are those by which the di-

vision of advantages is acceptable to all – in other words moral principle has now be-

come nothing more than procedure.

This is the most serious criticism of the use of reflective equilibrium in ethics,

because it seems to undermine the possibility of altruistic goal setting. However, con-

trary to what some critics have argued, Rawls does understand that the personal aims

and goods motivating self-interested, and yet conceivably moral, deliberations are not

restricted to material or social benefits; they can include religious, humanitarian,

scholarly, or artistic goals, making self-interest a misleading term for the motivational impulse (1975, 275). Norman Daniels assumes there is a distinction between self-interested, rational life-plans and moral life plans, because rationality is supposed to favor self interest when it conflicts with morality, staying directed upon the immediate satisfaction of personal goals, not universal goods. To Daniels the definition of morality must attempt universal inclusivity, while goals of maximizing one's personal utility remain local in nature (1996, 294). But Rawls does not accept this gap between the local and universal, at least when diverse people with diverse goals use reason to deliberate about and achieve their various outcomes.

A different problem for a notion of rationality as coinciding with self-interested goals, especially as it is supposed to motivate one to act morally, according to Barry Hoffmaster, in 1991, is that the procedural framework of self-interest doesn't help to distinguish moral from non-moral problems. Psychopaths, for example, are perfectly rational in framing their life choices, but immoral decisions might be included in their ideas about their personal best interest. Furthermore, sometimes moral decisions seem irrational when they don't further our own needs and desires. Hoffmaster says that "rationality in this sense [the Rawlsian account] helps to give form to the problem, but it is unable to provide a solution…it provides no substantive guidance for actually making the decision" (227).

How then, with all these criticisms, can reflective equilibrium be put forward as the most advantageous way to proceed in bioethics? Perhaps because bioethical problems are a mix of moral and non-moral, dependent on local custom and knowledge, and new technologies, so that reflective equilibrium as a procedural approach of-

fering fewer moral absolutes and more emphasis on diversity of goods and outlooks appears to be more practical. It can, in the abstract, incorporate a broad array of opinions, beliefs, principles and facts into a procedure designed to thoughtfully constrain and narrow the diversity into useful, practical and immediate solutions to problems. But to be realistic, care must be taken to ensure that the process is wide enough to capture more than local, intuitive and customary viewpoints, and that reasonable answers are derived so as to avoid bias, discrimination and so on.

How can such general precautions work? The only possibility is for some sort of conscientious procedure to be in place, one that sets out a process by which diversity in moral opinion, moral principle, and moral theorizing be available and taken into consideration by rational actors. Unfortunately, this seems unlikely to be used at the level of the clinical ethics committee setting, which is the first and most basic arena for this type of problem solving. At that level, medical personnel do not have the inclinations or the training to pursue problem-solving through this detailed and broadly organized format.

In Part Three I will show that reflective equilibrium as a practical method for solving bioethical problems can be improved by adding a requirement for publicity. This means that when solutions are unstable or less valid at a local level, they can gain credibility and justification after wider levels of discussion and public input. But before I can make that case, I first must introduce the role of mid-level principles for the justification of bioethical decisions and then explore the actual way bioethical problems are worked through in the actual clinical setting.

CHAPTER THREE

IDENTIFYING MID-LEVEL PRINCIPLES

The advocates of principlist methods in bioethics, whether in the more or less deductivist frameworks, rely on moral statements at the mid-level range to justify the outcomes of their reflective equilibrium procedure in specific cases. For Beauchamp and Childress this might mean that a principle of beneficence or autonomy is invoked to defend a solution. To De Grazia and Richardson, it meant that a more specific and well-accepted maxim was produced, such as whether "informed consent" was adequately obtained in a case of withholding nutrition. Even to contextualists, the ability to cite a general mid-level principle is a useful way to ward off dissent and gain acceptance for a particular decision. But finding the best and most appropriate principles for the case at hand is not always easy, especially if a principle covering a certain type of case has not yet risen to the level of general acceptance.

Even more difficult is to cite a link between the local mid-level maxim and a broader, more theoretical principle on which to base the justification for a decision. Keeping in mind that the process of reflective equilibrium was said to require some input from general moral theories or broad principles to invigorate the back and forth dialogue, it is difficult to see how these are to be introduced on the practical bioethics procedure discussed here.

Advocates of coherentist models, in the abstract, do not often offer details about which principles (whether broad or mid-level) ought to be considered when undertaking the process of reflective equilibrium. Epistemologically, the structure of belief is stronger when one or more starting principles are justifiable outside of its

relation to the other beliefs within the system under construction. In other words, it is useful to have a strong, fundamental core principle such as in those utilitarian or deontological frameworks to avoid circularity. As I have shown, Rawls intended his special "selected" principles of justice, taken from his "behind the veil" thought experiment, to be the primary principles useful in preventing just such a circular outcome. He also advocated the inclusion of "broad standards and first principles" as tools to encourage reflection about the adequacy of moral thinking on the problem under investigation (1974, 288). The term "principlist" usually refers to those who take Beauchamp and Childress's four principles as stand-ins for those broad standards or first principles, because they allow for an independent reference point, while constraining the ethical debate from deviating too far from its bioethical intention. These four principles can be taken as "first" principles in this setting because they have achieved their status by having emerged from a semi-public, ethical, deliberative process; although the committee process from where the Belmont Report emerged did not include the kind of special circumstances contributed by Rawls's thought experiment to lend credence (and perhaps objectivity) to the principles derived from it. Nevertheless, there is no particular reason to find fault with the four main principles or to search for reasons to add to or subtract from them. The bigger and more important problem is to figure out the most appropriate and more specific mid-level deciding principle for a case, or set of like cases, and defend it, whether by its relationship to one of the four Beauchamp and Childress principles or on its own stature.

De Grazia, for example, expressed no concern about the source or basis of any principle taken to be used in a reflective equilibrium process; in fact, he proposed that

Beauchamp and Childress's four principles, or any other general principles, could readily stand in place of Rawls's principles of justice to create a viable deliberative process, as long as a "specified" mid-level principle was the result. Indeed he stated that "different sets of principles might yield similar, or identical specification;" although to him Beauchamp and Childress's set were a "plausible starting place" (1992, 532-533).

Likewise, Henry Richardson, the main proponent of specification, did not limit the use of first principles in his model to any specific set. His assumption appeared to be that an agent starts with his or her own personal "ethical precepts," expected to be "very general and abstract" (1990, 284). He says, "we may suppose that the deliberators or discussants start with a set of ethical norms to which they are in some important way initially committed. For our purposes, it does not matter where these norms come from, whether they change over time, or how they are grounded, if at all" (1990, 284-285). For him, the problem was not the difficulty in identifying correct starting principles, but in figuring out how to work through the inevitable conflicts that result when principles are interpreted and used to articulate judgments. He suggested that appropriate principles are a product of the deliberative process, rather than a necessary external reference point. Starting principles are not fixed, but are revisable in the course of reflective equilibrium, as long as the specification used to solve a concrete case is recognized as honoring the original principle or its best revised version. He explains:

> The reason that the models of application and balancing do not exhaust
> the field is that they each suppose that the set of norms invoked in ethi-
> cal discussion and deliberation is held fixed [but] as also implied by the

Rawlsian idea of wide reflective equilibrium, our norms are subject to revision. The model of specification starts from this recognition of revisability...This stability is essential to the claim that the initial norms are in some way *brought to bear* on concrete cases by means of more specific norms (1990, 290).

As a more concrete example of specification, Richardson would take from Beauchamp and Childress's general principle of respect for autonomy a more specific formulation: "respect the autonomy of patients by following their advance directives whenever they are clear or relevant." However even this mid-level formulation is unclear when applied to specific cases. He acknowledge the difficulty: "whether all cases of following such advance directives are cases of respecting autonomy may well be, because of the vagueness of the latter notion, too indeterminate to settle" (2000, 290). In any case, he thought that by sharpening or specifying a norm, while keeping the link to its more general, initial norm transparent, one could keep the justificatory procedure accurate. This accuracy was especially necessary if more than one initial norm could be seen as applicable to the specific case. In the case of this example all three of the other principlist norms — beneficence, non-maleficence and justice — could be seen to be the most important basis for the application of the norm in cases where advance directives are taken to be the valid reason for a solution.

Richardson is committed to clarifying a link between the specified norm and its parent principle, so that the "underlying rationale of a norm being specified can be laid out" and so that it would be clear if the specification was a concrete exemplification of the original moral idea, or an expansion or revision of the original (1990, 292). This clarity is necessary because the problem with universal formal principles is that they don't allow for necessary qualifications, (whether it be thought of as narrowing,

specifying, or sharpening), when they are couched as absolute statements such as "it is always wrong to lie," or "one must always respect the patient's autonomy." Richardson asserts,

> the norms to which we are commonly committed are not plausibly viewed as formally absolute in this way. Rather, they are typically qualified, at least implicitly, by variants of "generally" or "for the most part". This sort of looseness is a common feature of our norms as we find them, whether they be prohibitions, positive duties, or ends (293).

Thus Richardson has a problem not only in specifying one general norm into a concrete action-guide, but in deciding which general norm is applicable to which concrete case for the specification process. Sometimes the choices are contradictory. For example, when deliberating about a case of withholding a feeding tube, should one consider autonomy first (if the patient had written an advance-directive allowing death by starvation), or beneficence (if the patient seems to be uncomfortably in need of sustenance enabling forced feedings) or is there a better, more close-to-hand maxim to provide the answer? One choice means starving a patient, one means force-feeding. It isn't clear how specification solves this problem.

Richardson underestimates the difficulty of making these choices by asserting "once our norms are adequately specified for a given context, it will be sufficiently obvious what ought to be done. That is, without further deliberative work, simple inspection of the specified norms will often indicate which option should be chosen" (294). Such a statement seems simplistic, especially when one envisions new types of problems for which paradigm cases and multiple analyses have not yet been produced. As Richardson has admitted, it would be hard to see how "specification could be anything but a special employment of intuition" unless "the superiority of one specifica-

tion over another could thereby be defended" (300). He hopes that such a defense emerges from the use of reflective equilibrium, although he has not yet offered an explanation in its full complexity. However, even if he does, he has not given a way to ensure that the *best* set of "initial norms" can be enlisted, and even more disturbing, he doesn't explain how one is to identify and weed out principles that are totally wrong in the first place, despite their cultural acceptance. For example, for many years it was thought beneficent to paternalistically refuse to divulge to patients their grim outlook in cases of terminal illness. Now that is thought wrong because it violates autonomy. How is one to choose when customary norms bias our outlook?

Such counter-examples leave Richardson's detailed version of specification lacking in validity, unless he can show that the first principles themselves are derived from a reasoned argumentative process, or from some other foundational approach (as are Rawls's first principles) so as to provide strength to the justificatory process. And then, even if the justification for this process is acceptable, the next question is whether it provides usefully applicable, pragmatic solutions to bioethical problems.

Carson Strong, a critic of the technique of principle specification, said recently that the practice of specifying principles "fails the test of usefulness; that is, it does not provide a practical method for arriving at justifiable resolution of specific cases in which principles conflict" (2000, 324). Speaking as a defender of casuistry, he points out that specification does not rule out the possibility that an agent is biased from the outset, so that she might lean toward certain specifications of principles that suit her predilections in a case, because "one must choose between alternative ways of specifying principles, and this choice requires a prior decision concerning how priorities

ought to be assigned to the conflicting ethical principles in the context of the case in question" (327).

For example, in the case where one must consider whether to withhold nutrition from a malformed newborn, Strong points out that tacit principles about whether neonates have rights have been assumed from the outset. The facts of the case might be less important than the unspoken principles, so that one agent might tend toward withholding feeding, if he or she already has taken the standpoint that a cognitively-damaged child has no rights, by virtue of its lack of a mental state, whereas another might insist on providing nutrition, even to a severely brain-damaged infant with no potential, because of the presupposition toward rights being granted to all life, even the unborn embryo. Specifying is unlikely to resolve such cases of conflicting primary principles. Casuists like Strong are not opposed to a process of derivation of principles to guide actions in bioethics, nor are they opposed to the practice of specifying norms, as long as each case is worked out from the bottom up, considering all the salient details and distinctions. Strong even takes such casuistic methods to be compatible with coherence models of justification. His complaint is more simply that specifying norms is not in itself enough of a method to be practicable:

> How are we to decide which of these (or other possible) specifications we ought to accept? How do we decide which side of the issue the specifications should endorse – should they support or oppose providing nutrition and hydration in this case? Proponents of specified principlism would reply that we should choose the specifications that best enhance coherence among our total set of judgments and norms. However, how do we decide which specifications do this? Herein lies the main difficulty with specification as a decision process: it requires some method, other than or in addition to the specification itself, for deciding which of the possible judgments about the case at hand yields the greatest coherence with our other judgments and norms (329-330).

For Strong, the casuist agent should first look for a useful paradigm case for the sake of comparison, then identify the main ethical values at stake. The next step is to outline alternative courses of action, followed by the final specification of the "morally relevant' distinctions among the several similar cases, allowing for a particular, justified, decision for the specific case. Justification for the decision arises by expressing particular values in a "variety of ways" (331). To adopt such a procedure is akin to a coherentist model, according to Strong, although his notion of justification is something that emerges by comparing cases to larger values and paradigms, "bottom-up," and not from a full-blown coherentist model where revision occurs "from both ends." For him "the strength of the conclusions depends on the plausibility of the comparisons with the paradigm cases" (331). Validity can be found in case-by-case analysis, and not in consistency, so two similar cases might be treated differently, but both be equally justifiable:

> My description of casuistry given here and previously (1988; 1997; 1999) are not expressed explicitly in terms of coherence. Nevertheless, the casuistic reasoning process illustrated here seems to yield a set of coherent judgments about the cases considered. Thus, casuistry can help us decide which prioritization of values in a case is most coherent with our other judgments (334).

If we are searching for a "useful" method, Strong's might be more practical than Beauchamp and Childress's, or Richardson's, because he seems to describe more accurately how cases are actually resolved in clinical settings. It is easier and more natural for the clinician to call up cases for comparison either from his or her own experience, or from well-known published sources, so as to locate the most appropriate initial principle or action-guide to begin the discussion. The problem is when the

paradigm case at hand might be inadequate, too simplistically understood, or too different in detail, or the clinician might not be aware of the best case available. As Strong said, this sort of casuistry might "make use of specified principles," but they do not resolve the case or justify the outcome. He does not believe that *specified principlism* is the type of method that an agent can actually engage in for decision-making:

> No one has shown that it is feasible, or even possible, to arrive at justifiable resolutions of concrete cases by specifying principles within wide reflective equilibrium, whether using casuistry or not. In the absence of a demonstration that specified principlism actually works, the claim that it is the most promising method for resolving cases is unjustifiable (339).

Tom L. Beauchamp has recently responded to Strong's attack by arguing that principles and paradigms should not be seen as two exclusively disconnected moral entities. Rather, pertinent moral principles are contained within the paradigm, because cases become paradigms by virtue of their incorporation of various moral principles, maxims, and so on. He complains:

> Casuists sometimes write as if cases lead to moral paradigms, analogies, or judgments entirely by their facts alone or perhaps by appeal only to the salient features of the case. But no matter how many salient facts are stacked up, we will still need some transferable *value* premises in order to reach a moral conclusion…When philosophers now speak about "the top" (principles, theories) and "the bottom" (cases, individual judgments) in moral philosophy, it is doubtful that these poles can be either a starting point or a resting point without some form of cross-fertilization and mutual development (Reply to Strong 346-347).

It is interesting that in critiquing casuistry this way Beauchamp did not give priority to his own set of four principles. Indeed he said, "In this model, no level of moral reasoning- comprehensive theories, principles, rules, or case judgments – is regarded as having priority or as serving as a foundation for all the other levels" (347). In this

formulation of the coherentist process, even Beauchamp's own four principles are not to be thought of as action-guides, but simply as tools for entering into dialogue.

And yet, neither Strong in his defense of casuistry, nor Beauchamp in his defense of principlism, nor Richardson in his description of specification, have answered how one is to proceed when a paradigm case is not available. How is a mid-level principle to be located for a novel case in bioethics whether one begins with a more general first principle or not? For example, how does one go about deciding the case of the first "test-tube" pregnancy (Louise Brown), or the first insertion of a mechanical heart (Barney Clark), at the clinical level before the cases have been tested legally and debated publicly? That is the subject of Part Two, where I will explore how ethics decisions are made in an actual clinical setting, where both typical and novel cases present themselves to a scientifically knowledgeable group of experts in the field of assisted reproductive medicine.

CHAPTER FOUR

CASE SOLVING IN THE CLINICAL SETTING

Very little has been published describing how actual clinical practitioners go about the practice of ethical decision-making on the job. Ethics panels with a broad mandate — those devoted to public policy — are better publicized, while the work of hospital and private clinics are not. In addition, most of the literature devoted to method is non-descriptive, abstract, and refers to ethics commissions writ large – the sort devoted to delivering national policy frameworks or providing oversight to public functions. Even though many important paradigm cases are described in bioethics texts, such as Beauchamp and Childress's, the actual steps of a decision-making method are left unclear, other than to outline the steps taken in legal processes. By presenting a case analysis retrospectively, the textbook writer has the advantage of delivering a ready-made outcome for discussion, already set up for acceptance or rejection of the associated reasoning. However, in the clinical setting, comparable to the experimental work in a scientific laboratory, the clinician has to "work up" a case from scratch, a much more difficult and unpredictable situation, especially when similar paradigm cases are not available to provide guidance.[24]

Whether the ethics discussion is directed towards public policy or individual case-solving, one can assume that the work is done in group settings, with all the ramifications of interpersonal engagement entailed by the diversity and multiple relations

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[24] An example of a prominent work devoted to method in the abstract is Jonathan Moreno's *Deciding Together,* 1995, (7, 88-105), which provides a description and analysis of ethics in public policy. The distinct nature of the work of smaller and localized ethics committees, who must consider action in individual cases, is mentioned, but without details explaining what actually goes on in their decision-making processes.

within groups. It is also clear that the deliberations of public committees vary in their rules and procedural content, regardless of whether they follow an established method or model for decision-making. Furthermore, they vary in their goals, since hospital-based committees, for example, must not only make decisions on current cases but most likely spend time in retrospective evaluation and review of previous cases, so as to defend against future mistakes and litigation, as well as engage in educational and policy development for their institutions. Some semi-public ethics boards or commissions are devoted to the policies of single professions, both larger ones, such as the American Medical Association (AMA) or the American Nurse's Association (ANA), or more focused subspecialties, such as the American Society for Reproductive Medicine (ASRM), which I discuss more specifically later.[25] In commission work, real cases are only reviewed in an abstract sense, with no immediate consequences for the patients involved, though perhaps with more public import, while in committee work, actual decisions are directed towards immediate problems.

In either case, the decisions affect the patient, and his or her family. Over time, the evolving role of ethics committees have intruded more and more into the traditional physician/patient relationship, both offering help and advice to the physician beleaguered by worries over lawsuits, but also interfering with the physician's formerly clear sense of offering his or her expert advice to the less knowledgeable patient, albeit often paternalistically. As scholars like Moreno have pointed out, once the formerly sacrosanct decision-making power of the physician gave way to the democratizing in-

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[25] In this dissertation, I follow Moreno, in using the term "committee" to refer to the smaller, more private hospital or clinic-based ethics groups, deliberating on local, individual cases, as opposed to "commissions" which are larger, more public bodies (1995, 7).

put of other parties, including the patient and family, there was no turning back to more private decisions. Moreno notes the impact when the values of autonomy and beneficence clash:

> The ethics committee movement may be seen in part as a creature of the transition from the traditional medical ethics that supported an impregnable doctor-patient relationship to a new consensus about medical ethics...the democratic pluralism of ethics committees itself symbolizes the democratic pluralism that conditions modern doctor-patient relations. In a departure from the past, patients are now thought of as free and equal partners in that relationship. The transformation of the physician's role has, after all, taken place over a relatively short time, and has initiated a period of uncertainty and anxiety about values which has given rise to the ethics committee (1995, 36).

Moreno further notices that recommendations about what method, what membership model, what practices for decision-making (consensus, voting, the issuing of majority and minority reports, or any other model) are not set standards that have evolved into the stage where one style or model must take precedence over another. Even more problematic has been defining the role of the trained ethicist, who may or may not participate in such groups, and if so, might be paid or not, might take part as a member of the full committee or act only in an advisory capacity, might take part in the discussion and vote for specific outcomes or might only offer a range of suggested solutions.

Commissions, as opposed to committees, are public, or semi-public bodies, and generally prefer to use the deliberative process to attempt to achieve consensus, according to Moreno, rather than basing their final decisions on up or down type vot-

ing, because voting emphasizes disagreement. Ethical judgments are too important, or

too meaningful, to be determined by a win/lose process.[26] As Moreno said,

> The usual reluctance to subject ethical questions to a vote seems to stem from a sense that ethics should not be reduced to a simple matter of preference…some believe that there are truths about moral questions just as there are truths about scientific questions, and that, like science, ethics cannot be governed by a majority view. For them, there is something discomfiting about voting on ethical issues; it seems tasteless or in some ill-defined way inappropriate to do so. Others worry about the "tyranny of the majority" and wish to protect those with sincerely held but non-conformist moral values from majority dictates, hoping that consensus will preserve a degree of flexibility in social relations. One manifestation of this flexibility may be a general decision to reach a "compromise" (13-14).

But once this type of consensus is reached, it often has the status of policy or at least

has created a paradigm by which good reasons for similar future judgments can be de-

veloped. Such policies are unlikely to be toppled from their prominence unless serious

legal and/or public dissent occurs. For example, the recommendations that emerged

from the previously discussed Belmont Report (from which the four Georgetown prin-

ciples were taken), devised for the purpose of constraining and regulating human re-

search, have become more broadly construed over time resulting in their institution as

guidelines for public policy, in all arenas of bioethics.

Such power by commission has not gone unnoticed, especially by private phy-

sicians whose independence has become constrained by the advent of ethical inquiry.

Their generic (non-specialized) professional organization (the AMA) has questioned

the role and aims of ethics boards in general, as well as the quality and usefulness of

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[26] Moreno's expertise lies in the area of public policy implications and the relative importance of achieving consensus, rather than in moral theory or method per se, and his book is heavily weighted towards describing the implications of consensus as a public policy tool.

the ethics advice directed towards them in the clinical setting.[27] Donald F. Phillips, an

ethics contributor to the *Journal of the American Medical Association (JAMA),* re-

cently asked:

> Can a field like biomedical ethics, which rejects the idea of ethical ex-
> perts and encourages the assimilation of different viewpoints and per-
> spectives, ever agree on what should comprise a body of knowledge to
> be shared by those who practice within the field? Can consensus be
> reached on what constitutes quality in ethics consultation or how it
> should be measured? What kinds of training and skills are required to
> do ethics consultation (1866)?

From the standpoint of the physician expert, the bioethicist's claim to expertise is

shaky, especially among ethicists untrained in biomedicine and lacking sophisticated

medical knowledge. Phillips cites his colleague Joel Frader, a physician and a clinical

ethicist, who outlines some of the problems physicians have in taking advice and criti-

cism from outside their field. Frader questions the moral authority governing those

making ethical decisions and asks, "For whom does the consultant work? Whose

moral 'rules' should the consultant use, especially in hospitals that have a clear reli-

gious or ideologic tradition?" He names other sources of competing values that can

emerge from the history, mission or cultural identity of the institution and from the

subspecialties (1866-1867).

An ironic byproduct of the growth of bioethics is that in a quest to avoid time-

consuming and costly litigation, hospitals encouraged the development of ethics com-

mittees, only to now question whether the ethicists themselves have become a target

for litigation, because of their direct and immediate impact on human health and life

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[27] See "Ethics Consultation Quality: Is Evaluation Feasible?" in the *Journal of the American Medical
Association,* Vol. 275, No. 24, June 26, 1996, (1866-1867).

decisions. Along this line, Sheryl Stolberg recently reported in the *New York Times* on

the growing concern about the power of bioethicists:

> bioethicists themselves are coming under scrutiny, and the kinds of
> bargains they strike with scientists and companies are raising questions
> about their independence…the field has yet to develop rules on work-
> ing with industry. Some bioethicists accept corporate donations for
> their university programs, and others work as paid consultants for bio-
> technology companies, leading colleagues to charge that they are being
> used as public relations tools and damaging the field's credibility
> ("Bioethicists," Aug 2, 2001, A-1).

Given this upsurge in criticism and doubt about the status of decisions made by ethics

committees, it is important to consider how their judgments can be thought credible

and justifiable, especially when immediate and hurried case decisions are made. With-

out an understanding of the underlying method used, it is unlikely that the results pro-

duced by it can be easily defended. Moreno defends consensus as the best way of

offering a defense to the public about the internal decisions made by ethics commis-

sions. But as Jan Crosthwaite emphasizes in a recent essay in the journal *Bioethics*, it

is important to distinguish between "informed moral judgments" and "right answers"

in ethical inquiry, whether consensus is achieved or not.[28] She takes the position that

neither expert opinion nor carefully designed procedures provide sufficient constraints

so as to ensure accuracy in results, although she has not attempted to investigate

whether verification procedures in themselves (such as those constituted by the reflec-

tive equilibrium process) might work to provide credibility to outcomes. About those

outcomes, she said, "There is no independent verification of their correctness...The

only validation for moral judgements is in the reasoning which supports them…Where

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[28] See Crosthwaite's discussion of the difficulty in listing the appropriate responsibilities in professional ethics and the associated duties for the professional ethicist (361-379).

judgements are validated largely by the reasoning which supports them, it is particularly important that they be presented in the context of all the options or alternatives" (372).

Here it seems as though Crosthwaite is prescribing the inclusion of diverse points of view to add validation to a policy or a case decision, just as reflective equilibrium requires. Likewise, it can be said that Moreno's consensus goal isn't very valuable if the published judgments have not included input from a variety of sources and people, otherwise they are subject to the taint of seeming to be only the opinions of pressure groups or lobbyists. But Crosthwaite's fear is more specific: that a lack of humility, even in professionally trained philosophers, might detract from good moral reasoning and encourage the expression of ungrounded opinion. Moreno depends upon the process as being at least one way to add credibility to the moral judgments derived from it, encouraging objectivity. He advocates the inclusion of diverse points of view as an important factor for gaining credibility and an indicator of overall success when consensus is achieved, but emphasizes the importance of the deliberation itself:

> In practice this approach would be represented by questions such as: Have all relevant facts been gathered? Have all important arguments and points of view been aired? Has the discussion presented equitable opportunities for all group members to participate? And so forth. This approach emphasizes the deliberative process rather than its product...But why should it be assumed that a superior group process will tend to yield a superior product? We are intuitively inclined to believe that a result reached by an intensive, informed, and open group discussion of a difficult ethical problem will be superior to a result reached by, say the flip of a coin (1995, 129-130).

While not giving a specific answer as to how one could measure success in attempting to answer bioethical questions, Moreno has taken the process as providing its own in-

ternal support, as an indicator of correctness. While not advocating a specific method of decision-making, he does name principlism, supported by casuistic reasoning, to be the most useful technique. For him, it is unnecessary to seek an independent standpoint, or moral principle, by which to assess and validate moral judgment, because he insists that the "formalistic differentiation between the process of moral deliberation and the justification of the results of moral deliberation is untenable" (45). As to moral principles themselves, Moreno takes them to be the larger values by which a group coheres, but not specific tools to engage in logical decision-making. He adopts a vague sort of reflective equilibrium as the "natural" style for working out moral problems by committee, while warning that the process alone cannot guarantee firm outcomes, especially when confronting new issues. He says,

> In extending a moral consensus into new and controversial territory, we open ourselves up to the problem that values may be less stable than is desirable from the standpoint of the overlapping consensus. For instance, until the diverse members of the liberal polity are comfortable with the idea that artificial hydration and nutrition is a life-sustaining treatment that may be forgone if the patient or appropriate surrogate insists, the values underlying this highly articulated principle of clinical ethics will be unstable (63).

But it is in exactly such "unstable" and "controversial" territories that a locally based ethics committee is likely to be engaged. Lacking a mid-level principle by which a group of ethicists with diverse backgrounds and attitudes can be "comfortable" is the problem frequently undertaken by ethics committees, because they encounter tough issues and novel problems, before society, as a whole, has adopted a position.

One might ask at this point whether it is worthwhile to continue to place value on extracting or locating mid-level principles by which to assess cases. It seems plau-

sible that a committee could bypass principles and assess moral problems in a case-by-case casuistic style, acceptably for those involved. It is likely, however, that when a number of cases are heard, similarities will be noticed, comparisons will be made and inconsistent results revealed. Recommendations for future cases tend to be drawn from such experiences, often leading to the creation of guidelines and rules to assist future deliberations. In other words, mid-level principles tend to emerge. The harder question is how to accurately apply those rules to future problems and how to be sure the rules are morally sound. It is in this area of application where difficulties ensue because this practice occurs at a local level, sometimes involving novel cases where a handy principle or rule has yet to be developed. In Part II, I describe some of these local deliberations and show the difficulty of identifying mid-level principles and also in applying the best one to pertain to specific case situations.

Few studies have been made of practicing ethics committees at the local level and it is rare to find articles in the bioethics literature describing their actual activities in order to ascertain exactly how they work through these deliberations. In one 1992 example, Cynthia B. Cohen surveys twenty-eight health care institutions, describing their ethics committees in terms of their size and make-up; however, nothing is reported about their methods or processes for decision-making. Cohen describes the use of varying models for case review, from large group discussion all the way down to individualized consulting, but she presents no actual data about the review process in itself. She writes

> Great ferment and experimentation characterize the case review function of ethics committees today. An informal telephone survey of 28 representative ethics committee members from health care institutions

around the country revealed that request for ethics committee case reviews increased at 20 of these institutions during the last year. Moreover, 12 among those surveyed indicated that their ethics committee was switching from the use of one model for reviewing cases to another. They were choosing from among three basic structural models that are distinguished from one another by whom they authorize to carry out the review: the committee as a whole, a team derived from the committee, or an individual consultant (294).

Cohen believes that a "full committee model" is better able to provide multiple perspectives using a broader range of reason and justification for their decisions, than small teams or individual consultants, although the larger bodies are slower and less responsive than the smaller models. However, she does not explain how actual decisions are made, what method of reasoning or set of principles worked in gaining specific judgments, and how she measured the quality of the decisions overall.

In a more recent and data-oriented article, Diane Hoffman and her team present the results of a study in which the group investigated the participants and their associated skill level in all of the hospital-based ethics committees in the state of Maryland.[29] These investigators were particularly interested in analyzing the competency of the providers of ethics consultations, the ethicists themselves, by their experience, education, professional discipline and institutional support structure. However, specific cases and their outcomes were not analyzed in this study. Furthermore, the only investigation of the methods or processes used by the various ethics bodies was (similar to Cohen) to determine whether ethical judgments were primarily derived from group consultation or by the use of subcommittees or individual consultants. Hoffman and her fellow authors were concerned with the experience levels of those involved in

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[29] This 2000 study by Diane Hoffman, Anita Tarzian, J. Anne O'Neil ("Are Ethics Committee Members Competent to Consult?") is a result of the state of Maryland's unusual interest in and legislative oversight over measuring costs and outcomes in their state's health care industry.

this work, finding little proof of a coherent skill set or knowledge base among ethics

practitioners. They write,

> There are no data on whether those currently performing ethics consults possess the minimum competencies recommended by the Task Force. In fact, aside from their professional disciplines, there is little empirical literature describing the backgrounds of ethics committee members performing consults. No studies to our knowledge, have provided evidence as to whether those performing ethics consults possess a set of skills and knowledge base believed necessary to competently perform a bio-ethics consult. There is considerable disagreement, in fact, as to whether those doing consults possess the "necessary" skills to perform the task (30-31).

The investigators found in their study that fewer than one third of the groups estab-

lished as ethics committees had a "formally trained philosopher or bioethicist in their

membership," and that few members received any "training, apprenticeship or educa-

tion," or even formal orientation or apprenticeship to assist them in their work (35).

Furthermore, the institutional support for these committees appeared to be minimal,

both by budget and staffing. The authors admit they did not study outcomes and had

no independent way to measure the actual effectiveness, quality, or acceptability of the

judgments made by these unskilled practitioners, both because they did not observe

the committees or consultants in action and assess their decisions, and because there is

no evidence that ranking the training and skill of ethicists measures the accuracy of

their outcomes. Common sense, experience, and familiarity with such work might be

as effective as training in producing accurate ethical decision-making, or it may not.

From this study, we cannot learn whether certain methods or processes deliver better

judgments.

Only one article on this topic provided some actual information about the ethical reasoning of clinicians, although these were not trained ethicists, nor members of formal ethics committees. In 1996, Soren Holm and his colleagues presented the results of their study of ethical case analyses by bedside clinicians, none of whom were trained in philosophy or bioethics. The authors enlisted seven separate teams of nurses and physicians at five different Danish hospitals to discuss "representative" cases, each involving an ethical problem. The issues included the appropriateness of full disclosure of a health problem, and the role of family in health decisions (informed consent and the role of paternalism). The authors monitored the style of ethical discussion, the level of ethical reasoning and the amount of agreement obtained by the various teams. [30] Interestingly, although each team attained group consensus as to an appropriate action for their case, the seven teams did not all come to the same conclusions about identical cases, even though each team was made up of similarly matched groupings of physicians and nurses. Each team was found to use more then one type of ethical argument to defend their judgments: a mixture of deontological and teleological reasoning was common, even while reaching different conclusions. Holm et al wrote:

> In their moral reasoning health care personnel are neither consistently consequentialist, nor consistently non-consequentialist. Their moral universe contains both kinds of considerations, as well as considerations about the importance of building or maintaining relations with patients, and about a professional responsibility towards the patients and their families (Holm et al, 172).

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[30] The case examples used for this test of clinical reasoning were typical problems of paternalism, confidentiality, and autonomy in hospital settings; the type commonly seen both in the U.S., and Denmark where the study was conducted.

The teams tended to begin "casuistically," by listing the facts and details of the cases until certain mid-level principles seemed to emerge from the discussions — principles such as, "it is wrong to end life actively;" or "patients have a right to be told the truth." It was striking to the authors that the largest proportion of the discussion was devoted to clarifying contextual details (the mental state of the patient, their degree of medical knowledge, quality of life and family dynamics) before decisions could be rendered. Also the teams worked more on elucidating their professional responsibility and duties than expected. And yet, the seven team's decisions were split by as much as four to three in their final choices of solutions to the case problems. Although the teams were not pushed towards one method or another, it was expected that their expertise and familiarity with these sorts of problems might yield more unanimous results, but that was not the case. Even when citing large, universal, theory-based principles, or relying on context, or when looking to their own experiences, the discussions did not lead to consistency in the overall decisions.

Holm and his colleagues speculated about the possible influence that one powerful point of view may be held over others; in this case, the verbal dominance displayed by physicians over nurses in the discussions. However, it could not be said that this was the cause of the lack of overall consistency because, while nurses were less assertive, they were not disengaged from the process. Holm et al said "Twenty of the 21 discussions were "real" discussions with long exchanges of arguments and counter-arguments. There is good reason to believe that the individual participants were presenting the best possible case for their point of view, and that they were putting forward the ethical arguments they perceived as most cogent" (172). It was not clear

whether the differences displayed were because of the different professional character-

istics of the participants, their gender roles, or if some other social inhibitors repressed

some types of input, but it is also not clear that it made a difference in the final an-

swers. More problematically, no method or form of discussion emerged victorious. As

Holm et al put it, "The different choices made in these fairly similar groups indicate

that the different moral considerations are played off against each other in complex

ways, and there do not seem to be any simple priority rules which can resolve the par-

ticipants' ethical worries" (172).

This study, then, casts doubt on the idea that any particular method would re-

sult in defensible case solutions, although, at least in hospital ethics committees, it can

serve as a reminder that some larger review process ought to be available to assess

overall outcomes; perhaps a higher ethics committee to review ethics committee deci-

sions.

Most hospitals have voluntarily complied with accrediting requirements de-

manding the inclusion of ethics panels in their institutions; also their troublesome

cases are often vetted by legal counsel to ensure they do not blatantly run afoul of the

law. However, physicians in private practices are under no obligation to hold their

cases up to formal ethical review. Traditionally, the professionally trained physician

has been expected to perform ethically, as a calling, but without much oversight, at

least within the boundaries of the private practice. Only in controversial cases, when a

lawsuit ensues, does the patient/physician relationship become public enough to bring

troublesome issues to light. As I have said, many physicians consider the interest taken

by bioethicists and by non-medically trained, self-professed experts into their work as

intrusive and uninformed. Celebrating the 1997 anniversary of the advent of the original AMA code of ethics for physicians, the organization's internal house ethicist, Linda Emanuel, challenged bioethicists to develop their own standards of ethical compliance by saying: "physicians have thought of ourselves as the unique center of accountability [to professional standards] for long enough. Now physicians' new partners in health care delivery must be held accountable to professional standards" (1268). On the same occasion, another physician and bioethicist, Mark Siegler, said: "The future of medical ethics is up for grabs. During the past 30 years, there is little evidence that traditional medical ethics has improved the practice of medicine or the care of patients. There has been too much talking, philosophizing, legalizing, and reform. The time is ripe for a very different approach" (1267). However it is still not clear whether adopting special standards or methods can calm the criticisms of the medical profession, or whether medical clinicians are better at performing medical ethics than those outside the profession.

One arena where ethical problems abound but ethical review is not mandated is the private clinic, where physicians make autonomous decisions without much oversight. Of these, the most fascinating spheres of action are clinics specializing in assisted reproductive medicine (often known by the acronym ARM). They are on the scientific cutting edge of research-oriented practice, and face novel issues regularly, although like other groups of private physicians, they are under no requirement to have their internal work reviewed by ethics boards. Many physicians in the field choose to seek certification and comply with the professional rules established by their

specialty association, the *American Society for Reproductive Medicine* (ASRM), founded in 1944 (also publishers of the association's journal, *Fertility and Sterility).*

Clinics for reproductive medicine (known more familiarly as fertility clinics) are designed to not only treat the underlying physical problems preventing pregnancy and childbirth, but to sometimes bypass those problems by creating a possibility for reproduction outside of the afflicted patient, whether the underlying infertility problem can be treated or cured or not. For example, instead of treating the infertile woman, they may suggest a donor egg to be fertilized and carried by a surrogate. Thus their "treatments" are not always devoted to the afflicted party.

Assisted reproduction often entails what can be thought of as laboratory re-search with human embryos, or at least, it sometimes works with human embryos in ways that are restricted by the federal government when federally funded. Such activi-ties are not restricted when privately funded and have been carried out for many years in clinic settings, producing such routine current practices as *in vitro fertilization* (IVF) to achieve pregnancy. This disparity in oversight tends to be misunderstood, even by those patients participating in and benefiting from the practice.[31]   As Carol A. Tauer complained in a 2001 essay, "There are no federal restrictions on either type of research when carried out in the private sector. Extensive experimentation on repro-ductive technologies, most involving human embryos, occurs in clinics that treat infer-tile couples" (146-147). Where no government regulation of practice exists, no necessity of ethical oversight exists either. This disparity in regulation can be better

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[31] Many of the pros and cons of research and regulation in the field of human reproduction, including Tauer's, are set out in the volume *Cloning and the Future of Human Embryo Research*, edited by Paul Lauritzen, 2001, (145-161). Also see the recent *New York Times* editorial by Skloot warning the public about the lack of regulation in the field (A-35).

understood by realizing that from the standpoint of the consumer, practical research done with the immediate goal of pregnancy in mind seems more directly applicable, useful and therefore more defensible than research done in the laboratory for more distant goals. That attitude has allowed for basic, technical, and highly sensitive research into the origins of life to be conducted at the clinical level.

But a stronger reason for this laissez-faire attitude comes from the privileged position given to procreative rights in our society. The birth of a healthy child resulting from the use of IVF and related techniques is the explicit goal of human embryo research which is of much value to society. As Carol Tauer admits, "Making such techniques safer and more effective is precisely the reason the research is proposed and conducted. This goal, the eventual birth of a healthy child, may be considered one of the strongest moral arguments to justify human embryo research" (147).

Even though some critics complain that such procreative rights have been taken to an extreme, to the detriment of other social goals such as human justice (not to mention the religious goal of some groups in protecting the human status of embryos, and the worry over the possible commodification of important family relationships through the case of surrogacy, egg and sperm donations and the like), it is nevertheless clear that our political system has consistently favored procreative rights over the other values listed.

One well known defender of procreative liberty, John Robertson,[32] supports reproductive experimentation as basic to human freedom. He says, "Reproduction is so cen-

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[32] Robertson wrote his book *Children of Choice: Freedom and the New Reproductive Technologies* in 1994 and then published two law review articles in 1995 defending his pro-rights philosophy. This quote is taken from "Reproduction and Rights: A Response to Dorothy Roberts."

tral to personal identity and individual well-being that both morality and law would--
or should--recognize a strong presumption in favor of individual autonomy in repro-
ductive decisions. As a result, efforts to limit their use must satisfy the strict scrutiny
generally applied to infringement of fundamental rights (1024). Of course, one might
question whether the acceptance of such a "fundamental right" would necessitate that
every type of related research, or the development of every conceivable technology to
assist reproduction, must be accepted as ethical simply because it provides the treat-
ments that support such a right. From that point of view no regulation is acceptable,
while from a less radical standpoint, regulation could be seen as an acceptable means
of providing boundaries to the research without necessarily infringing on any human
right of procreation. To Robertson, such regulation would only be permissible if it
could be shown that "tangible, non-symbolic harms" were at stake, if the research
were allowed to proceed. As we have seen, it is controversial whether embryo research
not directly related to achieving a pregnancy, or whether any therapeutic cloning re-
search, is so threatening to the public good as to justify government regulation over
private clinics. One way or the other, it is clear that the absence of government control
over these types of private research activities has contributed to the tendency by the
general public to ignore their existence. Tauer worries that public fears over big issues,
like cloning, have distracted them from noticing other, perhaps more worrisome, re-
search enterprises, such as embryo research related to IVF in the private sector. She is
one who believes that these technologies ought to be regulated by the government and
finds it strange "that a federal government so bent on outlawing any use of federal

funds for research involving IVF is at the same time so uninterested in regulating these procedures and research on them in the private sector" (148).

It is not unusual for a private clinic to accept some form of self-regulation, such as certification within the norms of its association or (in the case of specialized practices, like office-based surgical clinics) to comply with national accrediting bodies such as the Joint Commission for the Accreditation of Health-Care Organizations (JCAHO). (JCAHO does not provide accreditation for normal office-based physician care, nor the research that takes place in that setting, but it does seek to address the safety of surgeries performed outside the hospital.) Private clinics are not required to seek such accreditation, but might choose to do so if they care to situate themselves well within the accepted boundaries of legal and customary practice. Beyond accreditation or certification, it is quite unusual for physicians in group practices to open up their decision-making to ethical inquiry – not only from external sources, but even more by their own associates in their own practices. This explains why so little published information exists documenting the internal functions of these medical groups. However, one private clinic specializing in assisted reproductive medicine has allowed me to observe and participate in their internal ethics reviews.

Introduction to the Clinical Observations

In the next section, I present my observations and analysis of several years of ethics committee deliberations at a private outpatient "fertility" clinic, identified here as ARM Clinic (for Assisted Reproductive Medicine). But first, I must clarify my objectives and briefly introduce my findings.

The clinic's ethics committee had been active for a year or so prior to my in-volvement, but members had no special training in how to conduct case reviews, nor did they initially include anybody with experience or training in bioethics. When I joined the group, I acted more as an observer and occasional consultant (with voting privileges), but I did not attempt to advise in the use of a method or style of delibera-tion. My interest was initially directed towards four general questions. Did they use any established model or specific mode of discussion to arrive at their conclusions? What sorts of internal rules or mid-level principles guided their process? How did they come to closure on a case: by consensus or majority rule? Did they have any means of morally assessing their conclusions?

I had some preconceptions as I joined the committee. First, I suspected from my experience as a registered nurse that committee members would be familiar with the four Georgetown principles taught in many nursing and medical schools and I sup-posed because of that they would use some form of principlism as a model, but this turned out to be only partly accurate. The physicians were more aware of the princi-ples than the nursing staff and often mentioned "autonomy" as a basic tenet underlying their work, but no specific method was implied by that. The style of reasoning was more casuistic in nature with a specific case presentation, including contextual details, followed by an open-ended discussion.

Second, I thought that the practice guidelines would include more "mid-level principles" of the sort I have discussed already, because these types of rules tend to ground many medical practices. However, fertility research engenders novel situa-tions, making it difficult for clinicians to obtain timely guidance from the higher stage

thinkers at the commission or the professional organization levels of practice, thus ARM clinic created some internal rules to support their decision-making, but found these rules often inadequate or stressed by the details of the case problems at hand.

Third, I found that the ethics committee desired consensus and worked hard to achieve it, but in some difficult cases resorted to a majority vote system. Consensus offered the highest comfort level to the group in assuming that the correct moral decisions had been made. Issues that were decided by a vote implied dissent and there was less confidence in the outcome. Furthermore, the same problem was more likely to return for discussion again in new cases.

It was clear that outcomes were also dependent on personal points of view and styles of the members. An outcome could vary by the variable attendance of members, since the physicians, particular, varied in their willingness to attempt new treatments and push the boundaries, and strong opinions could push more timid members into agreement. Over time, several firmly made constraints on the practice became more nuanced as more cases and more discussions led to new outlooks.

My reactions to the case decisions themselves are varied; some seem correct to me, others do not. The problem is that the case deliberations do not often deliver a principle or a moral reason by which validity can be measured, and even if they did, it may not necessarily be persuasive to others. It should be pointed out that I did not attempt to evaluate the cases theoretically, in terms of their deontic or consequentialist characteristics, although I do attempt to indicate how different types of reasons were informed by those attitudes. In general, medical treatments in infertility are judged from a consequentialist standpoint—the physical consequences to those involved and

how the treatments can increase or harm their over all well-being—with the birth of a healthy child being the best indicator of success. But these treatments and choices produce deontological and social challenges encompassed by asking what the world would be like if these methods for producing children become widespread.

In any event, the theoretical implications of committee deliberations are complex, as will be seen in the case studies, since the participants, both patients and clinicians, raise provocative problems from both consequentialist and deontological perspectives. Cases of risk to the participants in treatment were more easily handled in a consequentialist perspective, but more troublesome cases to the committee, such as homosexual parenting or creating an unrelated child from donor egg and sperm, tended to produce uncomfortable objections that I consider more deontological in nature. However, the committee was not always able to formulate these sorts of objections or uncomfortable reactions into a clear rationale; this created a group of cases that I refer to as being settled by the "yuck factor," described in more detail in the case studies and in a chapter devoted to the problem, both in Part II.

Overall, evaluating each case for its theoretical characteristics is not the goal of the case studies produced here. Of more interest is noting occasions when or if mid-level principles or rules or any sort of processes emerged that were useful to the committee in their deliberations.

One reason it was difficult to assess or grade the committee decisions by their methodological or theoretical consistency is that many of these issues have not yet been considered at the public level wherein a wider array of points of view can be established. It was clear in some cases that when a decision-maker confronted a new

situation of this nature without a paradigm situation for comparison, he or she tended to rely on personal perspectives such as their professional experience, liberal or conservative tendencies, religion, etc. It is for this reason that I did not focus in my observations on whether the decisions were morally adequate or not, but on how the group attempted to reason towards that goal. Selecting the most appropriate moral principle by which to defend their decision was not usually foremost in the group deliberations. Instead, other significant issues interfered; such as, defining the importance of the internal practice goals, deciding how rigidly to adhere to practice rules, defining the stakeholder so as to choose whose desires should be preeminent (the status of the principle of autonomy), screening out medical problems to better evaluate moral problems, and assessing the consistency of the outcomes in similar cases (where some members were more desirous of adhering to rigid rules, while others were more willing to entertain contextual distinctions). These concerns were important to the integrity of the group process and to the cohesion of the working members.

Instead of assessing the decisions themselves, I chose in Part II to present a wide variety of cases illustrating how they tended to cluster into certain types of problems and how committee members managed them (sometimes reasoning towards consensus, sometimes presenting varied arguments resulting in a majority-rules vote), so as to enable a focus on the process itself. Whether final decisions can be labeled "wrong or right" in retrospect, decision makers must grapple with desires and choices in parenting that affect real people's immediate life plans. By displaying some details of the decision-making process, I hope to illustrate the difficulty in the notion that moral validity can be produced by applying some specific bioethical method to prob-

lems in biomedicine. The case studies portrayed here lend credibility to my idea that no prescribed method in bioethics can guarantee perfection, or even adequacy, in moral results. On the other hand, improving the deliberative process by incorporating tenets of reflective equilibrium can work to improve the acceptibility, usefulness, stability, and strength of the decisions made.

It is questionable whether this wider degree of deliberation can occur at the level of the private outpatient clinic. It would be rare for such a clinic to have access to a trained ethicist or to the various ethical theories and methods pertaining to their work. Furthermore, a clinic, even a hospital, would normally lack diversity in viewpoints as well as membership by the nature of their make-up, and yet this is where novel cases enter the gate for deliberation. Better deliberations occur when problems are allowed broad, even national consideration. However, this often doesn't occur until inconsistencies become apparent, causing the legal system, professional organizations, or national commissions to engage in discussion. At that level, certain principles or guidelines become established, providing structure for those on the first level of patient intake. Even then, care must be taken to ensure that the deliberations are inclusive, so that the answer is applicable to like cases. Otherwise they seem arbitrary or too narrow to be explained. This is where it is useful to follow the outline of the Scanlonian reflective equilibrium that I present in Part III.

PART TWO

IDENTIFYING METHOD AND MID-LEVEL PRINCIPLES IN THE

CLINICAL ETHICS SETTING

CHAPTER FIVE

ETHICS DECISIONS AT A CLINIC FOR

ASSISTED REPRODUCTIVE MEDICINE

Several years ago, a well established and highly regarded clinic for assisted reproductive medicine, situated in the suburbs of a large metropolitan area, decided to create an internally established ethics committee for the discussion of their troubling cases. This clinic, which I will hereafter refer to as ARM Clinic (ARM stands for Assisted Reproductive Medicine) has willingly included me in their monthly meetings since 1998, both as a participating nurse ethicist, and as a graduate student observer of their procedures.[33] The overt reasons for establishing the committee were to set practice guidelines and review difficult cases that fell outside their established guidelines. Another, more tacit reason, seemed to be for the professional purpose of encouraging collegiality, both among the physician-owners, and among their professional staff, so as to forge basic group values, prevent internal wrangling, and possibly settle dissent over the types of cases accepted into their practice. The clinic's culture is somewhat conservative; that is, it shuns negative publicity of the sort that might portray it as being an on-the-edge, anything goes, rule-defiant organization; instead the physician-owners have attempted to project a less radical image. This clinic is unlikely to achieve the kind of notoriety spread out in the morning paper and discussed as trend-

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[33] In private correspondence, dated January 26, 2003, ARM Clinic allowed me to use the anonymous examples from their private deliberations presented in this paper. I am very grateful to the physician-owners and staff members for their willingness to allow me to disclose for the sake of analysis some of their operations and activities. My intent is to maintain strict confidentiality, so I have withheld identifying information about the patients.

setting. Achieving collegiality was important to the physician/owners, for the sake of

their business and personal relationships and also to merge their professional staff

(nurses, technologists, social workers, etc.) into a culture where their variety of reac-

tions to their work could be dealt with openly and incorporated into a well-functioning

corporate whole. Some of the health-care workers in this field exhibit more flexibility

with the rapid pace of change and the adoption of new technologies in the practice

than do others, who despite their expertise in the field seemed sometimes to be as

alarmed by the constant evolution of technology in their field as an outsider might be.

The physician-owners promoted the idea of inclusion and consensus, not only among

themselves, but for the whole staff, so that the ethics committee has functioned as a

sort of release valve for the discussion of "hot" topics. A broader but unstated value

may have underpinned the initial creation of the ethics committee: a desire by the phy-

sician practitioners themselves to come to grips with the rapidly changing climate and

complex internal dynamics of their chosen work, as it intersects with the boundaries of

science and ethical choices. Those who work in the field have proven to be as inter-

ested, and at times as troubled, by the implications of their own work, with its new

scientific and human possibilities, as are those making observations from outside the

profession. It was noticeable to me upon joining the committee that different practitio-

ners had internalized different values, probably as a result of personal differences in

religious backgrounds, cultural experiences, and education and training. The physi-

cians usually express a more careful, thoughtful, knowledgeable, and sometimes more

liberal stance, as compared to at least some of the staff nurses, who appear to have

maybe just "taken a job" only to find themselves disturbed by some of the moral ques-

tions at stake. In some instances, I was surprised to hear members questioning the basic morality of such practices as surrogate mothering or sperm donating that are integral to the work of the clinic, as if they had not previously understood the implications of their own work.

The monthly meeting was organized to allow any staff member to bring up a practice question or troubling case before the full committee. Generally, however, issues were added to the agenda by the case-nurse or attending physician, who brought cases up presumably because of their anomalous features, or their unusual context, or their lack of fit within ASRM practice guidelines for various reasons, or their overall novelty to the practice. When setting up its ethics advisory committee, the clinic had adopted certain conditions on its overall practice of medicine, mostly taken from (and sometimes more conservative than) the policies and standards already developed by their association, ASRM.[34] These policies did not always prove sufficient for determining whether a physician should accept a case, or proceed with treatment, because they were not always up to date with the real cases presenting at the clinic, or they were sometimes too general to seem to fit a specific problem.

In its current operating rules and procedures, the committee is open to all the physicians in the practice (although they do not all choose to attend every time), the

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[34] Moreno points out that private ethics committees of the nature I am describing here are expected to be developed on behalf of patient protection:. "Whereas ethics commissions focus on policies that are to apply across institutions, ethics committees are creatures of particular institutions. Their legal and bureaucratic authority is established by administration or by a medical staff organization, but their ultimate responsibility is supposed to be to the patients. They are expected to be respectful of legal constraints, disciplinary integrity, and institutional protocols but also to be critical of them and, if necessary, to appeal to higher sources of guidance, such as philosophical reflection. Perhaps the only element of the modern ethics committee's mission that is taken as mandatory is the protection of patients' personal autonomy" (1995, 88). This goal of defending autonomy seemed to me to be less obvious at ARM Clinic than the goal of creating an internal basis for accepting or rejecting cases along with a rationale for doing so that would be acceptable to their patients.

social worker, the specialized nurses who manage certain programs (the egg donor or gestational carrier programs, for example), the responsible case nurse (each patient is assigned to a specific nurse for the duration of her care), a chaplain (who ministers at a nearby hospital), and a nurse ethics specialist (myself). The committee's format is that individual cases are presented by each attending physician, but for the sake of objectivity, the doctor does not vote on his or her own cases, but is instead bound to accept the vote of the rest of the committee, which includes at least one of the other clinic physicians. Otherwise, the case will be tabled until another physician is available. In this way, the full committee has voting power, but can be effectively swayed by the power of one of the physician-owners, who obviously carries the most responsibility and liability for actions and treatments offered at the clinic. The meetings are generally informal, incorporating lively discussion in a relaxed give-and-take style, both on the factual-contextual issues at stake, and on the more philosophical issues adding content to the case. The format is not set in stone, but changes from time to time. Consensus is not set out as a formal goal, although it is striven for, and most cases do not require a formal vote, although sometimes a vote on a case or an issue is necessary when unanimity does not clearly emerge, or when it seems useful to make the differences of opinion and the reasons for them more explicit. Physicians tend to dominate the discussion and their opinions tend to take priority, while nurses and other staff members are more likely to listen quietly and deferentially, although sometimes the physician-presenter's point of view is overruled, either by a fellow physician or by the other committee members. These 'losses' are accepted in good grace, although are known to be rehashed by the physicians privately. Occasionally a case is tabled to al-

low for more thought; rarely a case decision is changed by the introduction of new facts or appeals by other physician members at a later date.

I joined the committee as a nurse bioethicist in March of 1998 and have participated in a few more than 100 cases since then.[35] I made specific notes on 87 cases (having omitted taking notes on some of the more procedural and pro-forma cases). While participating in and observing the ethical deliberations at ARM Clinic, I wanted to learn in contextual detail about the types of cases and issues handled there, so as to more clearly understand how the research and the medical treatments offered in this unregulated setting affected bioethics overall; also to learn what broad internal rules or specific mid-level ethical principles were applied or developed from the ethical discussions at this clinical level; and to ascertain or uncover any overt or tacit method by which the group made their decisions. Furthermore, I wondered how the members of the clinic justified their decisions overall.

My findings on these questions, especially the various informal rules and methods, will emerge in the following case presentations; however, my overall conclusion is that this group did not, and probably could not, engage in the kind of moral reasoning described in Part I of this dissertation. Even those members familiar with the Georgetown Principles, for example, could not find a way to "specify" them down into more particular principles or applications for the cases at hand. It is not a matter of training or knowledge, but the fact that reasoning on the immediate level of the private clinic is very difficult, both because of the concrete impact of the decisions and

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[35] In joining the committee, I emphasized my interest in making observations of their activities and interactions, their methods and results, for my own research as a graduate student at the University of Maryland at College Park. However, as an experienced Registered Nurse with competence in the field of ethics, I also contributed to their deliberations.

because novel cases appear here where the deliberators don't have access to wide opinions or paradigm cases to help them think through the ramifications. Furthermore, private clinics do not and cannot rely on diverse membership, including minority representation, although this clinic was unusual in not only forming an ethics committee, but inviting an outside ethicist (myself) and a chaplain with no particular medical knowledge. In fact, adding lay members from the public does not seem prudent to private clinics for fear of negative publicity or lawsuits.

My observation of the clinic's ethics committee activities leads me to argue that the style of reasoning most conducive to well-accepted and morally valid outcomes (what I introduce later as Scanlonian reflective equilibrium) must occur at a more public, more diverse, more abstract, and thus probably a national level. Mid-level principles generated at that scale can then be made available to help guide the decision-making at the level of the ARM clinic. I will show in the case discussions how members of the committee looked for paradigm cases and mid-level principle published by their professional association to help them in their endeavors.

In order to present the results of my experiences, I have categorized the cases, not only by topic, but by a larger bioethical framework in which they occurred. The first group, including about half the cases, involved what I call "risk and consent" issues, where the primary concern consisted in calculating the acceptable amount of medical risk to the patient, or to the donor participants.[36] When a certain level of risk or impact on health is at stake in treating infertility, the primary framework for ethical

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[36] In many cases, it is important to be reminded that the infertile patient is not the only one undergoing treatment in assisted reproduction; in fact, he or she might not be treated at all, but be replaced by an egg or sperm donor, or a gestational carrier (this term is preferred to that of "surrogate" in reproductive medicine).

discussion becomes informed consent. During the four years I have served so far on this committee, forty-one cases, or about half, fell into this category. The "risk and consent" category can be further subdivided into two general sub-topics. One is risk related to *age,* of which I heard twenty-one cases; the other is risk due to more general *health-related* causes, of which I heard twenty. Chapter Six is devoted to a discussion of these cases.

The second group consists of more complicated cases involving what I refer to as *relationship* issues. Here are the more novel cases in the field of reproductive medicine, involving a variety of ethical issues: homosexual parenting; "baby creation" (when a baby is created for parents with no genetic relationship by use of donor sperm and donor egg); mixed genetic fertilizations (when sperm pooling or mixing of embryo donations from more than one donor is used for reproductive purposes); and interfamily or transgenerational donations. Each of these sub-categories involves unfamiliar and even extraordinary changes in familial relationships, causing ethical controversy. Altogether I have collected data on thirty-five of these cases. (Some of these cases exemplify interesting ethical discussions in more than one sub-category; i.e., they might appear in both a discussion on the ethics of homosexual parenting and on the ethics of "baby creation," for instance.) Chapter Seven is devoted to a discussion of these more novel issues.

A small group of eleven cases involve broader policy concerns. I do not discuss them separately, but they will be introduced when they fit into the case discussions. They include more policy-oriented issues, such as the appropriate limitations on

sperm or egg donations, or the delineation of institutional responsibility for the upkeep of frozen embryos.

Following are three figures displaying my categorization of the distribution of cases heard at ARM Clinic.

Table 1
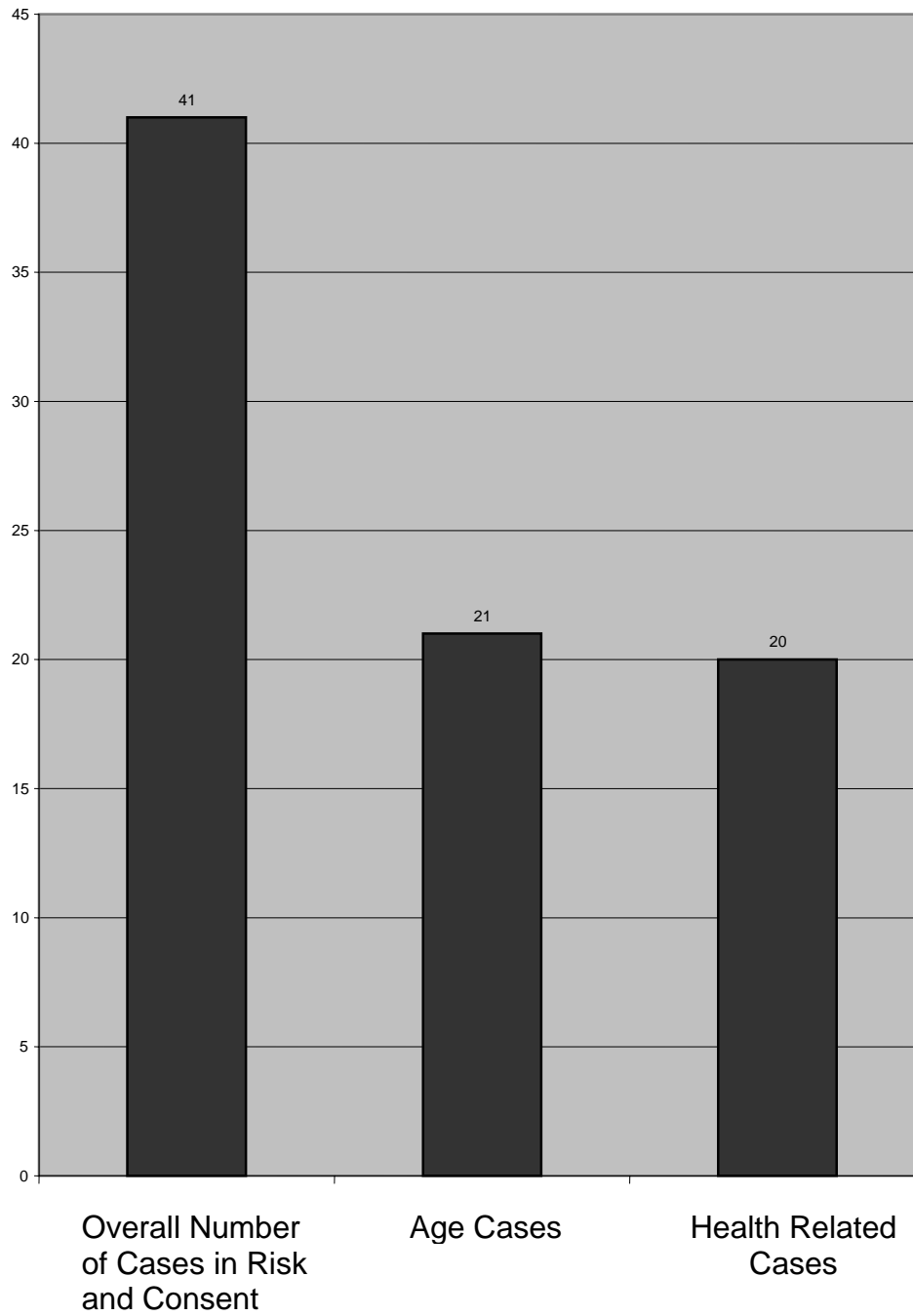**Ethics Cases Over Four Years at ARM Clinic**
Category: Risk and Consent

Table 2
Ethics Cases Over Four Years at ARM Clinic
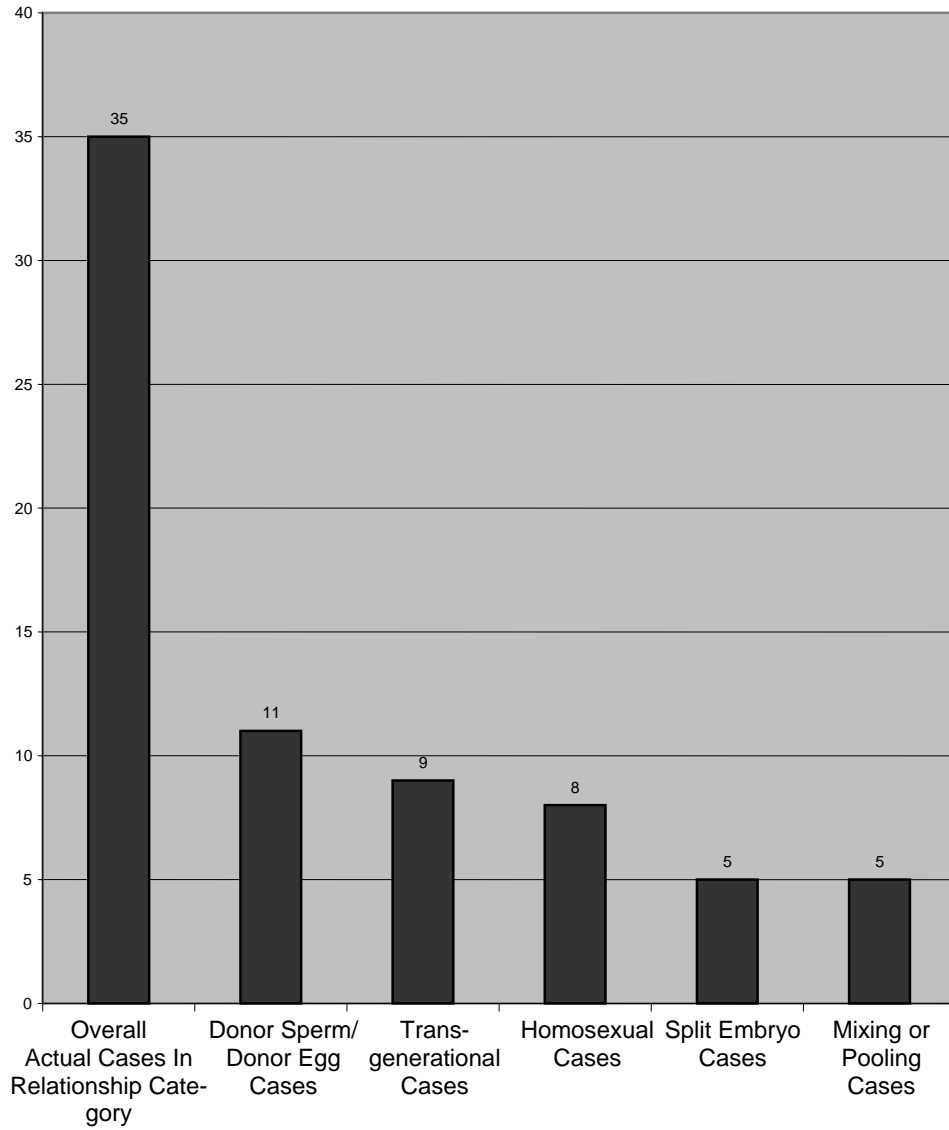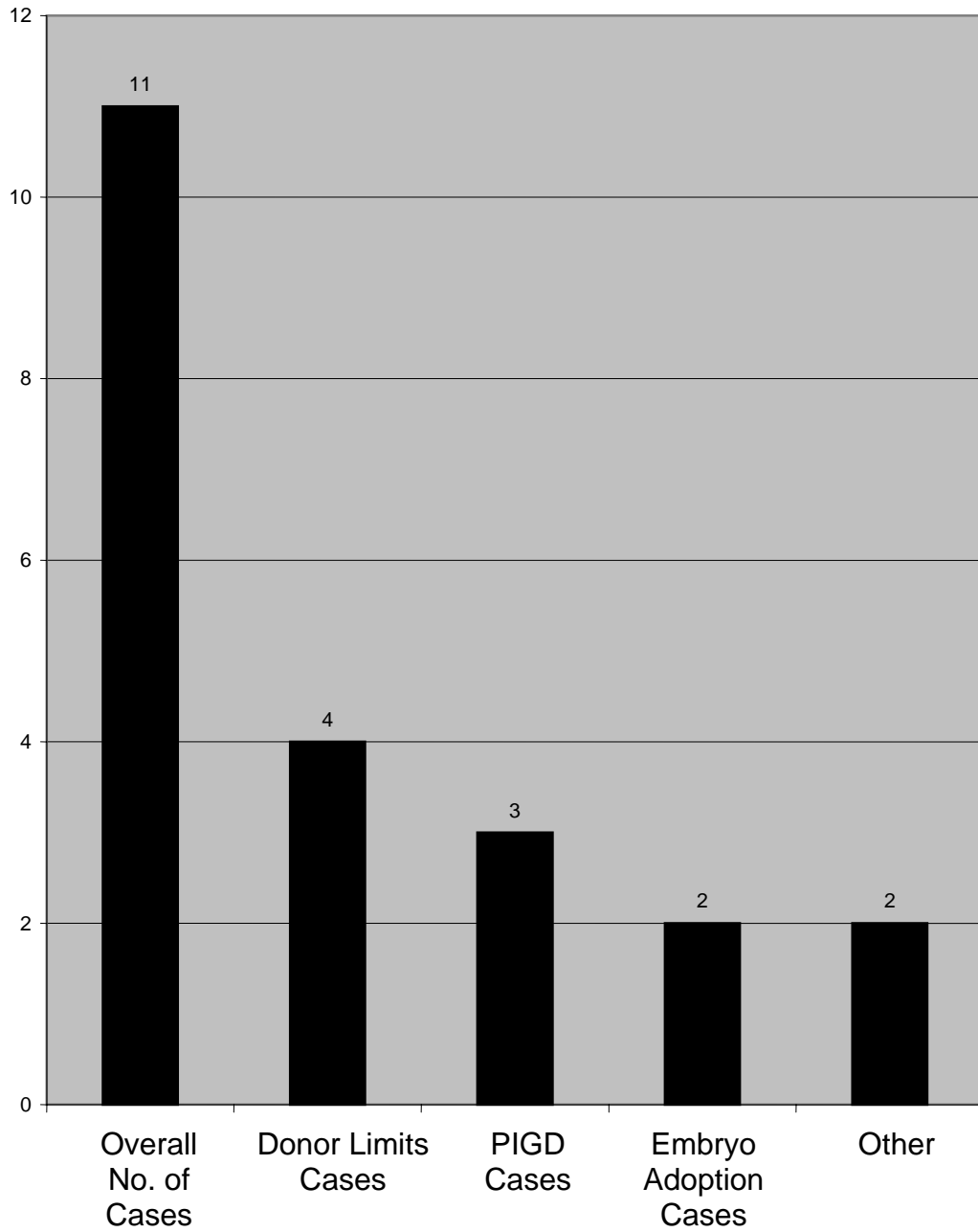**Category: Relationship**

Table 3
Ethics Cases Over Four Years at ARM Clinic:
Category: General Issues

CHAPTER SIX:

RISK AND CONSENT

The types of clients requesting the services of assisted reproductive medicine are not generally thought to be incompetent in any way, nor do they generally lack any capacity for making their own autonomous health-related choices, although some of them, whether patients or donors, might lack enthusiasm for treatment and have been encouraged to participate, or pushed to the point of coercion, by other parties. However, some may lack sufficient medical information or knowledge to ensure that their choices are considered and thoughtful. The hopes and dreams of would-be parents, or the financial desires of donor and surrogates, may sometimes override their common sense. For these reasons ARM Clinic has put guidelines in place by which to attempt to screen for the most obvious indicators of reduced competence, such as previous medical and/or social histories thought to limit suitability. The most important of these indicators is the age indicator—capturing those who fall under the age of legal accountability or fall over the age limit after which age is seen to be a medical barrier to a healthy pregnancy and birth. The clinic has depended heavily upon psychological and social screening, both by written testing and evaluation and by one-on-one interviewing conducted by licensed social workers or psychologists, to seeking treatment or offering their services as donations. (The reliability of these services in weeding out susceptible patients is the topic for a different work, but in general, they appear to protect the clinic effectively from legal liability.) However, despite psychological screenings and medical evaluations, some cases fall outside the mainstream. There may be doubt as to the suitability of the client to undertake risk, or doubt as to how to evaluate

the reasonable risk to be assumed, or to estimate properly the chances for successful treatment. Out of the 41 cases I have categorized as "risk and consent," half consist of patients whose age has either reduced their opportunity for parenting, or increased their pregnancy risks.

Aging Issues in Achieving Pregnancy

Reproductive medicine has not yet managed to induce pregnancies in women consistently past the age of about forty-four years, regardless of their previous status of fertility. In a January 2002 committee report, ASRM reported, "In a recent multi-center review of 431 initiated IVF cycles in women ≥ 41 years, there were no clinical pregnancies in women ≥ 45 years and no deliveries in women ≥ 44 years of age" (3).[37] However, many women of that age, or on the cusp, are desperately anxious to proceed with attempts to attain pregnancy despite the grim facts. Some have been in treatment and want to give it 'one more try'; others have missed previous opportunities for parenthood due to their personal life story and are reluctant to give up. Women of this age, or older, are often able to carry a pregnancy by use of an egg donor, but find it difficult to give up the hope of carrying their own genetically related child. Following are some case examples taken from ARM Clinic, set forth to try to bring out the ethical issues at stake, and to elicit the committee methods as they emerge from their discussions.

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[37] See "Aging and Infertility in Women, A Practice Committee Report," produced by ASRM, January 2002. The reports, produced regularly by the association, carry a disclaimer that says: "A Committee Opinion offers consensus-based (or evidence-based when there is sufficient evidence available) guidance relative to a given practice activity. This guidance, in addition to scientific and clinical information, may take into account issues of ethical and financial concerns." The reports carry great weight with affiliated members.

<center>**Example 1**[38]</center>

In a typical example, a 45-year-old woman had previously used IVF to freeze embryos, but had not become pregnant after two attempts to use them. Because her physical, hormonal, and other medical indicators were good (she was referred to as a "high responder"), she wanted to try to produce more eggs for IVF. She was aware of the expense (which can easily be more than $10,000, depending on all the medical circumstances and medicines involved). Her case was presented to the committee because she was barely over their age guidelines of 44 years and 11 months. After some deliberation about her medical history (that she was a "young 45," not a typical person of that age), the ethics committee decided to give her "another try for the sake of closure." Discussion ensued as to the ethical implications of offering 'closure' as a solution, when the statistical chances were slim. One physician felt it was wrong to offer false hope, noting that by accepting the fees the clinic might seem mercenary, even though the patient understood and signed off her informed consent. The committee was clearly more motivated by beneficence than greed, simply unable to say no to a sad and wishful applicant. Some worried about the clinic's legal position when the procedure failed, as it was likely to do, and the woman might, in a litigious world, file a lawsuit. Nevertheless, sympathy won out in this case, and the committee agreed to allow a last attempt, as long as the issues were once more clearly laid out for the patient, consent forms were signed and she accepted 'closure' after this last trial (5/99, Case 1). Although no pregnancy ensued, the patient was satisfied.

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[38] For the sake of reference, I have numbered the cases sequentially as I present them, but they are also identified by the case number and date assigned to them in my own personal notes.

Example 2

In a similar example, but one that illustrates how contextual issues add to the ethical reasoning, a 44-year-old woman, having had two successful pregnancies culminating in childbirths, followed by a tubal ligation, had after a divorce married a man who very much wanted a child of his own. The committee agreed to allow a trial to stimulate egg production, primarily again because of the personal sympathy aroused by the case, but this time by preparing the patient more actively to face her ovulatory failure, while encouraging her to evolve towards an eventual pregnancy enabled by a donor egg with her husband's sperm. This solution would allow the couple to carry, bear, and raise his child together. The woman was within the age guidelines set by the clinic to carry a surrogate pregnancy (at ARM Clinic, the preferred term is "gestational carrier"), because despite the normal ovulatory failure by age 44 or 45 in most women, many are able to carry a pregnancy in their older years with the assistance of reproductive medicine. Here, the approval by the ethics committee included a notion of achieving "closure" for one medical procedure, but also adding counseling and information so as to allow a possible second level of success (10/99, Case 3).[39]

Example 3

In another case where sympathy or beneficence overruled the clinic's self-imposed age limit, a political refugee had been forced to abandon her children in a war-torn country after having also been sterilized by tubal ligation against her will.

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[39] Recently, new research has been published assessing the risk to the mother in achieving pregnancy in "advanced" ages. See Richard J. Paulsen et al in the November 13, 2002, *JAMA*, where the conclusion in this research was that "Appropriately screened women aged 50 years or older can successfully conceive via oocyte donation and experience similar pregnancy rates, multiple gestation rates, and spontaneous abortion rates as younger recipients…there does not appear to be any definitive medical reason for excluding these women from attempting pregnancy on the basis of age alone" (2320).

Here, after immigrating and entering into a new marriage, she wanted another child, and against the odds, the committee decided to allow her to try for a pregnancy (5/99, Case 3).

In discussion, the medical staff often found themselves frustrated by the growing number of patients who delay pregnancy attempts while approaching their age barriers to fertility, and yet appear surprised when they realize that the reproductive limitation exists for them. Overall advances in the field have apparently led many otherwise fertile women to misunderstand the age limit to their capacities and "put off" the decision to engage in reproductive activities until it is too late, although it is true that the deadlines have been somewhat extended by scientific success. Furthermore, the actual physical risk to a prospective mother embarking on a pregnancy in her mid-40's appears to be acceptable to most women in this situation, probably because of an assumption that in modern medicine, serious risks rarely lead to death, so that the overall reward of achieving parenthood is deemed worth the trial. However, certain medical risks such as preeclampsia and gestational diabetes are increased, causing informed consent procedures to be taken very seriously by ARM Clinic (Paulsen 2322-23).

The concerns about aging and risk are similar in cases where infertile women have given up attempting their own egg production, but still intend to attempt to carry a pregnancy with donor eggs. Here, the physical age of pregnancy has been pushed into the 60's in some clinics. ARM Clinic has somewhat arbitrarily determined that their age cut-off for such cases should remain at 49 years, 11 months, although the new research may encourage reconsideration. Besides the physical risk of pregnancy,

however, committee members have raised the concern about whether a mother of advanced age might find herself too old to raise her child to adulthood (if the average age of death in the U.S. takes place in the mid to late 70's, then the chance for a woman who bears a child at 60 to live long enough to raise the child to age 20 or so seems statistically weak). More basically, committee members feel that post-50 pregnancies, by their distance from the norm, raise energy and health considerations too variant from traditional understandings of what "natural" pregnancies are thought to be. These concerns by the committee go beyond the consequentialist or the procedural, and are more deontological in nature because they seem to many members to be wrong despite any possibility of good produced by the overall outcome. However, the expression of good reasons proved difficult in these cases. Committee members questioned whether the clinic ought to push aside age boundaries set by nature and asked about the broader implications when doing so. (What would the world be like if the capacity to have late age pregnancies were available to all? Is it right to meddle with nature in this way, even if there are no untoward consequences?) However, the hesitance in allowing late-age pregnancies seemed illogical to committee members with a more consequentialist outlook. They pointed out that a woman deemed healthy enough to carry a pregnancy at age 50 was in every likelihood capable of living beyond her 70's to raise the child, and that women seeking treatment are often wealthy enough to pay for help in rearing them if they lose health or energy. Also, they noted that grandparents often raise children successfully, even in their old age, while nature carries no guarantee that young and healthy parents will necessarily live a long lifespan.

Some members who took autonomy to be a superior principle insisted that many aspects of life and death are out of our control (particularly our control over death) making it unpredictable whether or not any parent, young or old, might survive to raise his or her children, therefore, the choice of the parents to make their own decision to undergo late-age parenting should be honored as valid in itself. This argument was used to support the request of any infertile woman of varying ages to attempt parenting. But the logic of that argument did not win over some (both consequentialist and deontologically-oriented) members of the committee who worried about the ramifications for society if many parents moved to late-age parenting. The notion that autonomy must always play a decisive role, in bioethical decision-making, was not taken as a paramount concept to this group.

Example 4

In an example of an advanced-age pregnancy, a 50-year-old woman had recently entered her first marriage, with no previous opportunities for pregnancy, and wanted very much to carry a pregnancy with a donor egg. Preparing a woman for pregnancy at this age cannot be thought of in terms of one trial, it is more of an investment in setting up a series of hormonally induced cycles in the woman over time where certain physical and medical factors indicate readiness. To the physician, it is a situation of "following the curve" consisting of an upslope in readiness, followed by a downslope, perhaps lasting three or four cycles altogether. This means that a woman entering treatment will continue to age as the preparations and treatment commence, so that to begin treatment at the clinic's established limit of 49 years 11 months could mean that the date of an actual pregnancy will occur well after the age of 50. The

clinic is unwilling to start new cases beyond their self imposed limitation, but is some-times hesitant to stop an on-going process. In this case, the added sympathy factor for the situation of the woman's "missed opportunity" encouraged the committee to allow the treatment even though she was past 50 (1/01, Case 3).

Example 5

In another example, where sympathetic responses by the committee led to an exemption from their policy, a woman in her late 50's had successfully carried a preg-nancy during her 40th decade for her daughter who had lost her uterus due to cancer. Now, she wanted to repeat the experience to enlarge her daughter's small family. Be-cause it was argued that neither her health nor her physical status were appreciably different than during the previous pregnancy, and because she was not going to raise the child herself, the consensus of the ethics committee was to allow the late-age ex-ception to the rule. In this case, the selflessness of the mother's desire worked to coun-teract concerns over the amount of risk and the "unnaturalness" of the pregnancy (12/01, Case 3).

Age-Related Issues in Donors and Surrogate

If it is hard to decide what amount of risk is acceptable for the would-be mother, it is even more difficult to make a decision when the person taking the risk is a paid surrogate. Age limits are even more restrictive for egg donors and gestational carriers than for potential parents, to avoid risk and maintain health. Nevertheless, even here, women seek to push the limits.

Example 6

A woman in her late 30s, with a large family of her own, had previously served as a gestational carrier, and now wanted to participate again, although she was beyond the age guidelines, normally 35. The committee questioned why the age guidelines should not be breached for this fairly young carrier when older women with less successful health histories are allowed to carry their own pregnancies well into their late forties. Other members were more cautious and perhaps paternalistic, considering her case to be slightly risky, because there is a reported tendency towards excessive bleeding in women after multiple pregnancies; a few others were unsympathetic because her motive was predominantly financial, making the risk seem less worthwhile in her case. In the end, she was refused another opportunity, primarily because a perceived responsibility to protect women from their own choices assumed importance in a case where the risk was not offset by the gain of something presumed to be of more value than money, the bearing of one's own child (3/01, Case 4).

In this type of case, the problem is larger than whether to prescribe a set age rule, how risk can be adequately measured. ASRM guidelines are presumed to have been developed with risk in mind, but the supporting premises are not always clear to the users.

Example 7

Here, a fairly young egg donor had produced eggs in four previous ovulatory attempts. She wanted to donate again, but was refused because of ARM Clinic's rule of limiting donors to four. However, it turned out that the ASRM guidelines have been recently relaxed to allow five or six donations. It has not been clearly medically estab-

lished what risk is involved in stimulating ovulation, whatever the number, four or six. For the committee, the problem was to find some reason either to back up their original policy or to drop it and adopt the ASRM number, and for help with reasoning they looked to the context – especially the donor's motivation for her request. Without that information to "fill out" the details, they simply couldn't decide, so they tabled the case for later review. This was a good example of how, even with clear policies at hand, a principle of risk analysis needs to be clarified by attention to personal details, or very clear medical reasoning (3/01, Case 7).

In other cases, reasoning about age limits is less about risk and more about the impact on the competency or capacity of the prospective donor to make informed decisions. Many egg donors are strangers to the prospective parents, participating for a fee; but occasionally, the donor is known, usually a close friend or family member. These cases are carefully screened for coercion to be sure that full and free consent is given and also screened for legal considerations to prevent possible future claims on the child by the donor. Because of these concerns, the age of consent for donors is generally set to be 21, but occasionally a question arises about how rigidly to adhere to that age. Comparing two such cases illustrate how contextual issues can frame the debate.

Examples 8 and 9

In the first case, a woman wanted to use an egg volunteered by the daughter of a close family friend who was slightly under 21. In the second case, a woman wanted to pay for the use of a willing, but anonymous, egg donor who was also slightly under

age 21. The first case was felt to be inappropriate, while the second one was easily approved by the ethics committee (5/99, Case 4 and 10/99, Case 5).

To those who supported both cases, the age limit was thought to be an arbitrary standard, and in any event, set too high, because many natural births occur before age 21, and additionally because the age of consent for such practices as voting, joining the military, independence from parents, and marriage is usually 18 and sometimes even younger in many states. But those who supported the age limit of 21 worried that because the medications necessary to encourage ovulation and egg harvesting cause uncomfortable and time-consuming side effects in women, it might eventually be found to have some overall health implications; reports have hinted that future cancer rates might be found to be increased by these treatments, although no sure evidence has so far been produced. To this group, it seemed wrong to encourage the participation of a young woman under 21, particularly one who was unmarried or childless herself. An associated concern was that the emotional experience of donating the personal genetic material embodied in an eventual child could be especially psychologically harmful to a young woman with no sexual experience at all and perhaps disturbing to her as she later embarked on her own sexual and family relationships. Should a virgin go through the physical stresses of medicalized ovulation, or even further, should she be allowed to bear a child? Could a young woman under 21 assess these issues and make her own decision adequately?

The committee reasoned that an anonymous donor, by virtue of the distance and lack of relationship between her and the prospective parents, was more protected against these possible problems. An anonymous situation more closely resembles a

business transaction where published safeguards and legal representation provide some institutional protection to the donor. In contrast, a known donor has only the protection of her family for support, which could be positive or negative depending on her personal circumstances. Many members, stressing the principle of beneficence, nevertheless support known donors because the young woman is thought to participate in something more important than money, the unselfish satisfaction of helping someone for whom she cares. However, the possibility of coercion, either blatant or subtle, could not be overlooked by the committee in these cases, and an added problem, the transgenerational nature of the transaction (to be discussed in more depth in the next chapter) proved to be too troubling to the group because it allowed for the possibility that the younger women could be too easily swayed or intimidated by the older. Some mentioned that such scruples seem overly conscientious, considering that egg donations are a growth industry on college campuses nowadays, even among women under the age of 21, and that sperm donation by young men is fairly routine (although for them, the physical risk factor is absent). However, in these donations, there is no relationship to the prospective parents, whereas in the known donor situation the impact for a young woman to experience and watch someone else raise a child with some of her genetic input may prove stressful. In these deliberations, one notices how the issue of motivation became very important to the committee as it attempted to make an ethical decision. Also certain background assumptions about the factors that might cause psychological harm or prove to make life more problematic to future people were absorbed into the deliberations, and became more important than the actual psychological screening presented by the specific individual whose problem was at stake.

Frequency of Attempts

If the risks in medically stimulating egg donation and/or pregnancy were clearer, the ethical answers would also be clearer, since much of the debate, as I have shown, revolves around potential risk. No matter the age of the female donors or of the prospective mothers, one cannot help but wonder how many times a woman can go through the physical demands of infertility treatments, egg donations, or surrogate pregnancies safely. Besides worrying that the treatment might cause future health problems, women must be concerned about the impact of fertility treatments on their current health, and in the case of donors, on their own personal hopes for childbearing. One reason to restrict the number of egg donations is that a woman's fertile years can be "used up" serving others, causing a confrontation with her own infertility when and if she finally gets around to planning for her own pregnancies. For that reason, both in egg donations and surrogacy, ARM Clinic has preferred to use women who have already successfully borne a child, and are presumed less likely to worry about impairing their later fertility.

However, the clinic did not maintain or administer its own program for obtaining gestational carriers, and kept only a short list of possible egg donors. More often, the client in need had to procure her own donors from known sources, perhaps from family members or from presumably reputable companies or agents, contracted individually by a lawyer. More recently donors can be located on the Internet, where the legal and psychological screening may not be so scrupulous. Known donors, especially close family members like mothers or sisters, are valuable despite serious con-

cerns about their age, numbers of pregnancies, and so on, because their desire to participate is thought to be based on beneficence.

Examples 10 and 11

These two cases were similar in that the egg donors in both situations wanted to override the clinic's limitations of four donor cycles. The difference was that one donor simply wanted to go through the process again, presumably for the money, while the second donor, who had previously contributed to a successful pregnancy, wanted to contribute to the same satisfied infertile couple again after they requested her particular services to create a half sibling to their first child. The idea that the second woman had a more unselfish motivation, and that the family would gain by adding a genetically related child to their family, led the committee to accept the overriding of the limit in the second case, while rejecting the first (3/01, Case 7 and 5/01, Case 2).

The clinic is less conservative in cases of women under treatment for their own infertility, putting no limit to the number of tries they might take to achieve pregnancy, because the risk, if one exists, is essentially her own, not one imposed on another agent, either surrogate or donor. The issue of how long to continue treatment has more to do with her own body's success (clearly age-related) in generating eggs or retaining pregnancies, or her own current health, rather from any concern about unpredictable future health risks.

But there is one more reason, other than health risks, to worry about the number of donations to be allowed by both egg and sperm donors and that is the desire to prevent future reproduction among related couples.

Consanguinity

ARM Clinic allows four, or rarely five, egg donations from a single female donor (as I have mentioned, ASRM allows six), which might produce in theory as many as 25 pregnancies from a single donor because each donation can average five embryos (although in practice some are stored and left unused). Although not every fertilized egg results in a pregnancy, it is conceivable that since many embryos are frozen for possible later use, a possibility for many live births in one geographical area exists. It is thought that by limiting the number to about 25, the possibility of future consanguineous relationships is deterred. (Consanguineous relationships are those where sexual relations between closely related pairs, such as siblings or half-siblings, might produce children). The rule on male sperm donors is to generally restrict them to the production of 10 children from their donations in any one geographical area, although some clinics allow a far larger number.

The problem of consanguinity has been assessed by epidemiologists, who declare that both hypothetically and mathematically, it is unlikely to be a problem, even in a small locale. Nevertheless, ASRM guidelines are set to limit the possibility as much as is feasible. Only in the future will this risk be made more apparent, if DNA testing or record-keeping on children born of these new techniques becomes more routine, so that the knowledge is more readily available. We are only beginning to reach the time in which children born of these reproductive practices are reaching marriageable ages.

Overall concerns about risk in reproductive medicine are complicated by the fact that even the natural, unmedicated state of pregnancy, and the various hormonal

cycles of nature, carry a certain amount of risk: e.g., ovarian cysts, tubal pregnancies, blood clots, miscarriages, hemorrhage, toxemia, and so on. So far, I have discussed cases of risk avoidance, but at times the committee has been faced with the question of how to evaluate the reasonableness of health risks women will accept for a pregnancy. Some women have been willing to go too far to protect themselves by looking to surrogate pregnancies unnecessarily. Others have willingly ignored serious concomitant health threats to themselves as they proceed with fertility treatments. This introduces a strategy used by members of the ethics committee at ARM Clinic: "doing the medicine first." This involves an attempt to distinguish medical issues before embarking on a conversation about ethical issues.

Doing the Medicine First: Concomitant Illness

Physicians believe, in general, that they have a responsibility to protect their patients from assuming too much risk, but in a few examples, some women want to escape risk altogether. Should reproductive medicine be used to transfer the problems of fertility and pregnancy onto other agents without a good reason?

Example 12

In one case a woman had previously carried a multiple birth pregnancy, after receiving fertility treatment, and she wanted another child. However, she did not want to endure the discomfort and inconvenience of stimulating ovulation, with the attendant possibility of multiple births; instead she wanted IVF so that she could control the number of embryos. While it may seem reasonable to use caution to prevent multiples, the use of IVF as an insurance policy was seen as "over-medicalizing" her problems by using more intrusive treatment than was warranted by the features of the original

infertility problem. Other contextual issues, such as the woman's obsessive exercise and weight control, seemed to indicate a pattern of attempting to over-control events. She was advised to stay focused on the routine inducement of fertility by medication because IVF was thought unnecessary if she cooperated in basic treatments (8/99, Case 4).

However, this case led the committee into a discussion on how to distinguish between medical therapy versus life enhancement. How far is it appropriate to go in assisting reproduction when the issue is discomfort or inconvenience, rather than risk? Would complaints about headaches or mental health issues, or perhaps busy work schedules, be worthy of enlisting a surrogate to carry a pregnancy? To the physicians at ARM Clinic, although agreeing that no bright line separated correct from incorrect approaches to this problem, clarity could be achieved by what they referred to as "doing the medicine before doing the ethics," because often then the ethical question was dissolved. What this means is that the focus should always remain on the physical symptoms, medical diagnosis and available treatments before moving toward more complex solutions or debating the morality of a problem. Many ethical problems disappear when a medical solution to infertility is found. This might mean that a repair of a woman's ovaries or a treatment to enhance sperm production in the male can interrupt the need for donors or surrogates, for example. Only when all medical or surgical treatments have been tried is it necessary to turn to "hard" solutions, so that the ethical problem might be resolved or is delayed for later, perhaps more complex discussion, if not entirely put off. This approach can be understood by looking at some cases where

women suffered from illness but where the level of risk in attempting childbearing was uncertain.

Examples 13 & 14

In these two examples, each woman wanted to use a gestational carrier to carry her pregnancy because of her problematic health history; one had a severe clotting disorder, causing bleeding and necessitating the ongoing use of drugs; the other was taking the drug Tamoxifen to ward off a future recurrence of breast cancer. Although the exact health risks of pregnancy in both cases were unknown, they seemed to provide reason enough to validate the use of surrogates. ARM Clinic never forgets that the use of such carriers is, in fact, pushing risk onto someone else, but presumably to a much lesser degree than was present to the original patient; however, they don't want to embark on a new discussion about the morality of the use of surrogacy in general each time the need for it arises. By comparing known similar cases, by investigating actual medical options, and by assessing statistical known risk (when it is quantified) the decision about the ethical implication of using surrogates for these two cases disappeared and the outcomes were determined by "medicine" alone (9/98, Case 2; 10/99, Case 2). Doing the medicine first decreased the tension in the ethical decision at stake, although the moral problem might arise again in a hard case.

Example 15

However, in an opposing example, a woman wanted to create and freeze embryos for use in a future IVF pregnancy, because her husband traveled frequently, missing opportunities for her impregnation when her cyclical readiness had been prepared by fertility medications. By starting with "medicine first," the woman was not

seen to be a candidate for the more intrusive and expensive treatment of IVF, because her implied need was based on logistics or expedience and not required by her health. To the physicians, this case appeared to be "social medicine," intended to simplify a lifestyle problem. And yet, it appeared pregnancy would never spontaneously occur for this couple without help, so a compromise idea developed: to freeze the husband's sperm to be used for insemination when he was unavailable and she was ovulating. The hard ethical decision of "social medicine" was deferred, or at least diminished, by thinking of the simplest medical solution first (12/01, Case 2).

However, in many cases, it is difficult to evaluate the risk from concomitant illness or difficult to determine the personal risk that an autonomous agent ought to be allowed to assume, so that doing the medicine first is not a simple series of steps.

Examples 16-18

Each of these three examples were solved by "doing the medicine first," but in different ways. In Case 16, a woman with a history of ovarian cancer wanted to attempt to generate eggs from her only remaining ovary, to preserve for a possible, future IVF pregnancy, before the ovary was surgically removed as was thought necessary by her prognosis. Her form of cancer was not hormone-dependent, decreasing the danger of its recurrence while being treated, so it was believed safe to allow the fertility treatments to proceed (5/99, Case 2). She was at risk, but the medical determinations allowed the ethics of the decision (if she should become a mother, the possibility that her life span could be dramatically shortened by the disease) to remain on the back burner, so to speak.

But in another case of cancer (Case 17), assessing the situation through the lens of "medicine first" was more difficult. This woman required a hysterectomy due to a "molar" pregnancy, a cancerous condition, but one with a high cure rate after treatment; she now wanted to generate her own egg to be fertilized by her husband's sperm and placed in a gestational carrier so the couple could produce their own child. For her, and for any possible children, the risk was deemed reasonably low. However, the scientific question at stake was whether transferring her egg to a gestational carrier might also transfer molar material, increasing risk to the surrogate carrier. Although medical knowledge was sparse, it was believed that the process of ICSI[40] could reduce the risk. Here the difficult problem was that the lack of a good medical paradigm case by which to quantify the risk made the ethical paradigm more important. How could reasonably informed consent be obtained under such questionable circumstances when medicine can't fully legitimize an opinion?

In Case 18, a woman with a previous history of Hepatitis C and sexually transmitted diseases refused to take an HIV test. It was easy to dismiss her as a candidate for treatment, not because of the difficulty in assessing the risk to her or the prospective child, but because her deceptive behavior or her denial about the reality of her health problems made it impossible to calculate the level of risk overall (2/01, Case 5). Here, doing the medicine first allowed the question of whether fertility treatments should be offered to someone infected with HIV to be delayed; in effect, dismissing

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[40] ICSI is an acronym for "intra cytoplasmic sperm injection," where a single sperm is injected into an egg, increasing chances for fertility in sterile men, and creating a greater likelihood for viable embryos to be transferred to the surrogate.

the case based on her previous history and poor psychological evaluation by the social workers.

HIV Cases

Cases of HIV infection are good examples of how "doing the medicine first" can contribute to the solution of the ethical problem at stake or delay the necessity to decide hard cases.

Example 19

An HIV-positive woman wanted to use IVF to attain pregnancy with her non-infected husband, so as to keep him free of the possibility of contracting the disease. The question was whether stimulating an egg from the infected woman was an ethical activity even though current medical knowledge indicated a high possibility of preventing disease transmission to a child in pregnancy by aggressively treating the mother. Besides the risk assumed by the prospective child, the ethics committee wondered about the level of risk that could and should be assumed by the staff members at ARM Clinic. They have little experience and little exposure to infectious diseases from their patients and were worried about whether "universal precautions" in their laboratory and surgical areas would be successful, and whether their current practices in labeling charts, medications, supplies, and human byproducts were adequate for their protection without violating the patient's privacy. More scientific experience is available about pregnancies in which the male partner was HIV-positive, so the physicians were partly attracted by the possibilities of producing a publishable paradigm case from the standpoint of the infected woman (11/00, Case 2).

Eventually, by "doing the medicine," the committee came to the conclusion that it was permissible to allow the case, not for their personal interest, but because the known risks to the child were slim enough, and the risks to themselves reasonably enough prevented, that to disallow it seemed to violate their professional code of conduct of providing medical treatment where necessary. The overriding ethical question of how much risk should be assumed by medical personnel in treating their patients was deferred.

In a later follow-up discussion of this case, the group noticed that an editorial in the ASRM journal "Fertility and Sterility" had been published proclaiming it "unjustifiable to exclude HIV+ women from pregnancy," offering a professional validation for their earlier decision (8/01, Case 5). As an attempt to further refine their arguments, supporters pointed out that the clinic did not hold itself legally or morally responsible for birth defects or illnesses in the children produced by their treatments, although they did attempt to screen out the possibilities for their production. As examples, techniques have been developed to lower the probabilities of Down's syndrome or of Tay-Sachs disease, but the clinic specialists are not thought to be blameworthy if their techniques should fail to prevent these defects. Similarly, specialists do not think of themselves as morally blameworthy if they should try but fail to prevent HIV infection being passed to a child during infertility treatments despite their efforts.

Example 20

Soon after this first case of HIV had been presented to the ethics committee, a similar but inverted problem arose, where an uninfected woman wanted to bear a child using sperm from her HIV-positive husband. Initially this case seemed to include a

greater possibility of risk, since the uninfected woman would, by necessity, be exposed to HIV herself, through achieving pregnancy. Data indicated the chances to be reasonably low, especially when new techniques for "washing" the sperm were used, although ARM Clinic did not yet have the capability to try the new procedure. This case was eventually rejected but not because it was found unethical. Rather the clinic wanted time in which to gather data, create protocols and policies, and obtain the knowledge-base necessary to manage such cases. By beginning with the medicine first, they were able to resolve the issues of risk, and delay the consideration of another ethical problem at hand: is it right for an infected father to attempt to create a child? (10/00, Case 2).

Medicine First as a Method

In the previous cases, doing the medicine first was shown to be useful primarily in risk assessment. Here the main ethical problem was in determining how much risk to whom, is acceptable in treating infertility. The assumption is that a medical inquiry or an investigation of the scientific knowledge at hand (as in the AIDS cases) will reveal determinative facts settling the question as to whether to proceed with treatment: danger to the health of those involved; side effects, lack of surety that the procedure will be effective, and so on. Presenting medical facts and statistics encourages consensus on problems of this nature. However, in the next section on relationship issues, some cases are presented in which doing the medicine first is not related to risk or medical facts, but is more an excuse to avoid treating certain patients, or more accurately to avoid discussing some difficult ethical issues, such as gay parenting, or whether or when to use the baby creation technique of donor egg/donor sperm.

The problem in relationship issues is that not all clients seeking fertility services are afflicted with medical problems. In many cases, only one partner in a relationship is infertile and in some cases nobody is infertile at all, such as when a single woman wants assistance from a physician to be enabled to achieve pregnancy through sperm donation. The phrase, "doing the medicine first" was understood by some of the physicians to mean that their first professional obligation was toward the person with the medical problem, but when no medical problem existed, it was interpreted to mean that they had less obligation to assist the client. A regularly occurring example was how to deal with gay couples, where neither partner was infertile, but pregnancy couldn't be achieved without assistance. In Case 21, doing the medicine first was invoked to turn down a request from a gay man who wanted to independently parent by use of a surrogate. Single, possibly gay women were accepted as clients, but the committee was uncomfortable with a single man wanting a child. The argument against the case included the idea that the potential parent was not infertile and thus had no claim upon the clinic's services, even though this was inconsistent with the female cases. Furthermore, married men with infertile wives were not rejected when they similarly wanted a child. The use of the excuse, doing the medicine first, was actually a way to ignore focusing on the moral implications of homosexual parenting.

I found that the position of "doing the medicine first" was sometimes useful in resolving the ethical question at stake, especially in quantifying and dealing with risk. But it served at least three other purposes for the ethics committee. It delayed the need to make tough decisions, it served to defend certain decisions by asserting a medical protocol, and it helped to narrow or restrict the ramifications of the problem so as to

avoid setting new precedents or fall down slippery slopes. However, each of these three purposes sometimes masked the adoption of a strong moral position (as mentioned above in the case of gay parenting) without incorporating the necessity of providing good reasons or a moral rationale for it.

In many cases, working through the medical data in this way served to calm fears and prevent emotional, poorly reasoned decisions in issues heard by the ethics committee. I suggest that it functions as more of a method or procedure for case deliberations than has been recognized in the bioethics literature, because while common, it is comprised of a multiplicity of responses to problems. Here I offer more details of the way this practice allows tough decisions to be delayed, defended and narrowed.

The first feature in beginning case deliberations by screening out medical issues first is the way it tends to delay the ethical problems at stake until they are made more explicit. To health care clinicians, the professional model is to try basic treatments before the more complex (fertility drugs before IVF, for example), or to consider fundamental diagnoses before the more esoteric (for example, they will assess common reasons for infertility before moving to the more elaborate diagnostic procedures), until the problem at hand has been clarified. Sure knowledge is sought over conjecture, so that experience, statistical options or similar cases from the medical literature can lead to solutions. By this step-by-step procedure, both patients and donors in the world of reproductive medicine receive as accurate information as is available for their informed consent, keeping risk levels low, and positioning medical clinicians to ward off legal accusations if treatments don't go as planned. As I have shown in the former case examples, this approach sometimes enables the ethical problem to disap-

pear, become unnecessary, or makes possible a later and more careful evaluation in terms of its importance and impact on the overall case.

For example, one might notice in the cases presented herein that the ethics committee did not re-think the morality of established practices, such as whether it is acceptable to use donors or gestational carriers in the first place. Likewise, the morality of IVF pregnancy production was not debated; it was simply assumed. Old controversies like Louise Brown, the first "test tube" baby, and Mary Beth Whitehead, the first prominent surrogate mother, are taken as settled to those in the field, and the use of the techniques is taken for granted. The only concern here is to protect all the participants from physical harm or legal mishap in their reproductive treatments.[41] In practice, the re-hashing of the ethics of such basic tools of reproductive medicine cannot be reconsidered without rethinking the basis for their own use. Their morality or lack thereof is no longer a useful consideration.

A second attractive feature for clinicians in doing medical screening first is that by following published medical protocols or policies, the ethical responsibilities of the medical clinician, both in diagnosis and treatment, can sometimes be deferred to others. Both common sense and professional responsibility indicate that ignoring established protocols so as to "reinvent the wheel" in each new case is hazardous, both because it wastes time and allows uncertainty when it is unnecessary.[42] Few want to pioneer a new situation unless it is necessary or the outcome offers a high probability

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[41] See Pence's *Classic Cases in Medical Ethics* for his review of groundbreaking cases and their aftermath in public policy; Louise Brown (95-119) and Mary Beth Whitehead (120-144).)

[42] The sort of protocols I am envisioning here are the policies written and introduced by the field's professional association. In reproductive medicine, policies for age limitations, number of fertility trials, the use of certain drugs in certain types of cases, and so on, are published regularly by ASRM.

of success. Even medical experts begin their work by following sets of established protocols, presumably because these practices are set up by an even more experienced expert group who have access to more data and more time to consider them. If cases don't go well after following the protocols, the individual physician can at least point to his or her adherence to them as a defense. It is doubtful that these sorts of policies come about by the application or specification of vague ethical principles: autonomy, beneficence, and the like, or even the "do no harm" fundamental principle of the medical profession. It may be that such overriding principles are assumed and already internalized into the health professional's standpoint, but it seems more likely that these kinds of principles simply don't lead to anything as specific as the policies they require to "carry on" their functions. For example, the rules governing consanguinity are produced by statistics, age-related rules by known risk, and so on. The ethical content is based upon more data-oriented and scientific outcomes. Although the method of specified principlism (presented earlier) is intended to produce very specific rules, it is difficult to imagine how an agent is to bridge the gap between a general prescription of autonomy or beneficence to attain a very specific mid-level policy like ASRM's statement that "44 years 11 months is the latest age that should be considered for IVF treatments." The specific policy may be ethical in its attempt to alleviate harm, but it is based on certain medical facts taken from scientific data or beliefs, not from ethical principles alone.

Besides delaying and deferring, a third reason that doing the medicine first is attractive to clinicians is that an ethical problem can sometimes be narrowed or restricted, thus avoiding a slippery slope. ARM Clinic avoided situations where they

might accidentally find themselves setting a new precedent by engaging in uncharted territory. They preferred to be guided by the idea that medical necessity underpinned their work, envisioning themselves as providers of treatment for medical conditions such as infertility, rather than as random creators of babies. By attempting to keep each case specific and reasoned-out, they hoped to avoid any assumption that one case could open all barriers to similar cases. If, for example, they were to accept one gestational carrier, they wouldn't necessarily want to make all gestational carriers acceptable, or if they assisted one homosexual couple's need for fertility treatment, they wouldn't want to imply they would treat every case.

These type of slippery slope possibilities are diminished by using the method of "medicine first," because the context of each case is used to tie each decision to its specific set of reasons, so that not only is the slippery slope avoided, but validation is provided to the judgments themselves. The ethics committee considered important details such as the emotional stability of the clients, their compliance with protocol, their intelligence, and the capacity of each involved party to understand his or her own case so that each decision was unique to its set of particular circumstances.

Other facts, such as the reasons for which age limitations might be overridden, the level of desire for a child exhibited by would-be parents, the importance of the fees and costs (especially in the case of paid donors), the overall fairness to those who may not be able to afford the treatments, the types of relationship issues at stake, the level of support by relatives and friends, and many other details are taken into consideration in each case, even though this attention to detail sometimes undermined overall consistency in decision-making. The ethics committee at ARM Clinic was averse to mak-

ing "exceptions to the rule," although that is often the point of committee delibera-
tions, otherwise there would be no need for group discussion. It is in context and detail
that the group sought to locate supporting principles and good reasons to override their
own policies, although they often found it difficult to articulate them.

I have tried to show how the method of 'medicine first' was valuable in delay-
ing, deferring and narrowing the ethical issues at stake in case deliberations at ARM
Clinic, while allowing for individual and contextual decisions. While striving for con-
sistency, decision-makers can also avoid the tendency towards a slippery slope which
might be thought of as a result of overly generalizing decision-making. These are all,
in general, positive attributes of this approach to decision-making, but they are associ-
ated with two conservative side features. One I have already mentioned, that avoiding
discussing the moral issues in some cases is actually taking a stand, but without actu-
ally constructing a defense. A second problem is that it prevents publicity, which dis-
allows a wide range of opinion on the morality of a problem to enter into discussion.
The reluctance to engage the ethical issues allowed this clinic to keep its 'head down'
so to speak, avoiding public comment about its policies and practices.

The tendency to avoid unwanted publicity was an important side feature that
contributed to decision-making at ARM Clinic. The clinic disdained the frenetic will-
ingness by some reproductive medicine clinics to draw attention to any new experi-
mentation, to offer any new treatment, to grant the desires of every patient who enters
their door. They referred to this acceptance of publicity and notoriety as the "Daily
News" factor. In this view, some clinics with poor rates of success in achieving preg-
nancies are thought to venture toward more radical treatments, or engage in more ethi-

cally suspect areas, because they accept all comers without regard to health-data effectiveness, perhaps driven by the profit motive, or because of a misguided sense of scientific drama. To ARM Clinic, a new treatment breakthrough is also a producer of negative publicity, as when the first woman in her 60s achieved pregnancy, or when the first child was conceived to produce therapeutic treatments for her sibling.[43] Whether positive or negative, such breakthroughs cause controversy, and produce business and social impact on the clinic. ARM Clinic prefers to avoid the likelihood that a case might put them on the "front page." This conservative position can allow them to abstain from taking a stand on novel ethical problems, or perhaps pass the 'moral buck', by referring troublesome cases to clinics with less cautious behavior. The ethics committee has resolved some cases by the use of such statements as, "Just because we can do it, doesn't mean we should do it," as an explanation for rejecting a case without producing good reasons or "We can always send the patient to a (competitor's) clinic where their needs can be met more easily." In this way, they avoid making an ethical decision without totally disparaging the patient's desire for treatment. In some cases, when alternative treatments were known to be locally unavailable, ARM Clinic was forced into decision-making, but generally they avoided that situation because other more laissez-faire clinics, the type which ignore ethical case reviews, were available.

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[43] See the CNN Online report from the *University of Southern California Trojan Family Magazine* of Autumn 1997 for the details of their 63-year-old patient, who delivered a healthy baby after having received IVF. Also see the USA Today Online update on the Anissa Ayala story, where the Ayalas conceived a child to use her bone marrow to donate to their older daughter Anissa who was born with the genetic disease Fanconi's Anemia. Since then, other similar cases of conception for donation have occurred although PIGD can now be used to prevent the conception of afflicted children.

It can also be noted in the cases I have presented here so far that the larger principles, if they were to be used, would often be in conflict, just as their critics have complained. The practitioners of reproductive medicine are by inclination supportive and respectful of the autonomy of their patients, because that principle is fundamental to their work. The patients who desire these services do not appear at the clinic doors unconscious or ill, but arrive as independent actors asserting their own rational choices. It is assumed that the desire and intent to parent a child is rightfully theirs and that the reproductive medicine clinic exists to support that basic right. But even this strong bias towards autonomy cannot overcome the need for beneficence in fulfilling the right, and avoiding maleficence (as when treatments might be dangerous, as we saw in the cases of concomitant illnesses like HIV). It is inevitable that paternalistic impulses will emerge to provide limits to autonomy, when expert, knowledgeable (and perhaps dispassionate) physicians expose and help to weigh the risks to be assumed by anxious and desperate patients.

The value of a procedural solution is here made clear. By setting up rules, taken from general sources, such as the rules of the profession, then narrowing them by internal needs, the rules generated by the sub-profession or practice are given content. The protocols developed by professional groups such as ASRM become powerful shapers of public opinion, informing scientific ethical choices, because of the group's access to medical data, and the reasoning power achieved by their group expertise offers credibility over the individual experience of a lone clinical practitioner. Professional associations are presumed to have access to more facts, more varieties of cases and experiences, and more expertise for deliberations, so that in their service as repre-

sentatives to practitioners, they are able to generalize their accumulated knowledge and save each clinician from the fall-back position of creating new and ad hoc policies for each daily decision, which is apt to be inconsistent and lacking generality. In fact, the levels of practice protocols, built on top of association protocols, allow practitioners to put two steps between them and patient demands, deferring the ethical decision-making even further. The onus is lifted from the physician in the front lines, who doesn't want to take the time to ruminate over every case ramification, or who might find it difficult to refuse or turn away a patient with strong desires. Certainly the physicians at ARM Clinic found it useful in turning away some troublesome cases to say that "the ethics committee advises against it."

CHAPTER SEVEN

RELATIONSHIP ISSUES

The cases presented so far have had in common a basis in issues of risk and the need for informed consent. I demonstrated how the use of medical data and its dissemination to the patient has often worked to delay, defer, and narrow the overall moral worry about whether the solutions to the various problems were right or wrong. Ethical decisions were either dissolved or could be temporarily shelved. But in the following set of 35 cases, overall moral factors are not so easily dismissed, even after the medical issues of risk and consent are dealt with.

The committee often resorted to another escape clause to try to avoid the moral problems: the so-called "yuck factor" or the "argument from repugnance." [44] At times the committee has found it extremely difficult to describe why they find a case troubling, or to elicit a specific reasoned principle or policy against it, despite their strong emotional reaction. This vague sense of repugnance tends to be thought of as a reason in itself, prompting discussants to reject a case because "it just doesn't feel right." Even evoking the term "yuck factor" could sometimes be enough to kill discussion on a case, although it could not deliver unanimity or consensus on the decisions. Sometimes the feeling caused doubt as to the levels of professional responsibility, such as when members felt "unconvinced" of their duty to engage with certain problems, such as treating an HIV case. Others mentioned feeling a floating sense of

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[44] The term "yuck" (sometimes spelled "yuk") factor is often associated with the work of Leon Kass, the University of Chicago bioethicist and currently the Chairman of the President's Council on Bioethics, who also uses the phrase "argument from repugnance," to denote cases or situations in bioethics that are emotionally upsetting or disgusting. Some evidence points to Arthur Caplan, bioethicist at University of Pennsylvania, as the originator of the term (see "In Brief," in *Hastings Center Report* 33.1, (2003): 8). I will discuss the implications of these feelings in full in Chapter Eight.

"wrongness" about certain decisions even though they were logically acceptable. This unclear and vague feeling became labeled the "yuck factor," because of the difficulty in articulating good reasons for the lingering sense of doubt.

In this set of cases, the unsettling nature of the yuck factor was a block to achieving consensus and generating validation for decisions. These cases were more difficult than cases of risk because they all involved disquieting and new issues in family relationships and because many of them include novel features, lacking precedents for decision-makers.

I consider the predominant moral problem tying these cases together to be "relationship issues," because each one presents a challenge to the standard way of looking at family connections. In some cases, family genetic ties are bypassed altogether, while in others new ties are forged out of the newfound, highly technical ability to generate pregnancies. The moral problem does not disappear when solving the medical, or risk, problem in these cases, because an ongoing, new type of family link will be established among the family members, one which presents ethical challenges.

One overriding principle serves as a basis for many decisions at ARM Clinic, a desire to maintain some sort of genetic link between at least two members of the family group whenever possible. There are several reasons for their emphasis on this principle. The first is legal: there is always a concern that science is running ahead of current adoption laws, which, depending on the state, are not always equipped to handle the complexities of ensuring the legitimacy of parent-child relationships when other parties are involved through the donation, purchase, or exchange of genetic material. Second, the clinic accepts an assumption that the parental sense of obligation to

a child may be stronger when actual genetic relationships are in place, so that difficult or "imperfect" children can't be seen as returnable consumer products. Third, the clinic sees itself as engaged in an altruistic medical practice, by which they encourage reproduction, but reject a vision of themselves as a designer workshop, where parents "select" children as products to suit their own preferences. They consider such characteristics as overall health, appearance, sex, or intelligence as part of the natural lottery of parenthood, where variations are more acceptable if the child is genetically linked to the parent. Of course, would-be parents are allowed to make some of these selections in choosing characteristics for their children in certain circumstances, such as during the process of choosing among sperm or egg donors, for example, where prospective parents are able to sift through a general list of characteristics. But if at least one parent is genetically related, it is believed that he or she will tolerate more imperfection in the child. It can be argued that the example of adoption refutes those concerns because few people would argue that obligation, love, and concern are not equally allocated to children in those relationships as compared to that of natural parents to their children. However, ARM Clinic believes that they can produce safer relationships with fewer legal problems by attempting to maintain some genetic ties in their reproductive treatments. Nevertheless, many cases appear at the clinic that challenge this internal principle and must be decided by the ethics committee. Sometimes the issue isn't whether one parent has a genetic tie or not, but acknowledging the underlying medical basis for their need for treatment.

One set of cases that challenges the notions of family relationships concerns homosexual parents.

Homosexual Parenting

ARM Clinic has regularly treated fertile and infertile women who are lesbian, without discriminating on the basis of either their single status or their shared parenting arrangement with another woman. But they have been unwilling to assist in reproduction for single men, or men with male partners, because in those cases the men do not generally present at the clinic with an illness or disease; infertility isn't the cause for their need for reproductive services. Instead these single men or couples are, in a sense, using the fertility practice to create a baby without the necessity of a mother.

Example 21

One man wanted to produce his own child, with his own sperm, but in order to maintain independence and non-interference from any supposed genetic "mother" and preserve his sole legal right to the child he wanted to obtain an anonymous donor egg and use IVF to transfer the embryo to a gestational carrier instead of by the more simple insemination of a known female. By hiring the egg donor and genetic carrier as two separate individuals with no emotional attachment, he felt that neither would be likely to express any parental rights. His request encouraged a lively debate about whether men have rights to reproduce independently of women. The case was ultimately rejected (11/98, Case 1).

The discussion made clear that most members of the ethics committee, both male and female, held a subtle presumption in favor of women's rights to reproduce, whether gay, single, or married, but felt less supportive of the same rights being extended to men. Committee members expressed doubt about the motivation of men's desire to parent and their abilities to handle the obligation. They questioned this spe-

cific man's desire to exclude the female parent from the process (calling it "social medicine"), although some women have expressed a similar intent to prevent the interference from a "father."

This case produced the "yuck" feeling. The main reason put forward to reject the case was that the man involved had no infertility problem, so it seemed to the clinic that they were not being asked to provide a service in the sense of a medical treatment or cure, but were put in the position of acting as a factory or business to provide a baby. In a sense, this was a case of doing the medicine first. It was clear that the clinical staff felt their work was more defensible when conceiving it as treating diseases or impairments, but not when it could be taken as a simple provision of a service to someone who disdained the trouble of forging a relationship by which to create a family. The prospective father was envisioned as someone who wanted "no strings," rejected female involvement, and was thus irresponsible; at the same time, women who wanted children were viewed differently, as being constrained by the lack of an appropriate male, from fulfilling their instinctual desire to parent. Such viewpoints were admittedly not based on 'facts,' but no data was available to counter such feelings either.

Another reason given to disallow the case was that no risk to the father was involved; instead, he was proposing that two women (the egg donor and the gestational carrier) assume the risk of pregnancy for him, whereas when infertile women choose to become mothers, they assume their own risk for their own choices. This assumption of responsibility gives validation to female parenting and provided a stronger reason to reject the case. However, this case was controversial enough to require a committee

vote, instead of an emergence of consensus, and the committee members found themselves divided, although all members felt weak in their positions.

Example 22

In a variant of the previous case, a single man enlisted a female friend to act as a known egg donor, and a second female friend to act as a known gestational carrier for his child. All he needed was the help of the clinic to put it all together through IVF treatments. As in the previous case, the committee rejected his plan, on the grounds of his lack of need for medical treatment and the transfer of risk to others besides himself. They didn't recognize him to be a 'patient' of the clinic, because he was not infertile, but simply wanted to have a baby without the entanglement of a relationship with the child's mother (10/00, Case 3).

Example 23

In a challenge to the presumption that women are more acceptable as patients of the clinic by virtue of their supposed infertility, a lesbian woman asked for assisted reproduction after having already produced a child by donor egg and donor sperm elsewhere; that is, to say, the child did not contain any of her genetic product, although she intended to carry the pregnancy. Now she wanted to produce a half-sibling for her child by using the remaining frozen sperm along with a new egg donor. This case violated two policies of the clinic: that the woman herself was not being treated for infertility and that it would be creating a child genetically unrelated to the parent. In this case, the fact that the new child would be genetically linked to its already existing sibling gave the committee a reason to "back into" the approval of what would normally be a rejected practice of donor egg/ donor sperm. The mother's infertility added plau-

sibility to the request, although she was not really personally being "treated" any more than the gay men would have been. She was the recipient of a created baby with no entanglement by a genetic father, and perhaps being female gave her the benefit of the doubt. Many infertile women resort to donor eggs after other fertility treatment failures, but usually it is in the context of marriage and the use of their husband's sperm. In those cases, it could be argued that they are no longer patients of the clinic, since their infertility is no longer being treated; however, it was not seen that way in most of these types of cases.

Example 24

In a few cases, the parents want more entanglements in their parental relationships rather than fewer. A lesbian couple included one partner who had failed in an attempt to carry an IVF pregnancy (by her own eggs and with donor sperm). Although she remained capable of producing eggs, she now wanted to act as the gestational carrier for a surrogate pregnancy by using donated eggs from her slightly younger partner. The younger partner was perfectly capable of generating both an egg and carrying a pregnancy, so it seemed overly complex to include the older partner in the events. The committee wondered why the younger woman would not simply use donor sperm to generate a less expensive, more "natural" pregnancy, but apparently both women wanted to share in all aspects of the process, so that each had a part in "mothering" the prospective infant. The older partner worried about losing the chance to participate in the process due to the statistical lessening of her own fertility as she aged. Somewhat surprisingly, the ethics committee agreed to allow this case, using the reasoning that the egg donor was akin to a "known donor," accepted non-controversially when a sis-

ter or other closely related female offers assistance, at least when psychological as-

sessments showed the relationship to be free of hesitancy or coercion on either side.

Some committee members wondered whether this sort of parenting would be emotion-

ally traumatic for the prospective child, when it later learned the details, or if a later

dissolution of the relationship between the two co-parents could cause difficult legal

custody issues in the future. Such questions might be valid, but are actually no more

challenging in this case than in any other of the 'new relationship" type cases, and are

minimized by careful legal contracts written to protect the impact on the child (11/00,

Case1).

Example 25

In a very similar case, the outcome was the opposite. A lesbian couple was re-

fused treatment by the ethics committee, because infertility was not a factor. In this

case, similar to the last, one of the partners wanted to donate an egg for the other to

carry in a surrogate pregnancy, with the stated reason of "binding them closer to-

gether." Neither partner was infertile, so the committee treated this case as more like

the case of the men who wanted to create their own children. They argued that neither

a "desire to bond" or a "desire for convenience" in choosing who carried the preg-

nancy were strong enough reasons to compel medical treatment; in other words, there

was no medical necessity (12/00, Case 3). This case was perceived as analogous to the

problem in genetic therapy of distinguishing between enhancement and treatment. To

some, the case was a step down the slippery slope toward "designing babies" for per-

fectly healthy couples, while to others the case resembled that of the men, mentioned

earlier, who were intent on avoiding the entanglement of the opposite-sex parent in the

relationship. The search for consistency introduced additional reasons to put forward to reject the case; the risks in pregnancy, while small, was nevertheless more admissible to an individual or couple whose choices are constrained by infertility, but less admissible for the couple who have undertaken the process for an emotional reason and not a physical one. Gestational carriers might be agreeable to putting themselves at risk, but should only do so because medical indications have made it necessary, not just to fulfill someone's desire for a child (although this reasoning seems inconsistent with the previous case).

The overall difficulty in making judgments on these cases turned out to be not only the homosexuality of the would-be parents, but the nature of the medical necessity of the case. Defining medical necessity is problematic in this field, because, as I have said, often the person with the medical problem is not under treatment at all in assisted reproductive therapies. If the infertile partner, whether male or female, has been found untreatable, the assisted reproduction continues through the use of donors. In the next section, this problem is highlighted in the discussion of when it is ethical to create a baby through *both* donor egg and donor sperm.

Donor Egg/Donor Sperm

The clinic's policy of "no donor egg/donor sperm" (baby creation) was established to prevent the creation of designer babies with no genetic link to the parents. Nevertheless, sometimes good reasons (at other times unusual reasons) are produced for exceptions to the policy.

Example 26

One woman had tried IVF unsuccessfully; the problem seemed to be her poor quality eggs. She embarked on the use of an egg donor, and then added a request for the use of donor sperm as well, creating the donor egg/donor sperm situation. Her reasoning was that her husband was not sufficiently fertile to support pregnancy. At some point her physician realized that her desire for a sperm donor was not based on her husband's supposed infertility, but on the fact that the woman did not want to become pregnant with his children, unless they were also created by use of her own genetic material, her own eggs. It seemed that she thought of his children, born in a previous marriage, as inferior to her own (also from a previous marriage), due to some health problems and minor psychiatric disorders. Apparently, it was one thing to take the chance of bearing his children when they included her genes, but to do so with an egg donor became a bigger gamble for the woman, since the children would then not be biologically related to her. Her plan was turned down on the ground that it would violate the "no donor egg/donor sperm" policy, but also because no evidence had been presented to suggest that the husband's biological children had problems that were genetically heritable in nature. The case seemed to elicit a sense of "eugenics" in that it was more about "selecting a designer baby," and less about avoiding obviously heritable health disorders. Furthermore, infertility on the part of the husband was not proven to be an issue (10/00, Case 5).

In some exceptional cases, the policy against donor egg/donor sperm has been overridden at ARM Clinic, but only when the decision could be "backed into," mean-

ing that other options were tried and eliminated, until the exceptional case became the only remaining option.

Example 27

One woman had a child from her own egg and a sperm donation, because of her husband's infertility. While still hoping for another child, her fertility diminished. The only option available to the couple at that point was to use both donor egg and donor sperm, which was approved in their case because, similar to the lesbian woman mentioned earlier, they had available to them some of the same (frozen) sperm that had been used to create their other child. The prospective child would be a half-sibling to their original child, and thus genetically related to one family member, although unrelated to either of the parents. The intent of the prohibition against donor egg/donor sperm was thought to be fulfilled by this reasoning; and the exception to the rule was "backed into" without a need to confront the advisability of the policy itself. This "backing into" is more likely to occur when urgent, on-the-spot decisions become necessary. This type of situation happens, for example, when during the fertilization of an egg for the purposes of IVF, a fresh sperm donation is required. Other times male infertility was not recognized until the woman was at her height of cyclical readiness. In some situations, the physician might have planned to procure a minimal amount of sperm by biopsy in borderline-sterile men to be used immediately, but if the procedure fails, back-up sperm must be available or the whole effort, including the time, medication and money required by the donor to "ripen" her ovaries, has been wasted. In a situation like this, the urgency leads to the exception to the policy so that the ethical question is said to be "backed-into."

Example 28

While working with a woman who failed ovulation and hired an egg donor, the physician found that only two of many donated eggs had become fertilized in the laboratory, due to unforeseen problems with the husband's sperm. After such an expense and physical strain, the physician didn't want any more wasted chances, so he asked the ethics committee to agree to a plan where fertilization was again attempted with the husband's sperm (after a more concerted effort to retrieve it), but to have a back-up sperm donation at hand just in case. The intent was not to mix the final embryos, but to assess the options in selecting the best embryos for IVF from both possible sperm options. The couple understood their realistic options in the informed consent process and agreed to them, knowing that very likely the baby would be unrelated to either parent. Although the prospect was planned for, the actual occurrence was again "backed into" and therefore granted approval by the committee (8/01, Case 2).

Known Donors

Interesting relationship problems occur when known donors are used to contribute either the egg or sperm for assisted reproduction. These donors are usually motivated to help by familial affection, and are often free or less expensive than paying the fees of contract donors, but other entanglements can ensue.

Example 29

A woman who had been found incapable of generating eggs later realized her husband was also infertile, so they developed a plan to purchase a donor egg, but have it inseminated with sperm donated by the woman's father, thus preserving a maternal genetic link with the proposed child. The woman intended to carry the pregnancy her-

self, in effect becoming the gestational carrier and adopted mother to her own half-sibling. This case immediately generated the "yuck factor," a somewhat emotional reaction of disgust to the plan under consideration; it simply didn't "seem right" to many of the committee members, although a principle by which to frame the reasoning could not be located. They stated and re-stated, as if to remind themselves, that the case did not literally involve incest, because sexual relations did not occur between the woman and her father, although she intended to carry "his child" in the pregnancy. Two rationales were suggested to deny treatment. The first was to cite the clinic policy against the "creation of unrelated babies," the "donor egg/donor sperm" rule, although this case was not, strict speaking, a version of that type since the woman would be genetically related to her baby. The second alternative view was to cite the clinic preference against "transgenerational" cases, where members of different generational cohorts become parties in the same parenting process (9/98, Case 1). This policy is generally thought to avoid coercion by the older, more powerful, or more wealthy participant, but in this case, it was not coercion, but a discomfort with the idea of a woman becoming a mother to her father's child that evoked the use of the policy. Both of the two policies, while valid in a general sense, were useful here in providing a reason to reject the case while avoiding the ethical complexity. Is it really wrong, or immoral, for a woman to carry and raise her half-sibling, and if so, why? In the next case, a similar plan did not evoke such strong feelings.

Example 30

A woman with an infertile husband planned to be inseminated by the sperm of her father-in-law, rather than an anonymous donor, so as to preserve a genetic link be-

tween her husband, the prospective father and the child. In this case, the woman would be carrying her father-in-law's child, literally a half-sibling to her husband. Here, the use of the mother's own egg meant that the policy against donor egg/donor sperm had not been violated, but the problem of a transgenerational relationship still existed. However, this case was approved by the committee (after psychological screening was completed), and the "yuck factor" did not arise because of the lack of genetic relationship between the woman and her father-in-law (12/00, Case 1). Comparing the two cases seems to imply that the "yuck factor" represented a sense that the incest taboo had been violated in the first case, but not the second, although the reaction was more emotional than logical. Furthermore, in Case 29, the desire of the woman to retain a genetic relationship, so that her family line could "carry on," was thought to be a little over-dramatic, and overvalued, while the same desire by the young father in Example 30 was seen as more "natural," indicating that we still take male genetic lineage to be of greater importance.

Example 31

In a variation of this problem, a woman born with functional ovaries, but no uterus, had previously attempted to use her own eggs with her husband's sperm to attain a pregnancy to be carried by a surrogate, but she eventually proved to be infertile. Instead of purchasing a donor egg so as to produce a child with her husband, she requested the assistance of the clinic in "creating a child" by use of her brother's sperm and a donor egg from the sister of her husband, to be carried by a surrogate, and then given to her for adoption. In this way, she intended to preserve a remnant of her own genetic family in the child she intended to raise, still including her husband's genetic

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heritage through his sister. He couldn't participate directly, although he was fertile, because to use an egg donor from outside the family would mean that one of the two parents would lose any genetic link to the child. The effect of an approval of the case would be that both potential parents would adopt and raise their own niece (or nephew), and both partners would be equally related to the child (10/99, Case 1).

The confusing relationship issues in this case stimulated much negative discussion, but also great difficulty in locating a reasonable principle by which to make a judgment. To proceed would not provoke a violation of the transgenerational policy (everybody involved was of similar ages), and it would not exactly violate the donor egg/ donor sperm, no baby creation, policy, because both parents were related to the donors. The problem for the committee was that it didn't exactly violate anything, and yet it aroused the "yuck factor" as an obstacle, causing it to be rejected without any clear principles asserted

One way to approach cases of the sort I have been describing here is to consider the effects on the child's future life and happiness when she or he became of age to understand their genetic relationships. It seems possible that a young adult would be shocked and embarrassed to realize that an uncle or grandparent was really the genetic father, and so on. But such relationship problems have occurred more or less "naturally" in families over history, so one could question how new or transgressive they really are. Also, it is not clear how realizing that a genetic parent was actually an anonymous paid donor would be any less shocking to the young adult. Some members worried that a slippery slope was developing, in which future individuals might lose the ability to discriminate among any family genetic link, because of the careless inter-

reproduction going on. Some comments heard were, "No genetic link may be bad, but too much genetic linkage can be worse, causing confusion and narcissism"; "We just want to be conservative and not go too far"; "Just because we *can* doesn't mean we *should*"; and finally "Some people are just not destined to have children and should face it." The last comment was particularly interesting from this sort of committee, because if accepted at face-value, then it would lead one to wonder why such a clinic existed to treat any infertile patient at all (or why the staff member wanted to work in the field of assisted reproduction).

Some members found it perfectly acceptable to take the case because it was not inconsistent with previous cases of known sibling donors (usually a sister-to-sister egg donation, or brother-to-brother sperm donation), that were accepted by the clinic. Also, because the relationship was not literally incest, the "yuck factor" did not refer to anything real in particular. However, even those leaning toward approval could imagine some real, tangible family problems as a result of such a case, although these problems could be applicable to all cases of unclear genetic heritage. One possibility was that the wife's brother and the husband's sister, in Example 31, by each having a genetic link to the child to be produced, and each, in fact, raising half-siblings to the prospective child, could claim legal custody if something (a divorce or a death) happened to disturb the adoptive parents. The genetic relatives were in a position to use emotional manipulation to cause relationship problems among the whole extended family. Furthermore, the child's potential security and happiness could be imagined to be at stake when he or she learned of the real relationship. (Imagine an angry or rebellious teenager proclaiming that he or she wants to live with his or her "real" parents.)

Another reasonable approach to this problem was to "do the medicine first," thereby narrowing the medical problem. By that thinking, because the husband in Example 31 was not infertile, the clinic had no real reason to bypass him and his genetic input in bringing forth a baby. It could be thought of as a case where the overcomplexity was unnecessary; there was no medical necessity to go the route requested by the family. This gave the committee a good reason to deny the case.

This case was eventually put to a vote, because no consensus was achieved, and it resulted in a tie. The even split was taken by the physician-owners as a good reason *not* to proceed, since they generally sought to avoid the sort of dissension and ill-will that could detract from their overall collegiality. But these three cases stand out as illustrative of the methodological problem in formulating ethical advice for unusual and novel situations. No maxim or principle governing such a complex interrelationship was available to guide the deliberators and no step by step method worked to advance the reasoning.

One problem for decision-making of this nature is the difficulty in extracting comparisons from the novel case to any sort of paradigm case. In this situation, attempts were made to show how each case could be compared to more routine cases of using known donors, where informed consent, careful legal agreements, and psychological counseling could ensure a cooperative and loving relationship among the whole family set. But the differences in the actual genetic links were too major to make the comparisons hold, and without that, the committee members felt adrift, with no principles or firm stance to take hold of. They were unable to derive a more specific mid-level principle, and although the context and details of the infertility created

sympathy among members, the casuistic approach did not offer firm grounds by which to evaluate the various standpoints. Here is where the value of the professional association can be seen, when it develops and puts out ready-made policies, allowing the clinical ethicists to locate a prepared position. However, in the cases described here, no such policies have yet been articulated.

Mixing

Another more common challenge to family relationships comes from cases in which some form of "splitting or mixing" of donations, either of eggs, of sperm, or of the embryos themselves, is allowed. Several variations of thinking can occur. In some cases an infertile woman might want to augment her hopes for pregnancy by using a mix of embryos, some created with her own egg donation and others with eggs from a donor, for IVF, or she might use her own eggs but with sperm taken from one or more donors. Besides mixing embryos, one might pool various sperm samples used in fertilization or pool eggs from various donors to create embryos. ARM Clinic's policy is to refrain from genetically mixing the products of fertility together in a fertility treatment, because it causes the genetic parenthood of the child to be confused, even though it might augment chances for reproduction to take place. This practice is not uncommon in other, less scrupulous clinics, perhaps not only for the sake of increasing the prospects for fertilization and pregnancy, but possibly sometimes to confuse any legal claims to the child by causing uncertainty as to its genetic parenthood.

In opposition to that point of view, ARM Clinic takes seriously the idea that a potential child has a right to gain access to his or her own genetic make-up, for the child's own future knowledge, as well as the sake of the child's own future health. The

clinic does not try to control how such knowledge is imparted to children born from assisted reproduction by his or her legal parents; some are not told of their genetic origins at all. Children born from such confusing circumstances are still too young to have reached adulthood, thus are unable to give us access into how such knowledge will be accepted; the science is too new. In any case, should these adults attempt to learn their own history, it is considered by ARM clinic to be their right to be able to do so. Thus the clinic maintains careful record-keeping and documentation of the personal and genetic information of their patients.

A frequent example of this situation is when an infertile man hopes that mixing sperm from multiple donors, in addition to his own, will increase his partner's reproductive success. Sometimes the would-be father's fertility is diminished but not extinct, and he still wants to maintain some chance at fatherhood. By pooling his sperm with that of a donor, it has been thought of (paternalistically) as a way for him to achieve fertilization without having to totally confront the most likely possibility that the resulting child is not genetically his. Presumably, his never knowing for sure whose sperm fathered the child is a way to ensure his full participation and investment in its rearing. Pooling eggs in infertile women is a less common treatment, because women must be medically treated to provoke the ripening and retrieval of the egg, making it unusual that two women could be stimulated to the same stage at the same time so as to enable concurrent embryo production. It is simple for two fresh sperm samples to be ready simultaneously. However, in some cases, it can happen that a woman and her egg donor's eggs are both used in the same time period to create embryos that can be mixed together for implantation.

Example 32

In an interesting case where sperm pooling became an issue, a sterile husband with a fertile wife had the advantage of having several healthy brothers, all willing to donate their sperm. The couple suggested that she be inseminated with a mix of sperm from all three brothers simultaneously and anonymously, so as to dodge the possibility of confronting any specific and personal interest in the pregnancy and child by whatever brother became the successful genetic father. Perhaps the notion of pooling developed because the prospective parents feared that one brother would brag about his fertility to the others, or take an overly familiar interest in the child produced by his sperm; or maybe they hesitated to choose among the brothers so as not to hurt any one's feelings. It was also possible that the wives of the several brothers could feel less threatened by the interfamilial relationship to another child if it was not made explicit who was the actual genetic father to the child. Perhaps the husband wanted to lessen chances of sibling rivalry or intrusion into his life by the sibling, or perhaps the prospective mother didn't want to be faced with the typical comparisons, where commonalities between parent and child are searched for, by friends and associates, and so would be happier to be left in ignorance. Perhaps the grandparents were thought prone to interfere, or make knowing comments, or perhaps in later life, the child's cousin/half sibling relationships were feared to become problematic. The ability of the committee to develop so many of these "what-if" scenarios illustrated how family ties are envisioned to be threatened by known-donor pregnancies in general.

Out of these many issues discussed by the committee, one objective remained clear: the need to deliver a transparent process so that the right of the prospective

child to have knowledge of his or her own genetic make-up could be protected. When sperm is pooled, so that no one clear father is recognized, it is thought that the adult might face undue anxiety about his or her specific health history or genetic background. Obtaining the facts later by way of DNA testing is possible, but may not be a reasonable option, considering the possibility that one of the involved parties may not be available or may refuse to consent to participate.

In screening and counseling the group of brothers involved in this case, they all preferred to maintain secrecy, both toward the prospective child and among one another as to which one was to become the genetic father. They eventually came to see (through counseling) that at least the clinic ought to know and maintain the record for future reference. They eventually conceded that pooling was not an option and instead decided to each donate sperm, but leave the choice of whose sperm would be actually used for the fertilization to the physician. In turn, the physician agreed to analyze both the sperm and the embryos fertilized by it, and select from among them whichever seemed to be the most healthy and viable for IVF, while keeping the information private. The records could then be maintained for future reference, but the family could be left in their desired state of ignorance. This solution appeared to appease everybody, and the principle of transparency was maintained (2/01, Case 2).

When embryos are mixed for implantation, similar issues are at stake. The impetus is usually to give the infertile parent a chance to participate in the creation, while leaving in doubt the final genetic nature of the child. However, besides the transparency principle, where the child has a presumed right to know his or her genetic line,

physicians feel they are forced to make uncomfortable moral decisions if some embryos aren't used or must be eliminated to create a safer outcome.

Example 33

Four embryos were transferred to a woman, causing her pregnancy, but only one or two were fertilized by her own husband. All four began to develop creating the possibility of a quadruple birth. However, because of the danger in carrying four fetuses in a pregnancy, both to them and to the pregnancy overall, it was planned to use the process of "selective reduction" to eliminate at least one embryo. In this procedure, an injection into the selected embryo through the uterine wall destroys it, making more room for those retained. However, in this case, the parents balked at selective reduction for fear that the one embryo selected to be eliminated might be the genetic product of the husband rather than the sperm donor. The mother already felt more attachment to the continued existence of the related embryo, the one fertilized by her husband, than to the others, but at that stage of development it is impossible to determine which one was the genetic product (2/01, Case 6). This case was cited as a reason to avoid mixing in general. Nevertheless, pooling can sometimes improve the overall chances for reproduction.

Example 34

In this rare circumstance, the laboratory results showed one "good' embryo from a donor sperm and one "good" embryo from the sperm of the husband. (Embryos can be graded or ranked by various scientific criteria for their overall healthiness.) In such a situation the chances for fertilization are much improved if both are implanted, and in fact it is possible, and has occurred, for 'twins' to develop, one from each ge-

netic father. In these cases, it is hoped that the child's "right to know" is indefinitely deferred because of the presumed shock of disclosure of different parentage (8/01, Case 3). But because such cases are often "backed into," or in other words only encountered in the medical setting while engaging in treatment, the ethics committee had little to say about the future effects, if any, on the children. In other words, the decision to implant mixed embryos was rarely made in advance, but was a decision made "on the fly" by the physician.

Splitting

Splitting embryos between two women is another way to occasionally maximize the chances for the probability of pregnancy, but like mixing, causes similar ethical questions.

Example 35

A woman had two children followed by a tubal ligation to prevent further conception, but later wanted another child. Because she couldn't afford the necessary surgery, she hoped to earn the money to pay for the reversal of the ligation and the possible future pregnancy by serving as an egg donor. However, she worried that in donating an egg, her own opportunity to reproduce might be bypassed. She developed a plan wherein some of the embryos produced by her eggs could be donated after fertilization to an infertile woman while others were kept for herself, ensuring two pregnancies for two different families. This had the potential of producing two full siblings who would each be raised separately.

One of the first worries about this plan was the possibility that pregnancy could occur for the donor but fail in the recipient, so that ill will ensued. Also, if successful

for both, the children might later be shocked to learn of each other's existence, or one family could intervene in the life of the other. However, these problems were assumed, in this case, to be manageable by legal contracts, and so the case was accepted (10/99, Case 6).

Example 36

In a more controversial case, a woman had failed after many trials with IVF to successfully achieve pregnancy, possibly due to other hormonal issues. Her plan was to maximize her chances of producing a child while retaining some hope of carrying her own pregnancy, by splitting some of the embryos between a gestational carrier and herself. She was well informed and willing to take the chance that, in a worst case scenario, all the pregnancies could succeed simultaneously (if three embryos were transferred to each woman, six children could conceivably be born at once!). She felt that she could enthusiastically accept any number of children, whichever pregnancies were successful.

The first step in this case was to "do the medicine first" by re-evaluating her former problems to evaluate any necessity for splitting embryos. To the physicians, it was putting the "cart before the horse" or to assume that the embryos would do better in some idealized carrier, when it was possible that the embryos themselves were the problem and not the woman as a carrier. On the other hand, for various reasons, some women cannot retain pregnancies even with perfect embryos, so in such a scenario there would be no need to split the embryos. The case could be resolved by using a gestational carrier alone.

A concern more related to ethics was that if both women became pregnant and selective reduction were required, the pregnant woman might choose to keep her own pregnancy intact, gambling away all the embryos if she later failed to carry them. Her objectivity would be compromised. Another side worry, if both women produced children, was to consider whether the woman or her husband might take more interest in any offspring from the wife's pregnancy, ignoring those from the carrier, so as to later favor or bond with some of the children over others. Data on outcomes from splitting embryos, or from siblings gestated separately, is scanty. ARM Clinic has done very little splitting of this nature, so that no paradigm was available, and the possible ramifications for siblings related genetically but gestated separately are unknown. Here, the negative decision was made to deny the case using the grounds of the "delay" factor in doing the medicine first, and the worry about the "Daily News" effect, where if the plan were to become well-known, it could be the type of case to attract publicity (2/00, Case 1).

Example 37

In a similar case of splitting embryos, a woman with a defective uterus and a history of failed pregnancies wanted to try to carry a pregnancy, but wanted to 'hedge her bets' by simultaneously using her sister as a gestational carrier. The worries expressed by the committee in the previous case were glossed over in this one, possibly because the likelihood that the patient would be able to sustain a pregnancy was more clearly medically improbable so that other concerns, such as multiple births, became moot. However, this case could be seen to include other, different concerns, such as rivalry and jealousy between the two sisters, whether the patient would be upset when

and if her sister established a more successful pregnancy, whether the children from the sister's pregnancy would be treated differently or made less welcome by the husband, whether two or more children might be generated from both pregnancies and if so, whether the parents would be more attached to one set more than the other. Although raised, these concerns were taken by the committee as easily managed by proper counseling sessions. The "yuck factor" wasn't raised in this discussion, the "Daily News" factor wasn't mentioned, and the obstacle of "medicine first" was thought to be accomplished; so the case was accepted with little more discussion. It is not totally clear why, although, the idea of a sister assisting her sibling is assumed to be more understandable and less fraught with problems than that of a paid surrogate. Also, the second case, by following the first one, seemed to be more easily worked through, perhaps because of the experience and insight thought to be gained by the previous case. Or perhaps the slippery slope was in place, and the committee's familiarity with the problem had encouraged easier acceptance when encountering a similar problem for the second time. Or perhaps the ethical problem in the first case was less than met the eye, and the possible problems were actually less important than first thought (1/02, Case 2).

Transgenerational Relationships

In discussing how age affects informed consent in the last chapter, I pointed out how coercion was a special issue to be considered. Similarly, in cases that cross generational lines, coercion can be the major harm to watch out for, although the "yuck factor" is an unarticulated side-problem, causing inconsistency in some of these results. Here, participants in assisted reproduction may be widely separated by age,

raising the fear that the older may have too much persuasive or social power over the younger. Of more interest in these transgenerational cases is that family relationships can also become confused.

Example 38

A woman with one child had a long history of trying fertility treatments without success. Finally, confronted with the need for an egg donor, she chose her 18-year-old sister to act as a known donor, with the sister's full agreement. The use of sisters in such a relationship is generally not controversial at ARM Clinic, since the sibling bond usually creates a cooperative and willing pairing, but the committee could not accept the 18-year-old as a donor for two reasons. One reason was simply that the younger woman was under 21, violating their routine informed-consent policy, established for reasons I have already mentioned. But an even greater fear voiced by the committee, in this case, was discomfort with an age gap of 17 years between the two sisters, because it was thought that the younger sibling could be overly desirous of pleasing the elder, or to be in a position where she found it difficult to consider her own preferences and say no. The age gap can be equally wide in other egg-donating situations, but because the parties are generally unknown to one another, it is less troubling. It is believed that this type of case can easily be solved by confidential interviewing so as to identify and intercede in these personal entanglements, even when transgenerational relationships put them in particular danger from coercive elements, but this one was not accepted (4/02, Case 3).

Example 39

A similar case occurred in which the donor was not underage and the relationship was not as close, allowing the committee to be more accepting. A 44-year-old wanted to use her 27-year-old niece as the egg donor, but here the niece was married, had children and lived out of the area. Although the age gap was as wide as the previous case, it seemed unlikely that the elder could wield undue influence on the younger, and the younger had more life experience with which to consider her options (4/02, Case 2). However, transgenerational cases can be much more complex than the two mentioned so far.

Example 40

A woman in her 40s wanted to receive an egg donation from her daughter-in-law, who was nearly twenty years younger. The younger woman was happily married to the infertile woman's son and they had two children of their own. She was apparently willing to donate her eggs, without coercion, but the relationship problems in store for the potential child were certainly confusing. The prospective baby, if born, (I will assume it is a male to keep the example simple) would not only be a half-brother to the man who is the spouse of the egg donor (his genetic mother), but he would be the genetic son to his father's daughter-in-law who will legally relate to him as a sister-in-law. He would not be related to the woman who would carry the pregnancy and become his legal mother. He would be an uncle to his half-brother's children, but also their half brother. The potential father of this child would be thrust into a subtle relationship with the genetic mother, who was also his daughter-in-law, because of sharing in the genetic parenting of the child, although he would also raise the child, while

the genetic mother would resort to her role as sister-in-law, all while living within a close family circle. The committee could not help but wonder whether all these entangled relationships might not intrude upon the marriage of the younger couple, as the young man would be forced to observe his parents raise a child that was genetically the child of his own young wife and his much older father, while the young wife observed her own genetic child being raised by her parents-in-law.

Initially, the committee gave serious thought about extending approval to this case, allowing the family members to take the step of attending required psychological evaluations in preparation for their participation. However, time did not make this case more palatable. Both the intergenerational and transgenerational factors, and the ambiguous "yuck factor," were finally insurmountable to the committee, and the case was rejected (2/01, Case 1). (See also the associated discussion from 3/01, Case 2).

Although lacking clarity, the yuck factor was certainly a big reason for the rejection of this case. Although some warned of the "Daily News" factor, it seemed unlikely that such a case would be publicized; in fact, it may not be so unusual. Other cases of known donors involving confusing genetic relationships certainly exist, but the combined effect in this case served to overwhelm the committee with its potential for awkwardness in one extended family. In some cases, where the age gap is reversed, coercion can go the other way.

Example 41

A woman in her 50's had carried one pregnancy for her daughter and now wanted to carry another. The daughter had suffered a hysterectomy at a young age, and the mother wanted to help her create a family. It was assumed that some risk could

accrue to the older woman, but no concerns about coercion or transgenerational prob-
lems were expressed by committee members, probably because the older had no ge-
netic input; presumably her older and wiser status, and her motherly selflessness, also
precluded such a problem (12/01, Case 4). Nevertheless, one cannot help but wonder
how the older mother might refuse to help her daughter without appearing uncaring.

Example 42

In another older to younger transgenerational case, a father willingly accepted
the position of back-up sperm donor to his son, even though he knew it necessitated
surgery due to his previous vasectomy. The idea was to use the father's donation just
in case the son's sperm biopsy failed to retrieve viable sperm. Although the father-to-
son age gap was large, coercion was not taken to be a problem, as in the last case, be-
cause the father was thought to be motivated by parental selflessness. However, a dif-
ference between these last two cases is that here the father was making a genetic
investment. The prospective child would be the actual child, although raised as a
grandson, whereas in the other situation the older mother, because an egg donor was
used, acted as a non-related gestational carrier although she invested her body, time,
and risk. Nevertheless, the two cases are similar in that the good will of each elder
parent was assumed, so that any coercion or other relational issue is more likely to be
dismissed or overlooked (10/00, Case 4).

Child Replacement – Child as Treatment

Among the relationship issues confronted at ARM Clinic are cases that could
be thought of as child replacement issues. The first is sex selection, which is not con-
sidered to be a valid reason for assisted reproduction at ARM Clinic; neither is it much

requested. Public controversy over the possibility of choosing the sex of one's child has given an impression that, if available, many people would not only want to control their choice, but even worse, might generally choose boys over girls, creating the sort of imbalance said to occur in China today because of its one-child-only policies. However, only one case of this nature has been brought to the ethics committee at ARM Clinic and it evoked sympathy, although not acceptance.

Example 43

An immigrant from a country with a high value on male children lost her only son in an accident. Although left with other female children, she very much wanted to produce a son, to replace, in a sense, the one lost to her. Although sympathetic to her plight, the committee rejected the request on the grounds that sex selection is objectionable on its face and that replacement of a lost child may be a poor reason to have a child (5/01, Case 3). In this case, another disqualifying reason was that no infertility or medical reason for assisted reproduction was asserted, so by "doing the medicine first," none of the sorts of reasons that might have compelled treatment were presented.

Sex selection can occur as a byproduct of producing a healthy pregnancy when screening out heritable diseases that are sex-linked. ARM Clinic provides the service of Pre-implantation Genetic Diagnosis (PIGD) available as a tool to screen embryos for diseases like cystic fibrosis and sickle cell anemia. The process can be used for sex selection, especially when it is necessary to prevent a sex-linked disorder. However, the ethics committee took the stand that to purposely create a child of one sex over an-

other is superficial, commodifying, and an objectionable reason to embark on assisted reproduction.

Example 44

Another use for PIGD is to ensure the production of a child who can serve as a means of treating the illness of an already existing child. Some cases of children with Fanconi's Anemia, a generally fatal inherited disease, have appeared at ARM Clinic. Here the parents want not only to prevent the heritable disease in a new pregnancy, but to pre-select a child who can serve as a bone marrow donor to save the life of the current child. In one case, the parents wanted to produce, select and freeze enough embryos for their whole future family, not only to treat the child they had, but to ensure the health of all their future children (8/01, Case 4). The ethics committee has agreed that such medical reasons are reasonable conditions that warrant the use of PIGD as a means of selecting healthy embryos. Perhaps because of the well-known paradigm cases of this nature (mentioned earlier in this chapter) they no longer raise ethical eyebrows.

In Chapter 6, the case examples based on risk and consent were most often decided on procedural grounds, what I called doing the medicine first. However, in this chapter, where the cases exhibited new family relationships, elusive footings of a more deontological nature provided the basis for decision-making, generally what I have called the yuck factor. In these cases, the consequentialist goal of attaining a positive outcome (a pregnancy) is not seen to be as important to committee members as an overall sense of "wrongness" about how the end result is to be achieved, or the resulting family configuration. Although it is rarely mentioned in the bioethics literature, the

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"argument from repugnance" or the "yuck factor" turned out to be of more importance in the bioethical deliberations at ARM clinic than has been known or previously reported. Many members of the committee experienced the sensation of dismay or disgust upon learning about certain novel requests from patients or new techniques available to the practice, and they interpreted this feeling as a reason to reject the treatment plan, without finding it necessary to produce an argument, or to more fully discuss the problem at stake. The question is whether there is a value to this feeling and how it should apply to the practical problems confronted by bioethicists.

In the next chapter, I present in some detail the views of Leon Kass, mentioned earlier as one who takes this feeling seriously and has used the "argument from repugnance" to try to retain traditional human reproduction and delay or limit research in the field. While Kass admits that feelings of revulsion are not arguments in themselves, he gives them great weight as an emotional expression of a deeper moral knowledge. However, I argue that the reaction is often just a sense of shock when facing something new, and that its actual moral value, whether right or wrong, must be gleaned through the more active process of argumentation put forth here as Scanlonian reflective equilibrium. Nevertheless, the fact that the proclamation of repugnance was used so frequently at ARM Clinic to support the rejection of a case causes me to put out more fully in Chapter 8 an explanation and analysis of Kass and his argument from repugnance.

CHAPTER EIGHT

KASS AND THE ARGUMENT FROM REPUGNANCE

The use of the term "yuck factor" has most often been associated with Leon

Kass, the University of Chicago professor, physician and bioethicist currently chairing

the President's Council on Bioethics. Kass has used his political platform to warn

against the dangers incipient in modern science and technology, particularly in cloning

and therapeutic stem cell research. He has stated that the tendency of humans to recoil

from some of their own intemperate practices (he lists incest and bestiality as among

the worst) is a natural and important warning sign of moral danger. Similarly offensive

to Kass are some of the "unnatural" achievements of hubristic science and technology.

The repugnance felt (or said to be felt by the majority of the population, who accord-

ing to opinion polls are opposed to cloning, for example) when exposed to various

practices, or their supporting ideas, is supposed to be an indicator that something is

wrong, that human dignity is endangered, or, at least, that moral qualms have been en-

countered. As one journalist described this emotion, "in the bioethical debates it has

come to be known, not very technically, as the "Yuck Factor," the instinctive revul-

sion most people feel toward many prospective biomedical innovations, such as the

screening of embryos for (say) sex selection or eye color, or the cloning of human be-

ings – for reproductive purposes" (Ferguson 3).[45]

Kass has developed this "argument from repugnance" into a more general de-

ontological framework by which to elaborate his views on human nature and the level

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[45] See Andrew Ferguson in "Kass Warfare," *The Weekly Standard*, 2/4/02, page 3.
Kass does not use the term "yuck factor" regularly, although he is associated with it (for example, see
his book review from 9/23/98). He prefers the term, "repugnance," to express his deep-seated horror at
these scientific activities.

of respect due to humanity. His well-known popular articles against cloning, as well as his 1997 testimony to the National Bioethics Advisory Commission, may have been responsible for elevating him to his current status, giving his argument from repugnance special significance and serving to disseminate the notion of the "yuck factor" into contemporary bioethics discussion. Certainly, it was more than once used as a reason against the acceptance of certain cases at ARM Clinic, as I have reported in the last two chapters.

Some of the strength of Kass's argument comes from his linking of new technologies like cloning to abhorrent practices such as murder, referring to highly technical practices as bizarre, grotesque, narcissistic, revolting and a sign of "Frankensteinian hubris." The arousal of such strong feelings are proof to him of immorality: he refers to the powerful feeling of revulsion as something akin to an expression of human wisdom. In a widely read *New Republic* article in 2001, he said:

> Revulsion is not an argument; and some of yesterday's repugnances are today calmly accepted – not always for the better. In some crucial cases, however, repugnance is the emotional expression of deep wisdom, beyond reason's power completely to articulate it. Can anyone really give an argument fully adequate to the horror that is father-daughter incest (even with consent), or bestiality, or the mutilation of a corpse, or the eating of human flesh, or the rape and murder of another human being? Would anybody's failure to give full rational justification for his revulsions at those practices make that revulsion ethically suspect?...I suggest that our repugnance at human cloning belongs in this category…repugnance may be the only voice left that speaks up to defend the central core of our humanity. Shallow are the souls that have forgotten how to shudder (2001, 32-33).

In spite of the drama in this invitation to shudder, Kass recognizes that something more than the emotion of repugnance is necessary if his point of view is to be elevated into a political or moral position; the argument needs to be put into a princi-

pled form. In general, it is less an argument than a declaration, calling for respect for the "natural human" against any form of dehumanization. He feels that values once accepted as basic to humanity (as recently as 25 years ago) have now been eroded by technology. He complains that "once-given natural boundaries are blurred," that "moral boundaries are seemingly up for grabs" and even worse that "man gets used to everything—the beast!" His vision of humanity is deeply pessimistic because it has lost a sense of respect for tradition due to "modern notions of individualism" (1997, 18).

The use of human reason can be blamed for this "fall" because of its tendency to reduce and narrow the bigger picture of humanity, allowing us to slide into "piece-meal thinking," simplistic notions of freedom, "compassionate humanitarianism," and "cultural pluralism," so that economic interests and technological achievements take on their own speed to advance, until the means are forgotten in a race for "clever" human ends (2001, 31). And yet all that has been gained by this approach, in Kass's point of view, is a false separation from ourselves and our natural essences. We have become depersonalized as we have slipped into these passive patterns of behavior.

In 1985 Kass published his overall philosophy in a book[46] deriding reproductive technology. Here he made clear his feeling that the use of anything artificial violates "the nature of man himself" (73). As recently as January 2003, in a *New York Times* editorial, Kass continued to emphasize the same concern about the ability of technology to overrule "natural" human life. Speaking about cloning in particular, he said, "It is the first step toward a

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[46] *Towards a More Natural Science: Biology and Human Affairs*, published by Free Press, New York, 1985.

eugenic world in which children become objects of manipulation and products of will" (2003, A-25).

Kass's concerns about objectifying children are not totally in opposition to some of the attitudes expressed by clinicians at the ARM Clinic in their defense of "natural" physical processes, although it is odd to hear "natural conception" extolled as though it is morally superior by those whose work is to overcome "natural" defects with "artificial" practices like IVF. However, as they exemplified, even those who applaud the superiority of the "natural" find it difficult to articulate specific ethical principles that imply the artificial is immoral. However, sometimes in the deliberations of the ethics committee, the expression of the attitude of repugnance was enough on its own to doom the acceptance of an unusual case. Other times it just reflected, in an unarticulated way, an aesthetic or visceral reaction, feelings that couldn't be successfully verbalized.

Kass stated that he understood the need to articulate some reasoning to explain how his attitude of repugnance is supposed to stand in for real principled objection, but his ideas depend upon a traditional pre-scientific standpoint about human nature. Before clarifying his reasoning, I set out a review of his earlier work, so as to analyze the history and development of his standpoint and show how it applies to my project in this paper.

In 1971, Kass's attention was focused on IVF, the newest reproductive technology on the horizon. Steptoe and Edwards had recently reported their initial successes in the fertilization of a human egg, its maturation into the embryonic stage in the laboratory, and the two had published their intention to implant these early em-

bryos into human subjects. Kass objected to this research, using terms similar to his objections later put forth against cloning, referring to what he believed was the objectionably high risk involved to a child conceived under such circumstances, citing the possibility of "deformity," "retardation," "gross abnormalities," and "malformation" (1971, 1175). He argued that experimentation should cease until the risk was resolved, and he demanded a high standard before any such experimentation should occur in the future; the ability to prevent *any* defect must be proved before attempts at human implantation were to be implemented. (He didn't say how such proof could be obtained without doing any experimentation.) For him, experimenting on the embryo was unacceptable, because he had already collapsed any distinction between the blastocyst, the embryo, and the more developed fetus: to him they were all potential human children and deserved protection. Kass took experimentations on early embryos to be equivalent to human experimentation without consent, because it deliberately imposed risks upon potential children who could not possibly agree (1174).

His framework of risk and safety was supported by three other claims, besides potential personhood. First, he argued that parents should not consent to experimentation on their children for any reason other than the hope of therapeutic treatments, but never for scientific knowledge. In the case of IVF, he saw the purpose of embryonic manipulation to be the development of a treatment for infertility in the parents, so it could not be said to be therapeutic for the child. Thus, no experimentation was warranted.

Second, he questioned whether infertility could be seen as a disease requiring treatment. For him, it was more akin to a desire, a valuable desire to be sure, but one

that should not impose any demands on the scientific community as if it were a disease:

> It is one thing to accept for yourself the risk of a dangerous procedure (or to consent on behalf of your child, even your intrauterine child) if the purpose is therapeutic. Some might say that this is not only permissible, but obligatory, in line with a duty to preserve one's own health or the health of one's children. It is quite a different thing deliberately to submit a child born or unborn, to hazardous procedures which can in no way be considered therapeutic for him (and, as I shall argue shortly, is "therapeutic" for you only in that it "treats" your desires, albeit unobjectionable ones) (1971, 1176).

Here, Kass exhibited a preference for the cellular embryo over a treatment of the disease of infertility in the mother. He suggested that her condition ought to be endured and accepted. He went on:

> If it is any kind of disease, it is a "social disease." …To consider infertility solely in terms of the traditional medical model of disease (or in terms of a so-called right of an individual to have a child) can only help to undermine, both in thought and in practice, the bond between childbearing and the covenant of marriage….Just as infertility is not a disease, so providing a child by artificial means to a woman with blocked oviducts is not treatment (as surgical reconstruction of her oviducts would be). She remains as infertile as before. What is being treated is her "desire"...to bear a child (1971, 1176-77).

At this point in time, fertility research had not yet resulted in the achievement of pregnancy for the participants; it was too new. Kass thought that the hopeful couples who cooperated with researchers were being cruelly exploited by the scientific community by participating in research that was unlikely to fulfill their particular dreams of fertility.

Kass's third claim was that no distinction could be made between the embryo and the fully developed child. He portrayed any scientific manipulations as a purposeful infliction of injury on a fetus and thought it should be prevented by law in the same way as the use of thalidomide.

These were the stated reasons why Kass asked for a moratorium on IVF human experimentation in 1971 (though he would have allowed animal research to continue). He called for the establishment of critical professional study groups to assess the future for such research, and he sought publicity so that the undesirable social consequences would become widely known. He wanted ethical and legal limitations to be firmly established, and he wanted international groups to cooperate in preventing a race toward making babies, "evils committed in the name of international competition" (1971, 1178).

But behind these concerns for human safety, allusions to deeper fears can be recognized in Kass's writings. He envisioned a dire outcome for humanity by such possibilities as:

- "full laboratory control of human reproduction" by the state;

- a slippery slope toward other reproductive techniques that seemed to him unacceptable to the human condition, especially ectogenesis and cloning;

- the development of bizarre experiments because of poor medical judgment;

- reproductive capabilities becoming available to irresponsible parties presumably in other countries with fewer moral scruples); and

- the accumulation of power by the medical scientific community where the increasing ability to control nature in various ways could incite an "immoderate" public backlash (1971, 1178-79).

When Louise Brown, the first "test-tube" conception, was born in 1978, to all-appearances normal and healthy, Kass's opinions remained unchanged.[47] However,

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[47] See Pence's *Classic Cases* for an overview of the Louise Brown case and its aftermath (93-119).

he added a new concern to his list—that confusing human relationships would be developed and would be socially harmful.

> More important than the risk of bodily harm is the possibility – unique to these new procedures – of deliberately confounding the lineages of such children…the possibility of donation of eggs from a woman outside of marriage, or the use of a surrogate woman to carry someone else's child…The problems caused by confused lineage and identity constitute additional possible harm deliberately inflicted upon the children-to-be. Moreover such indifference to matters of lineage is a serious challenge to the whole meaning of the institution of the family (1978, 5).

The problem for Kass is that in order to prevent the social harms that he feared, the whole notion of the transaction model of medicine, where the goals and the treatments appear to be driven by individualistic transactions between physicians and their clients, would have to be altered. Kass's view was communitarian, seeking less individual autonomy in these personal decisions. Furthermore, Kass continued to blame women for their infertility, hinting that they caused the problem through their own sexual practices. (He didn't mention the possibility that men might share in the responsibility of spreading sexual diseases.) He said:

> We do know, for example, that gonorrhea and pelvic inflammatory disease are perhaps the leading causes of tubal obstruction in women – they account for probably a third of the cases. It would be curious if, with the aid of federal support, we had a program of Petri-dish babies before we had a vaccine against gonococcus. That strikes me as bizarre (1978, 7).

At this time, besides insinuating that disease is a natural state, to be accepted and endured (and perhaps taken as due blame for one's lifestyle choices), Kass also began to develop his defense of the 'natural family,' where repugnance was developed further as an intuitive moral position by which to keep limits on anti-family and anti-

human social behaviors. The value of using repugnance to identify moral behavior is illustrated by the following test:

> I have two tests of whether the embryo is nothing – and I do not regard it as a full person or a full human being. One, if one of these embryos should die, would it be mourned or buried? Probably not; we do not even do that for fetuses. On the other hand – and this is a grotesque thought, and I apologize- suppose it turned out that someone discovered the human embryo is a delicacy? It would be abhorrent to think of eating them, wouldn't it? Why? Surely because the embryo is covered by the general presumption that things human are not mere stuff. I grant that much good could come from embryo research, but to proceed we would have to be convinced that we are working on mere stuff (1978, 13-14).

To take a consequentialist standpoint of evaluating means solely in terms of ends is abhorrent to Kass, so he presumed here that to analogize between embryo experimentation (as done for fertility) and the ingestion of embryos as a delicacy serves to remind the reader of the importance of human life and the repugnance of "unnatural" manipulations of it.

By using such a colorful example, Kass hoped to encourage a feeling of revulsion toward reproductive experimentation in general, but perhaps to also inspire rhetorically a sense of outrage towards the overall primacy of science and technology in our lives, and more particularly against the practices he abhorred.

By 1997, Kass turned his attention toward cloning in particular. He saw the possibility of a human clone as the symbolic culmination of the negative consequences he had always feared in the slippery slope of reproductive experimentation. That year, he gave testimony to the National Bioethics Advisory Commission, (NBAC), a group organized to report and make recommendations to the Clinton Administration on the implications of human cloning (1997b S:99). He stated that his reaction to cloning was

informed and molded by his earlier concerns about the practice of IVF, but in recognizing that his emphasis on risk and harm had not been effective then, he now stressed "repugnance and revulsion" as the main framework for his objections to cloning. Responding to criticism that the expression of emotion does not contain an argument, nor even a rational justification for an argument, he tried to portray emotion as more meaningful than argument. In his testimony, he defended the emotional response this way:

> We are repelled by the prospect of cloning human beings not because of the strangeness or novelty of the undertaking but because we intuit and feel, immediately and without argument, the violation of things we rightfully hold dear. I doubt very much whether I can give the proper rational voice to this horror…But please consider seriously that this may be one of those instances about which the heart has its reasons that reason cannot adequately know (1997b 140-141).

Besides repugnance he mentioned three other reasons to support his position of preventing cloning research, reprised from his earlier anti-IVF work: the immorality of experimentation without consent from the embryo, problems in identity for "manufactured" children, and violations of the meaning of parenthood and childhood. These arguments have not changed since 1971 except to add more gloomy forecasts about the dangers of the experimentation. Kass now sees the overall culture as having fallen into decline, so that a position of respect toward sexuality and marriage is difficult to find. He said, "changes in the broader culture make it now vastly more difficult to express a common and respectful understanding of sexuality, procreation, nascent life, family, and the meaning of motherhood, fatherhood and the links between the generations" (1997a, 17).

Kass still hopes to defend some "natural boundaries" in our world views. To him, nature fixed a deterministic method of situating us in the world; the meaning of life is created by our acceptance and participation in the lot thrown to us. Holding to a "clear natural grounding" by refusing to tamper or to rearrange the world to suit ourselves, should be a matter of dignity and pride (21). The creation of new family relationships, inherent in assisted reproduction, and the way they subvert "kinship" is abhorrent, then, because it confuses one's sense of identity, and lessens one's sense of belonging. In addition, traditional relationships keep the world in its natural order. One meaningful feature of parenthood is that the child serves as a replacement for ourselves and our generation, and a reminder that life is not eternal. It is natural for the adult to surrender her grip on life, and recognize its brevity, as her (or his) children are born and grow into adulthood. To allow transgenerational fertilization is to cling to life unreasonably, by refusing to cede control of the future. For Kass, this is "inherently despotic" in its attempt to use one's will to control others (1997b, S:143).

Kass's overt concerns about the dangers in assisted reproductive medicine continue to mask a deeper fear, that humans have become "slaves of unregulated progress" (S:143). By blindly complying with scientific desires and enjoying the accomplishments, humans have lost their will and behave as though they cannot assert their freedom. Freedom and dignity to Kass lie in the ability to control technology – or more accurately to stop technology—and he clearly feels reproductive medicine has allowed technology to control us. He doesn't consider or acknowledge that if successful, his blanket condemnation of technology would itself be a restriction of human freedom.

His themes of dehumanization and the loss of freedom, written with religious fervor, are currently displayed in his work as Chairman of the President's Council on Bioethics. In the introduction to the committee's 2002 report on cloning, Kass warns against our tendency to use utilitarian frameworks for decision-making, particularly in our acceptance of "runaway technology" and "the utopian project to remake human-kind in our own image" (2002a, xvi). Here, such factors as human dignity and some sort of "life principle" were said to take precedence over "unintended consequences of research" and the use of "dehumanizing biotechnology" (xxi-xxii). Saving lives (the "life principle"), no matter how many, is not an appropriate way to measure morality, or to show respect for human dignity, according to Kass, because we become "de-graded" by doing so.

But Kass leaves unclear exactly how one is to define human dignity and worth, an especially important omission since it appears they can be sacrificed in some in-stances but not others. It is unclear how gaining control over human reproduction is an inherent threat to human dignity, instead of a means of ensuring its longevity.

His assumptions are problematic, for two reasons. First, he assumes that the slippery slope must prevail. He sets out no reason to believe that techniques for repro-duction necessitate that all human procreation will eventually be "manufactured." Second, he does not explain why gaining control over sexual reproduction means an inherent loss to human dignity. It seems odd to presume that human dignity lies in the random genetic mix that occurs in natural sexual reproduction rather than in the treat-ment and respect that humans display to one another during their lifetimes, particularly in the health care services that are freely given. Perhaps the development of wise and

carefully used power over reproduction is a reflection of human dignity, whereas a willful ignoring of the powers to diagnose and treat human illness and suffering would be lacking dignity.

By using the argument from repugnance to encompass all his moral concerns, Kass faces a two more technical problems. First of all, his original concerns about the danger and risk inherent in reproductive research have proved to be highly inflated, although this is not to say that there is no risk at all.[48] Bonnie Steinbock reported in 1994, for the Human Embryo Research Panel at NIH, that "IVF so far has shown no higher rate of congenital deformity than coital reproduction," although a different and smaller study in Australia did report that certain birth defects, spina bifida and heart abnormalities, were higher than normally expected (Steinbock 32-33).[49] In any event, the type of defects that have been reported appear to be low in number, minor, and/or correctable, and not the major deformities feared by Kass in 1971 when he queried, "what if the first "test-tube baby" turns out to be a monster?" (1179). Rather than being relieved by the fact that the medical scientific community in the 1970s has not turned out to be as reckless as he feared, he still maintains the same level of criticism towards the risks of reproductive and therapeutic cloning that he had used against IVF.

A second criticism of Kass's repugnance argument is that he has continued to deny any distinctions in the stages (or better thought of as the continuum) of reproductive cells as they move towards full-term infancy. Is a four cell organism deserving of

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[48] See "Eye Cancer" in the *Washington Post* (A9) and Skloot in the *New York Times* (A-35) for more current complaints that some illnesses are more common in children born from in vitro fertilization. The most often linked is a rare form of eye cancer; although the studies as yet are inconclusive, finding "no confirmed evidence."

[49] Bonnie Steinbock in "Ethical Issues in Human Embryo Research" wrote that research conducted by Roberson in 1986 and Morin in 1989 did not confirm high levels of deformity in infants born from IVF.

the same protection as a fetus or a neonate? Abortion law indicates that a distinction is made between pre-born and already delivered infants. Stem cell policy distinguishes between the first 72 hours of cell division and the cell thereafter. Does any cell need the full protection of the law? The basis for Kass's argument against risk was to protect the potential infant, but he has not demonstrated how such a claim of potentiality can be upheld. The body of legal work since 1971 has not demonstrated any principle by which parents can be held accountable for negligence, or even intentional harm, to an unborn embryo or fetus. As Pence pointed out, "So far, the courts have rejected almost all wrongful life suits" reasoning that life is a benefit even when pain and suffering are present (1995, 196). A problem for Kass is that many children (maybe even most children) are produced by parents who do not apply high standards to their personal health; they eat improperly, fail to exercise, use drugs, pick up sexually transmitted diseases, including the HIV virus; they smoke, drink, and take over-the-counter pills; they don't get married; they become pregnant thoughtlessly and by accident. In fact, the most healthy parents are probably those using reproductive medicine, because they are so highly motivated in their quest. Kass hopes that our disapproval of unhealthy practices in pregnancy can be transferred to outrage about embryo experimentation, but he fails because it is counter-intuitive to the public to imagine that irresponsible parents should be prosecuted. Perhaps unavoidable harms to a being who would not exist otherwise is less upsetting than purposeful harm to an existing being. But primarily his analogy fails because it leads to the consideration that natural fertilization is more risky than the laboratory; each home-based conception could be said to be an unsafe experiment. Focusing on the possible dangers in conception could en-

courage the more responsible and careful individuals to choose IVF, or even cloning, over natural parenthood, to avoid the risks that normal people take every day.

While placing so much emphasis on safety in the context of reproductive technology, Kass does not seem much bothered when naturally conceived offspring have poor outcomes. In his 1985 book *Toward a More Natural Science*, he blames many of the ills in society on the intelligent:

> After all, how many architects of the Vietnam War or the suppression of Solidarity suffered from Down's syndrome? Who uses up more of our irreplaceable natural resources and who produces more pollution: the inmates of an institution for the retarded or the graduates of Harvard College? And which of our genetic mutants display more vanity, self-indulgence, and the will-to-power, or less courage, reverence, and love of country than many of our so-called best and brightest? It seems indisputable that the world suffers more from the morally and spiritually defective than from the genetically defective. Thus, it is sad that our best minds are busy fighting our genetic shortcomings while our more serious vices are allowed to multiply unmolested (46).

Can human disabilities be the solution to social problems, or is he perhaps casting about for a defense of the fact that birth defects are a regular outcome of "natural reproduction?" It seems contradictory for Kass to be so complacent about natural risks, while being so concerned about experimental risks. If the techniques of reproductive medicine can produce healthier children (and if persons produced by such methods, when not harmed, are presumably pleased that such experimenting was done on their behalf, since it provides them with life where there would have been none), then it appears that Kass has clung to the issue of risk and potential harm unnecessarily, because without it he has a much more difficult argument to make as to why such experimentation should be thought immoral. What appears to be at stake is his definition of personhood.

His conception of the person is the third problem for Kass's argument from repugnance. His writings on the topic since 1971 are vague. He has not made abortion rights a center of his work, at least in writing, and in his 1985 book, he simply states about abortion: "there is likely to be little new that can be said and certainly not by me" (83). But without a fuller story of personhood, it seems odd for Kass to speak of reproductive technology as unethical because of the impossibility of obtaining consent from the "unborn and the unconceived," as if the fertilized egg has already been taken to be a consenting human being (50). Instead of following up on this line of reasoning, Kass raised social concerns; the weakening of the family, the way that technology might lessen dignity and respect for humans. Is the embryo really fully human, on his view? It is not clear except in the context that embryos can suffer harm and cannot give consent. He sometimes seems more concerned with what our treatment of embryos says about us as moral beings. In a recent news article he worries:

> Advances made in science and technology to relieve suffering could dehumanize us. Advances in reproductive biology such as in vitro fertilization, can do much good." "Yet," these bio-technologies may also cause us "to lose our awe and mystery at the coming into being of a new life….the risks go beyond safety, efficacy, and cost. The power behind these technologies changes the meaning of what it is to be human. They're seductive…They don't come at once. They come piecemeal. You get used to them without thinking (B9).

Here embryos seem to have status as symbols rather than as the actual means of reproductive success to real people suffering from infertility. To the persons they will become and to their prospective parents they are of immense value, but when not being used with that intention, they may have no value at all, symbolic or otherwise. They are, in fact, disposable and forgettable, as can be seen by the many "extra" embryos

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created, frozen, and stored away in reproductive medicine clinics. Like many other facts of nature, their value often lies in something other than mere existence, perhaps their overall usefulness.

Kass, then, is unsure what real value to place on human embryos; like many of us, he vacillates. In his 1985 book, when discussing the issue of surplus embryos, he admits to being "undecided" whether it is wrong or right to discard them. The whole problem of potentiality and personhood does not really appear to be the main problem after all; instead, his anti-experimental attitudes seem to arise from a different source: its effect on our characters. He comments: "Even if there is no wrong done by discarding at the blastocyst stage—and I am undecided on this question – there certainly would be at later stages. (Those who disagree should at least be concerned about the effects on the attitude toward and respect for human life engendered in persons who are engaged in these practices)" (1985, 58). As this excerpt reveals, his concern is not so much for the potential person, but about the types of moral decisions made in what he considers to be our primarily utilitarian society.

Kass fails to consider that he may be guilty of dehumanizing the human goal of reproduction even while worrying about dehumanization in humanity as a whole. The essence of his problem with technology is the way he thinks it destroys personal freedom, but he nevertheless continues to ignore or trivialize one of the most personal, natural, and basic of human freedoms, the ability to reproduce. Whether or not infertility is caused by disease should be beside the point; whether or not humans possess a "right to reproduction" is beside the point. The real point missed by Kass is how to lo-

cate where in society personal decision-making ought to be situated, if not by the affected individual. Kass's stated claims valuing human freedom and dignity do not apply to private and personal decisions when they don't comply with his anti-technology stance, even those basic to personhood. It seems unlikely that Kass could refine this argument to make it more acceptable to the public at large, because he is trying to persuade women, in particular, to reject a technology which has offered fulfillment for their goals of motherhood, and furthermore to assume personal blame for their own condition.

However, as I have pointed out, feelings of repugnance remain a strong source for anti-technological attitudes, even among practitioners in the field of assisted reproductive medicine itself. The yuck factor continues to work as an intuitive reason for taking a moral stand even as it fails to persuade as an argument overall. Kass has pointed out that many former practices thought to be repugnant are eventually, over time, accepted as benign, a situation which Kass takes to be a defeat for morality. The process by which people accustom themselves to change over time, even to practices previously rejected, is evidence to Kass that we are enslaved by technology, fooled by our own desires, and perhaps have taken on qualities of poor moral character.

The useful case in point, made clear by considering his work over time, is the way the public has turned away from revulsion to acceptance of IVF. However, contrary to Kass's position, the message is not that time causes an erosion of the feelings of revulsion; it is more likely that disgust was fostered in the first place by an overstatement of the risk and the dangers to society by critics such as Kass. For example, in 1971, he expected "sweeping" and "immoderate" public reactions if "the first test-

tube baby" turned out to be a monster," a fear that was not tested when Louise Brown turned out to be "normal" (1179). In 1978, he imagined a horrified reaction by the public when "scientists fill laboratories with human embryos for experimentation," a reaction that has not materialized (8). In 1997, he used sensational language to demonstrate the importance of repugnance as a societal reaction, when he compared cloning to such horrors as "father-daughter incest," although the public has not seen them as analogous (1997a 20).

Repugnance, as an emotion, has consistently failed to carry the heavy burden demanded of it, even as new stages of technology are reached and then exceeded by the next. Kass doubted that he, or anyone, could give "the proper rational voice to this horror [cloning]," (1997b S:141), but it may be his lack of rational arguments that explains why his appeals have not always succeeded in rousing the public. By depending on repugnance, rather than proper rational arguments, he has maintained only narrow support, while others with more persuasive and more reasonable points of views, or with evidence to allay fears, have prevailed. In the case of IVF, emotions changed because arguments like Kass's did not hold up to reality. If IVF had turned out badly, his emotional appeals would have substance on their side, because these types of appeals are only as good as their underlying evidential, logical and reasonable support. In other words, the consequences do make some difference in the overall supporting picture. The next test for Kass will be to see if his attempts to delay or end all cloning research are successful. Even if banned in the U.S., research is likely to continue outside our borders, and the consequences of the research will determine its acceptance.

A deeper reason to resist using arguments from repugnance is not only that they are unstable, but that they are sometimes immoral on their own account, a factor that Kass does not capture. It must not be overlooked that at one time in our country, it was thought repugnant to eat in the same restaurant, to go to the same school, or to engage in similar social events with persons of other races or cultures, particularly those of African-American lineage. It was thought particularly repugnant to establish interracial sexual relations. But we now acknowledge that the repugnance felt at these practices was clearly wrong, and those who felt such emotions have had to learn to rid themselves of them, because it is now considered immoral to feel them, as well as act on them. The instrument encouraging such dramatic social change was a reliance on reason, where the evidentiary facts of nature furnished by science provide illumination to the shared mutual qualities of our human natures despite differences in skin tones.

Feelings of repugnance should not necessarily be ignored. On occasion, they may serve as indicators and warning signals of some morally important issue at stake. However, it is unlikely that they "express deep wisdom," unless other deeper supporting factors are present. The feeling might only reflect squeamishness in facing up to the diversity of behavior and actions possible to humanity (as when we see blood or observe an injury). Repugnance in itself cannot be a sufficient reason for the creation of public policy, at least without the development of moral principle to justify the emotion, a fact that Kass has not yet accepted. As Richard M. Zaner argued in a recent discussion on Kass's yuck factor, "anyone disturbed by scientific interventions into the 'natural' order of things should consider the fact that, for instance, it is just as *un-*

natural to read books, drive an automobile, cut up carrots, or wear clothing as it would be to clone babies" (16).

Although Kass has not produced strong enough reasons to support the ban on various forms of reproductive experimentations, his warnings may be useful for public policy in this way: if new reproductive technologies are to be accepted by the public, particularly those that are refashioning familial relationships, they ought to reflect a certain deontological yearning, expressed by Kass, that children (born by any means) should be treated with respect, as ends in themselves and not as means for the gratification of others. History has demonstrated the difficulty humans have had in complying with that principle: oppression and abuse of children have existed regardless of technology. The deliberations of ARM Clinic showed that when a sound reason or principle could not be produced by which to solve the distressing relationship and other discomfiting problems instigated by new practices in assisted reproduction, the "yuck" factor filled in as a surrogate for those feelings to be given force.

The point of this lengthy elaboration on repugnance is to show its mostly negative force in examining and determining moral solutions. On the other hand it fails to elicit useful mid-level principles by which to establish general approaches to similar problems or to validate the correctness of decisions at hand. At ARM Clinic, the response tended to be evoked by novel problems, where more rational, principle-based standpoints had yet to be located. It is too much to ask that the localized clinical ethics group ferret out and apply new mid-level principles for their novel problems; that is more likely to occur in larger, more diverse and more public settings, so as to avoid the application of the unconditional "yuck" as a way to avoid considering the real

challenges of new technologies. In Part Three, I provide a theoretical basis for solving

the problem and deriving new principles from a more public use of reflective equilib-

rium.

PART THREE

LOCATING PRINCIPLES THROUGH

PUBLIC REFLECTIVE EQUILIBRIUM

CHAPTER NINE

BACKGROUND ASSUMPTIONS

In my presentation of the case examples in Chapters 6-7, I made three observations about how the ethics practitioners at ARM Clinic attempted to make case decisions on specific grounds without necessarily engaging in deeper, more general moral reasoning as experts in bioethics methodology seem to assume. First is the way they attempt to solve cases by using narrow medical grounds while avoiding the larger moral issues at stake, what I called doing the medicine first. Second, clinicians look beyond themselves and their own practice for guidance on moral issues. Third, certain background assumptions, although rarely made explicit, are more important in ethical discussion than has been recognized.

As I pointed out in Chapter Six, clinicians at this level of practice do not enjoy making novel moral decisions and do not feel equipped to do so. Furthermore, they do not want to continually re-think or renegotiate the big moral issues over and over again—such as the use of surrogates for pregnancies, the use of egg and sperm donors, the selective reduction of embryos growing in the uterus, and so on. They prefer to take these issues as settled; otherwise their daily practices would be in constant turmoil.

However, new types of cases continue to occur, forcing reflection, particularly in the realm of determining what is to be considered medical treatment or therapy versus what is said to be more trivially, life enhancement. The patient presented in Example 12, for example, who wanted to avoid the discomfort and inconvenience of stimulative ovulation, is a case in point. Contextual issues, such as her desire to stay

physically trim, put her on the side of choosing enhancement rather than medical therapy. Buy defining her desire that way, the committee was able to deny her case, butdefer more serious discussion about when or if enhancement issues of some kinds might sometimes be morally appropriate. Why is it necessarily wrong for a woman to want to control her body by avoiding discomfort while still producing a child? Will we one day accept the idea of the whole fertility and pregnancy process taking place outside the womb so that women's lives are less disrupted? Thee committee did not engage in these questions, simply stating that their mission is only medical, thus allowing them to resolve this case, and put the deeper moral questions to the side.

Another recurring issue of this type for ARM Clinic was whether or when to treat homosexuals. As shown in Example 22, the physicians were not anxious to assist gya men in particular, partly because of a sense that it violated a social tradition; partly because of a lingering worry that men might not parent children as well as women. The committee did not want to decide the morality of such a big social issue, but they were able to avoid taking cases of this nature by defining them as enhancement rather than therapeutic. The man asking for a baby did not really have any medical or fertility problems, he simply wanted a genetically related child. This clinic did not feel they were professionally required to assist him since he was not ill or infertile. In this way, the clinic could wait and see how the social issue developed over time before engaging in morally uncertain deliberations. Of course, their non-acceptance of the client was "taking a moral position" but one in which they were not forced into deeper moral reflection than they were ready for.

This situation also helps to explain my second observation: how clinicians at this practice-level seek guidance from above on issues novel to them. Preferably, such guidance comes in the form of well-established mid-level principles published by their professional organizations. In other words, they look to specific policy specifications on participants in infertility treatment: the age limits for patients and donors, the number of egg or sperm donations thought permissible to prevent risk or consanguinity issues, standards of care to prevent HIV transmission, and so on, to provide a basis for their decisions. When cases arise outside this framework of professional policy and medical practice, clinicians find it very difficult to make confident decisions.

Most of the cases I outlined in Chapter Six on risk could be handled by specific mid-level principles or policies put forth by ASRM, the professional organization. But in Chapter Seven, where relationship issues are set out, the organization is not as likely to have developed specific standards or principles. In Examples 26 – 28, for example, one can see the problem of when or if it might be acceptable to create a genetically unrelated baby by using donor egg and donor sperm. Here the professional organization gives little guidance, and the committee's decisions show their attempts to grapple with the issue. On one hand, it seemed wrong to allow a couple to walk into a laboratory and choose donors by certain characteristics. On the other hand, certain cases demand both donor sperm and egg to be used as a medical decision during an urgent episode of fertility failure. Sometimes the patient is in the laboratory prepared for insemination when it becomes clear that the embryos are not viable. Rather than allow her to go untreated, this is a reasonable time to use donations.

As I have shown, the committee's viewpoint changed over time on this issue, eventually formulating a new policy of accepting instances of donor egg/donor sperm when they were "backed into" in the way I described here, and can also be seen in Example 27. It is likely that over time the professional organization will receive enough queries on a problem like this to force them to consider it. At that time a new policy statement will appear to help others with similar decisions to make. However, in the meantime, each private clinic must work out, case by case, how to go on.

My third observation, about the importance of certain background assumptions in decision-making (to be discussed next at some length) explain how they encompass the professional policies that confirm the ethical decision.

No particular method stood out at ARM clinic to direct or assist in decision-making. Occasionally, one of the four Beauchamp and Childress principles was mentioned as a reminder that principles should be taken seriously. For instance, it was brought to our attention that it does not serve beneficence nor does it protect autonomy to deny a patient's wish to use a chosen (known) egg donor, as in Example Eight where the woman wanted to use her underage niece's egg donation. Similarly, in Example 15, where a patient was denied the chance to freeze embryos for use at a more convenient time, the principle of autonomy, beneficence and even justice was raised. However, in these cases, it was argued that autonomy was overrated and beneficence was secondary to the medical policies in place which were thought to protect both the clinic and the patient.

In general the citation of the Georgetown principles tended to cause dissension rather than unity, since some committee members always tended to promote autonomy

first as the predominant moral principle at stake, while others felt autonomy was overly protected and that some patients were allowed too much personal choice in these important decisions. The most effective methodological approach at ARM Clinic was akin to casuistry, in that cases were "worked up" by looking at the particular context, the local rules, and the professional policies pertaining to it, so that the decision was both clarified and validated by the paradigm comparison or stated policy. Cases of risk or those concerning concomitant medical problems such as HIV can be effectively settled this way. The approach served to avoid the need to draw broad conclusions about the overall rightness or wrongness of any specific case, and also to avoid the need to develop new mid-level principles to justify their stance. However, the casuist approach depended on their having access to paradigm cases or policies, which were not available in the novel situations. Many decisions were striking for their procedural emphasis with an associated lack of ethical content, such as the homosexual parenting. Even when one of these cases stood out in importance (such as the donor egg/donor sperm baby creation issue), little or no discussion was devoted to seeking any ethical grounding principle, perhaps for fear of creating a new precedent. Locating a grand overriding principle was especially avoided, even to the extent of explicating whether harm would be produced by a decision, who would be most affected by it, or whether the situation could be thought to be "right" in a deontological sense. Discussions tended to be more explicitly utilitarian, wherein the production of a healthy baby was seen as the overall good to be produced, taking into consideration the weighing of any medical factors that might work to obstruct that goal. In general, there was a hesitancy to invoke general principles, and if new principles emerged, as when rules material-

ized out of the practice itself, they were not always articulated or announced. Furthermore, certain background assumptions were implicitly in place constraining any discussions of method or principles.

Background Clinical Assumptions

In all the case discussions, whether organized by the primary features of risk and consent or by the issue of relationships, a context existed in which a specific normative stance was assumed: namely that assisted reproductive techniques are a valid means of permitting autonomous women, and, by extension, families, to make their own reproductive choices, unless the choices are too risky, or potentially harmful to the patient, the prospective child, or society in general. It is this context that makes the daily clinical ethics work so differently from that of abstract analysts, and makes the full use of the process of wide reflective equilibrium unlikely at this level. This standpoint precludes any broad version of reflective equilibrium from being applied to the specific topic at hand, at least in the Rawlsian sense of bringing a wide variety of philosophical theory and moral points of view to the table. An ethicist whose stance was that the creation of embryos, their selective reduction, or manipulation of them was a violation of their status as potential human beings, would not be able to engage in any meaningful discussion about the various options in the cases I have presented here, because to do so would mean that one had already taken a position against most of the work engaged in by clinicians in the field. On the other hand, the fact that the health-care worker involved in reproductive therapy had certain background assumptions, taking their work for granted, did not mean that every clinician had sorted through the variety of ethical positions possible on the nuances of the cases that they saw, as is

easily noticed by the varieties of points of view illustrated by the ethics committee on many cases presented in the last section.

Besides sharing an overall background assumption supporting reproductive medicine, clinicians can also be said to see themselves as working within the bounds of nature, not coldly manipulating it in the technical way that Kass portrayed such work. They believe themselves to be *assisting* reproduction by correcting diseases or malformations, or pushing the natural boundaries of age, but do not see themselves as radically upsetting any "intent" of nature. This is why the issues of aging and appropriate number of donations are such paramount issues in the field. It is taken for granted that some "natural" limitations of the body ought to apply when treating infertility. Certain policies that appear arbitrary on the surface, like the 49 years 11 month limit on assisting pregnancy in women, were developed because of a need to work within some perceived natural boundaries (in this case natural menopause). The lack of good ethical reasons to support such a policy was not enough to change the minds of the ethics committee members who accepted this "natural" limit (the new research mentioned in Chapter Six, published by *JAMA*, about the low level of risk in pregnancies over the age of 50 has had little impact on practitioners at ARM Clinic). Likewise, the policy of this clinic that sex selection ought not be tampered with seems to illustrate an assumption that "natural odds" ought to prevail over this basic reproductive outcome, even while attempts are made to screen out other natural outcomes (like diseases and malformations, not basic qualities of personhood.) For an example, it seemed harmless to me to allow a rare case of sex selection, perhaps to fill out a family that included only children of one sex, or to replace a dead child. In fact, I pre-

sented an argument that it might be especially beneficial in countries who have mistakenly allowed an overpopulation of male children to now perform some sex selection to regain a better ratio of males to females. But clinicians at ARM Clinic took the "repugnance" position here, refusing to perform sex selection because of a sense that it was tampering with nature in a way that could be detrimental to society over the long run even while giving balance to particular families. It is even more doubtful that the clinic could be persuaded to use its techniques, if available, to enhance any characteristics of the human race, such as screening for IQ, beauty, or athletic ability. However, background assumptions do change over time, and some have become more liberal at ARM Clinic; in the next chapter I will provide an example of one important change.

Methodological Assumptions

Besides their clinical assumptions, the clinicians at ARM Clinic had certain implicit methodological assumptions. They designed their ethics committee to function with a procedural format, rather than a methodological one. The procedures had less to do with ethical content and more with enlisting processes to encourage consensus and fairness in decision-making among members, so that no voice felt excluded or ignored. Few of the members (other than myself) were familiar with ethical theory (although as I have said, some were aware of the four Georgetown principles prominent in principlism). If and when a large principle was mentioned, it was not then "specified down" into a more meaningful application, in the sense hoped for by Richardson, because it wasn't apparent to anyone how to make that move realistically for solving particular cases. Turning the precepts of beneficence or autonomy into a specific maxim that gave a basis for deciding whether to override an age barrier to pregnancy,

as was shown in Example 4, or to allow a confusing family relationship to be created by using a known family donation of egg or sperm, as shown in Example 30, wasn't plausible.

A more reasonable action taken by the group was to compare either a specific policy at hand, or a mid-level principle, to the situation and draw comparisons between them by elucidating the variations in cases (which does fit into Richardson's scheme). But the policy or principle had to be available; the most useful policies were those published by the professional association, or the examples drawn from well-known paradigm cases, or from previous professional experiences. In effect, the deliberations were a form of casuistry, but not in a text-book style, because sometimes they began with a policy or principle to be applied, at other times they did not. In general, however, the clinicians did find it useful to compare the current situation to the paradigm or policy, look for salient differences and distinctions—both in context and in the personal details—and then seek out a principled reason for either following the policy or paradigm, or adopting a more individualized case response. This approach worked quite neatly in some cases, where some original policies and paradigms were clear. For example, when a woman started fertility treatment just before an age limitation kicked in, and yet wanted to continue to try beyond the limit, her probability for success could be calculated, her comparison to other similar cases evaluated, and the particular reasons for or against could be listed, including the all-purpose "for the sake of closure." While not a very strong ethical maxim on its own, it could be seen as a derivative principle of beneficence and was accepted as such in certain instances.

Neither principlists nor casuists have noticed, however, how important were the constraints I have stated on the practice of ethical case review. These included delaying, deferring and narrowing the ethical problem at hand by attempting to restrict cases into a medical model, so that they could be decided through risk evaluation, consent signing, psychological screenings and evaluations, and medical treatments, thereby putting off or foreclosing discussion as to the overall ethical implications. Members looked outside themselves for resolution of the larger ethical implications, especially in novel cases, presuming that better answers would be delivered by external experts, the professional organization, or from public debates. The importance of the professional policies for their decision-making cannot be overestimated, because these replaced the sort of principles and/or paradigm cases expected to be worked into a reflective equilibrium procedure.

Novel cases presented the most difficulty for reviewers, as one might expect, especially the type reported in the chapter on "relationships," where new family relationships were created through reproductive treatment. It is these cases where very little guidance or clarification exist, and where grander principles of autonomy or beneficence seem to be of little use. Why is it wrong to disallow sperm or embryo mixing as in Example 32, where several brothers wanted to work together to help their sibling achieve fertilization? It doesn't seem to violate any of the Georgetown principles, and yet it hardly seems fair to the unborn child to have such a murky heritage. On the other hand, wouldn't the child be grateful to have been given life by people who want him or her to badly? Is it really necessary for a child to know for sure who is the

genetic father? Many children grew up unaware of their specific genetic relationships even before assisted reproduction was possible.

Along similar lines, why is it assumed that a woman will always favor her own genetic embryos when they are mixed with non-related, as was seen in Example 33? The social workers worried that a parent might not love or nurture the non-related child, although there is very little evidence to know, either way. The committee members had no more to go on than their own sense that they might feel more attachment to their own child, but adoption cases, where the parents produce a genetic child near to the time when they adopted a child, seem to belie the problem of favoritism.

The committee members at ARM Clinic would have always preferred to rely on scientific data to obtain more objective policies and paradigms for guidance, instead of guessing by applying their own personal reactions to some of the cases. If psychologists were to produce studies assessing harms to infants born from mixed genetic parentage, or from the use of known family donors, then that type of data would lead the way to new and perhaps more morally principled decisions, because consequentialists, at least, would accept that as better knowledge to depend upon. A defender of traditional reproduction (like Kass), who hopes to hold the line against the further development of high-tech practices, would be better served by producing scientific studies, which may or may not show evidence of medical harm, instead of depending on his abstract, anti-scientific, deontological standpoint alone. But few such studies exist, because the practices are so new, leaving each case to be evaluated on its own terms. The lack of policy and paradigm leaves the door open for the less tangible

factors to become tools for evaluation: the "yuck factor," the slippery slope, or the "Daily News" factor.

Occasionally a useful mid-level principle emerged from the deliberations on certain types of cases: for instance, the supposed right of a child to its own genetic knowledge, otherwise known as the rule for genetic transparency (discussed in Chapter Seven), although it is not absolute. Pooling or mixing embryos from anonymous donors is still common; it is only a problem when the anonymous donation is mixed with the genetically related one. This principle, in particular, came about through the consideration of cases of sperm or egg pooling at the clinic, and by general discussions with lawyers and staff members about liability. Differing contexts in a variety of cases provoked a need for the principle in the way that casuists have believed would happen when such situations are fully deliberated. Here, a viable principle was constructed that is generalizable and defensible apart from its role in the specific case at hand. More often, using the casuist approach only helped in determining whether or when it might be appropriate to override a rule in a specific case—one where the contextual circumstances made it reasonable or wise to ignore or make exceptions to their own policies. But in the case of genetic transparency, the rule was worked out from the bottom-up, extracted from the variety of similar cases as they were examined.

Most novel cases did not yield such useful principles; instead they tended to be decided in an ad hoc fashion, lacking the sort of developed reasoning that could serve to ground the decision in morality. Furthermore, it was clear that in a few cases, familiarity made a tough decision become more palatable over time, regardless of whether a principle had been derived or not. In the first case where an HIV infected

couple wanted to conceive, or the first case where sharing an egg donation and pregnancy between both members of a lesbian couple, the discussions were negative and cases were sometimes rejected, while in the second or third occurrence, as the committee grew more used to the ideas, acceptance grew. These were not exactly situations of "slippery slope' because the cases did not grow more radical as each step of acceptance was taken, but emotional reactions to new cases became tempered over time, just as Kass supporters who proclaim the "yuck factor" have stated they would.

Overall, consistency in decision-making was not highly valued by this committee, although inconsistencies were held up as reminders of how regularly their internal policies were overridden or ignored. Inconsistent decisions were particularly common in age-related cases partly because a cycle of treatment might begin near an age cut-off and run beyond, or because certain cases of infertility encouraged more sympathy from the members of the group allowing them to let the patient have "one more try.' Consistency might be considered one indicator of validity in decision-making, but often contextual distinctions explained why one decision appeared to clash with another, despite surface similarities. In spite of variable methods, assumptions, and inconsistent decisions, most case decisions seemed reasonable and usually defensible. How can that be so? It seems that in practice, moral reasoning is less constrained by deductive reasoning (as the methodologists I have quoted have asserted), and more dependent on modifying rules situationally. However that seems to leave decisions unjustified by moral principle. It seems more useful to focus on moral deliberation as it is practiced, as an activity involving argumentation and consensus-building rather than some sort of prescribed algorithm. As described by Leonard Fleck, it is a "social" activity where we

inquire jointly as citizens about the "conflicting social values and interests" impacting

on us as individuals, families, or professionals (Fleck 133).

A Theoretical Position

One useful way to look at the problem of how to justify practical moral reason-

ing at the committee level comes from early Rawls, in his attempt to distinguish be-

tween "justifying a practice" and "justifying the particular actions that fall under the

practice." He compared what he called "a summary view," (which applies to the for-

mer concept of "justifying a practice)," to a "practice conception" of moral delibera-

tions (which applies to the latter concept wherein rules are set up to govern practices

thereby eventually "justifying the particular actions" that take place under the rules).

In the summary view, rules are thought of as "summaries of past decisions," so that a

rule is formulated to cover "like-cases supported by like-decisions" (1955, 19).[50] In

contrast, the "practice conception" supposes that the rules came first, making up and

defining certain practices as in an election or a baseball game, so that they are "prior to

particular cases" (25). The "summary view" describes how one might encounter a

number of similar cases over time, noticing in experience that cases appear frequently

enough and similarly enough to require the development of a covering principle, so

that when a similar case recurs in the future, the principle is ready-at-hand for applica-

tion. The "practice conception" offers an alternative approach; here one sets out cer-

tain rules to govern or oversee a specific practice, much as in setting out rules for a

game. These rules do not function as action-guides in particular cases (as judged by

some higher principle); rather they define the sort of cases that make up the practice it-

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[50] These ideas are taken from Rawls' "Two Concepts of Rules" (3-33), written in 1955 prior to his *Theory of Justice,* but applicable to the understanding of ethics as a "practice."

self. As Rawls puts it, "To engage in a practice, to perform those actions specified by a practice, means to follow the appropriate rules. If one wants to do an action where a certain practice specifies them there is no way to do it except to follow the rules which define it" (26). Actions are then justified by their comprehensive linkage to the practice, rather than by being subsumed by a more general rule.

When thinking of how clinicians are involved in their practice, and how their background assumptions work to prevent re-thinking of their moral standpoints, one can begin to comprehend why it is so difficult for practitioners to "specify" or "derive" the sort of mid-level bioethical rules that one might think are required for generalizing over and giving a moral basis to their judgments. In this context, to derive new rules would be to ignore the "concept of the practice" clinicians are engaged in, where background suppositions about the precedence of human autonomy, the necessity for risk avoidance, and the understanding of "natural" human parameters are preset indicators for the practice of reproductive medicine itself. To the clinician, implicit rules are already in place, so that it should not be necessary to constantly rethink their position or their value for each patient or case, or to seek a fit between their practice and some universal moral principle. Only when new problems challenge the fit between the implicit rules and the practice does the issue of locating an appropriate new mid-level principle or rule arise. The natural tendency, in practice, is to look for ways to confine the new problem into the comprehensive whole, rather than spend time attempting to locate a new covering principle from a "summary" point of view.

This also explains why clinicians' reasoning cannot be said to be exactly "bottom-up" in the casuistic sense either, because without a paradigm case, the casuist (or

the practitioner in the Rawlsian sense) lacks enough framework to know how to go on. In casuistic practice, when a paradigm case is available for comparison, the style of reasoning is akin to an extensive analogizing by "narrative" or "metaphor," where the ethical practitioner works to creatively construct some similarities, some alternative principles, frameworks, implications, possible outcomes and so on until the deliberative process churns toward an answer. How this differs exactly from reflective equilibrium seems to be both in the lack of big principles to guide the process, and in the elevation of metaphor over generalized cases, deviating from the moving back and forth between theory, principles, and the case as performed in traditional reflective equilibrium.

One advocate of this more metaphorical approach, who claims it is substantively based on the empirical findings of cognitive science, is Anders Nordgren:

> Ethical principles have their place in reflection and discussion, but one has to be aware that they do not have a strictly defined, literal meaning, and that it is not a matter of simply applying them to particular cases. The principles of medical ethics are important rules of thumb based on collective experience. They express what is valid in prototypical cases. What should be valid in nonprototypical cases is a question of moral imagination. Moreover imaginative casuistry does not imply that moral decisions become arbitrary. There is a psychologically realistic human objectivity in the sense of transperspectivity, i.e., the ability of a historically situated self to reflect critically on its own moral constructions and imagine other points of view (140).

In any event, something like this metaphorical style, or the sort of practice approach hinted at in the early Rawls, is a good way to describe the sort of procedurally-based method encountered at ARM Clinic, as distinguished from the content-full method envisioned by principlism, with its particular style of reflective equilibrium.

Although practice approaches can be thought of as similar to reflective equilibrium, the style has been criticized by communitarians and virtue ethicists for their emphasis on proceduralism, supposedly empty of ethical content. To them, there is something "incomplete and inadequate" about a conception of ethics reliant on principles and rules devoid of the supposed richness of discourse involving character and virtue (Buchanan et al 377-378). They further worry that scientific facts are given more importance than traditional values.[51] Communitarians are not alone in worrying that too much reliance on rules and principles like autonomy can obscure other pertinent moral issues. Too much emphasis on autonomy, for example, is said to reduce medical treatment to a service, available to be purchased by whoever can afford it, whether right or wrong. This was a concern expressed by staff at ARM Clinic. They did not want to be "driven" by the simple desires of the patients. If that model were accepted, the only means to justify the morality of a given treatment or practice would be by mutual consent, or by the validity of a contract, between the patient and the health care practitioners. The whole point of bioethics is to provoke a deeper work-up and examination of the ethical dimensions of these health-care relationships.

However, proceduralists like Jonathan Moreno believe that moral justification can be located in rule-oriented processes, through the consensus that can emerge from group deliberations. To Moreno, such modest claims for decisions as "stable" and "uncontroversial" are worthwhile and effective results from the reflective equilibrium-type process, at least when they emanate from groups whose members share common

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[51] Moreno (1995, page 13 and pages 41-45) discusses the kinds of distinctions between scientific facts and values in the terms of distinguishing between procedural and substantive consensus. The processes of ethical decision-making can be distinguished from their product, but he argues that such strict distinctions aren't useful in making progress towards ethical consensus in bioethics.

belief systems. For him, democratic, tolerant and diverse groups are the ones most

likely to accept what he calls "uncontroversial standards" such as mutual respect and a

willingness to entertain new evidence." Decisions that emerge from bodies constituted

by a "background overlapping consensus in a liberal pluralistic society" will forge

strongly justifiable results, because of the openness and variety of opinions (1995, 64).

From this standpoint, any effort to locate foundational truths, or absolute rights and

wrongs, is wasted, because the differences in society and individual aims and goals di-

rect us to more importantly focus on useful and practical decisions.

Courtney Campbell criticizes the procedural emphasis in bioethics from a more

virtue-ethics approach by questioning the value of consensus, even while acknowledg-

ing that it can "provide a form of quality control on the process" (150). To him the de-

cisions made in particular cases reflect a "shallow consensus" because the reasoning

used to back up the decision might vary among the participants even thought they

came to the same conclusion. He would prefer a deeper consensus that

"involves examination and agreement about the reasons or principles them

selves." To him,

> "it must be asked how valid and authoritative consensus may be when
> it is continually probed by medical technology and by philosophical
> scrutiny. An issue that both Singer and Engelhardt agree on – a higher
> brain standard for death – is a case in point. The societal consensus
> over a whole brain definition that has existed for the past quarter cen-
> tury is certainly unstable and shifting with the currents of new technol-
> ogy and philosophical concepts (150-151).

If he is right, then the outcomes of ARM Committee are more akin to "shallow

consensus" in their acceptance of the here and now status of technology as well as the

"unstable" definitions and values at large in the ever-changing world of reproductive

medicine. But one could question why such shallow consensus isn't "good enough," if it reflects current knowledge. Only the future can tell us whether we are wrong or right in basing our values on current scientific knowledge, but working toward a shallow consensus can be a stronger basis for reasoning than relying on intuition only.

One reason for retaining a more procedural model, even if the consensus is shallow, is that in our society individual rights and desires are thought to have precedence over government restrictions when possible. Reproduction is elevated in our society as one of the most important of these individual rights. For that reason, creating a method for decision-making that is filled with rich content of moral principles and judgments can be and is a difficult task because individuals vary so much in their personal goals and desires. Buchanan, Brock, Daniels, and Wikler use this reasoning to support reflective equilibrium as the superior method for reasoning in bioethics, especially in attempting to evaluate concrete cases (52). They recognize that "the aim of systematic moral reasoning is to develop a coherent set of beliefs that includes moral principles, other elements of moral theory and beliefs about what is right and wrong in particular cases." However, particular decisions appeal to different elements of the systemic whole on different occasions. To them, the best process "aims at what Rawls calls "wide reflective equilibrium" because "our moral beliefs are thus held to be revisable in light of other things we believe or reasonably come to believe" (22-23). To this set of authors, there is no alternative to such an approach in a diverse society, where any sort of foundationalist approach is unacceptable.[52] However, they do not

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[52] According to Buchanan et al, "Foundationalism is the view that ethical theorizing must begin with indubitable or self-evident, unrevisable moral axioms and deduce subsidiary principles and concrete judgments from them. It is hard to see how any reasoned approach to ethics that rejects foundationalism

attempt to explain where and how appropriate moral principles for novel cases can be located, although it may be that they can emerge from the process. Buchanan et al focus instead on how the process includes diversity in opinion and in knowledge:

> Seeking wide reflective equilibrium is thus the process of bringing to bear the broadest evidence and critical scrutiny we can, drawing on all the different moral and non-moral beliefs and theories that arguably are relevant to our selection of principles or adherence to our considered judgments (376).

As I have shown, the actual methods used at ARM Clinic could not be said to be so rich as this description of reflective equilibrium in the abstract. Some of their decision-making is less defensible and less justifiable than could be wished for, especially in novel and ground-breaking cases, although perhaps permissible in practice. In general, if any broad value was used (as I have said is the case), it tended toward a utilitarian goal of justifying the medical means through the end result of healthy parenthood. Clinicians did not spend too much time worrying about the motivation of clients or the effect on other participants in the process, in the sense of weighing their emotional risks, or the future psychological or social problems possible in donor situations.

Attempting to evaluate their own decisions from a deontological point of view proved difficult for participants. To assess the larger rightness or wrongness of the endeavor, while being bound by personal, religious or cultural convictions, was not really appropriate in the setting where immediate decisions were called for. Only one

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can avoid relying on the process of mutual adjustment between principles and particular judgments, each conceived as revisable in the light of the other…Once foundationalism is abandoned, it is hard to see how reasoned ethical inquiry can proceed without relying to some extent on the method of reflective equilibrium broadly constructed (372). See Buchanan's work, "Social Moral Epistemology" in September 2002, where he set out his reasoning why reflective equilibrium "is probably the dominant method in normative ethics" overall (127).

member of the committee, the chaplain, could be said to stand "outside the practice viewpoint," not sharing the clinical mindset. Not having absorbed the disciplinary conception and assumptions of the medical practice, he was the one most likely to express concerns about the big picture: the lengths people were willing to go to "make a baby," their unwillingness to adjust to their infertility and adopt needy children from other cultures and ethnicities, and the importance they placed on replicating their own genetic make-up. To him, starting from a different perspective, the goals of fertility medicine appeared selfish or narcissistic at times, and he wondered what the world would be like if everybody acted in such a self-motivated way. However, from the inside, speculating about the whole endeavor wasn't realistic.

CHAPTER TEN

SAVING REFLECTIVE EQUILIBRIUM

If bioethical decisions are justified more by their internal practice assumptions or by procedural consensus-oriented models, then what is the status of reflective equilibrium for daily decisions? I have shown that at ARM Clinic most local solutions to problems depended on policies given by the professional association or delivered by paradigm experiences, but those pre-delivered policies and paradigms had to be created from somewhere. It is my contention that reflective equilibrium can deliver the larger, more general, and more justifiable outcomes for which it is credited, but only in more public and more general settings. The "commission" level (where public or semi-public boards or nationally constituted, institutionally-based expert panels meet to analyze issues in a larger social context) can offer a model in which the objectives of diversity, inclusiveness, theoretical moral knowledge, practical expertise, and so on can be achieved. This is difficult, if not impossible, to do at the local level.

However, the model of reflective equilibrium that I have so far described, based on Rawls's work, could be improved upon in two specific ways, especially if it is to be used in the practical context. Earlier (in Chapter Two), I listed some defenses of Rawls' model against criticisms of relativism, subjectivity, and so on. But more should be said about its theoretical dependence on self-interest as the motivator for people to put their ideas, beliefs, and moral standards into the churning process, and second, its allowance of the results of reflective equilibrium to stand untested by public criticism.

The best way to re-think reflective equilibrium, at the theoretical level, comes from the work of T. M. Scanlon, who has defended a variation of reflective equilibrium, one more dependent on consensus, on inter-social negotiations of practical problems, and one more situated on shared group moral perspectives. Scanlon shows how the addition of publicity to the process can substantially increase the impact of any consensus achieved, adding to the possibility of a morally justifiable answer as well.

In his 1998 book *What We Owe Each Other*, Scanlon articulates some important revisions to the contractarian project, improving coherentist frameworks. He argues that Rawls's contractarianism implies a certain view of human nature, one in which the incentive for fair and reasonable human interactions consist in the self-interest of socially-motivated agents. In the Rawlsian version, self-interested individuals negotiate the means for attaining their personal goals just as they bargain for goods by negotiating over any surpluses produced by their joint activities. Self-interest is also said to provide the motivation for people to consider the attributes of justice from "behind the veil of ignorance." But this view of human behavior is rejected by Scanlon, who said that "self-interested bargaining is foreign to my account." He prefers to use the term contractualism (instead of contractarian) for his project, so as to put emphasis on the more "other-oriented" idea that agents are "assumed not merely to be seeking some kind of advantage, but also to be moved by the aim of finding principles that others, similarly motivated, could not reasonably reject" (1998, 5)

Self-interest can be thought essential to the human condition and cannot be entirely dismissed from Scanlon's contractualist conception. But more important to his project is the idea that humans possess, as a core quality, a cooperative willingness to

modify their personal and private demands and wishes, when necessary, to create a basis for shared notions of right and wrong. His conception of a person is broader than Rawls's portrait, where personal autonomy seems paramount and where personal choices are thought to comply only with rational desires to achieve one's own interests.[53] To Scanlon, people are more group-oriented, more socially motivated, and more naturally concerned with other people's feelings, desirous of maintaining overall good will. Here, the very basis of reason is more than rational self-interest; it is better understood by the ability to consider the concerns of others when making decisions: "When we say, in the course of an attempt to reach some collective decision, that a person is being unreasonable, what we often mean is that he or she is refusing to take other people's interests into account" (33).

In this view personal moral principles exist to serve this more social purpose, rather than simply to be used as individualistic rules for behavior. He goes on to say:

> According to my version of contractualism, deciding whether an action is right or wrong requires a substantive judgment on our part about whether certain objections to possible moral principles would be reasonable…It is not a judgment about what would be most likely to advance their interests or to produce agreement in their actual circumstances or in any more idealized situation, but rather a judgment about the suitability of certain principles to serve as the basis of mutual recognition and accommodation (194).

Judging principles as suitable for action is supported when they prove able to serve real people in real situations. They also provide justification for moral deliberations in a slightly circular way, similar to Rawls's reflective equilibrium, in the way all the facets of deliberation cohere and support one another. Instead of reflective equilibrium, Scanlon calls his method a "dynamic procedure," because of its supposed de-

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[53] See Rawls's elaboration of the qualities inherent in his conception of the person in his various works from 1971 (407-416); 1975 (283); 1980 (260); 1985 (396-8).

pendence on moral theorizing, stating that "there is no fixed list of "morally relevant considerations" or of reasons that are "morally excluded" (157).

Here a fundamental principle by which to defend decisions is not necessary to the overall scheme, nor is there any need to depend on a sort of contrived standpoint, such as Rawls's "original position" wherein special principles were obtained that led to justifiable moral judgments. Instead Scanlon envisions a sort of three-level process by which people are pressed to provide moral reasons for their actions, in virtue of specified situations, and where the principles referred to may be implicit or explicit. First, an agent must recognize the relevance, both to him or herself and to others, of the considerations at stake. Second, considering the context of the issues should bring out various reasons by which acting or failing to act morally become relevant. Finally, refining and revising the reasons, in the dynamic process, should work out the reasoning in a fuller way, especially by directing it towards the "others" involved (156-157). For Scanlon, this process of reasoning—developing "why" an idea seems to be wrong or right—elicits principles, although they may be left unformulated or uninvoked. He doesn't believe that important decisions of this nature are made by "invoking or applying" principles or rules, but he does take principles, understood more broadly, as still necessary for help in validating the reasoning:

> Principles, as I will understand them, are general conclusions about the status of various kinds of reasons for action. So understood, principles may rule out some actions by ruling out the reasons on which they would be based, but they also leave wide room for interpretation and judgment (199).

Thinking of moral principles as "generalizing rules" is simply not helpful to Scanlon's account, because it is in the exceptions and the clarifications where moral reasoning

emerges. In examining such principles as "keeping promises," or "refraining from kill-ing," the process of moral deliberations is only thought to have begun, not ended. An agent must figure out various courses of action (is it wrong to lie about a health diag-nosis to protect a patient's sense of optimism; must euthanasia be ruled out as kill-ing?), and each act is better expressed in "reasons" given to support or reject the available actions. Using moral principles is more akin to the way legal principles are used to create an interplay between the situation and various constraints so that com-plex considerations are entertained. He points out:

> Even the most familiar moral principles are not rules which can be easily ap-plied without appeals to judgment. Their succinct verbal formulations turn out on closer examination to be mere labels for much more complex ideas…
> When, in the light of our best understanding of this moral rationale, we make a judgment about the sufficiency of the reasons for an action in a particular case, this judgment is guided by, and expresses, our understanding of a moral prin-ciple. How many moral principles are there, then? An indefinite number, I would say (199, 201).

The attempt to interpret and consider these principles, in context, while taking into ac-count the interests of others, encourages the development of valid moral principles, (of which Scanlon says there are an "indefinite number"), structured narrowly enough to have constraining power for the case at hand, but also broad enough to take in the in-dividual differences in similar cases (201).

But no given set of principles can possibly "cover" or "apply" to the moral complexity of life. Only when we look to one another for guidance – to see who is hurt, who gains, whose expectations are diminished, can we begin to formulate cover-ing reasons for our moral choices. To Scanlon there are "no familiar and widely taught principles –analogous to "keep your promises"- that cover these cases" (202). How-

ever in discussion or deliberation we can recognize "wrongness" in the context of how others look at the same problem. Thus the "dynamic procedure" is not in itself constrained by selected principles, as in the Rawlsian version of reflective equilibrium; instead principles seem to be constructed by the process, or emerge during the moral dialogue.

In Scanlon's view, the justificatory process runs both up and down, either by beginning with the salient details of a case until applicable principles are located, or by starting with a principle to see how it impacts on a case, but always with the constraint that the attempt must be justified to others in a way it would not be reasonable for them to reject. In general, moving up from case to principle is thought by Scanlon to be more likely to achieve defensible results, although he admits that useful discussions are sometimes more reasonably derived from working down from a central idea to more specific conclusions. This is not to say he defends a totally casuistic approach, but he does find it more plausible to start with concrete problems or cases. His process is to begin "from cases in which it seemed clear, intuitively, that a principle could reasonably be rejected and then proceed to inquire how the grounds for this rejection should best be understood" (246). But to gain a principle, one must work up toward a wider range of conclusions until the argument develops a broader and more substantive range. If a principle is developed by considering a specific case, taking into consideration its salient qualities, the individual point of view it expresses, and then moving towards a more general formulation of considered judgments gained from close examination of alternative viewpoints, the moral judgment expressed by

the principles can assure that its end result is one that won't be reasonably rejected by others. That is moral justifiability at its best.

Scanlon believes that the "well-known objections to coherence views" do not apply to his own account although they are similar to critiques of Rawls' view (70). He lists the main objections as conservatism, relativism, and the mistaking of habit and custom for morality. The first objection, conservatism, could be compared to complaints about Rawlsian reflective equilibrium in that both depend upon "customary" moral judgments to get their theories moving from the abstract to the particular. Coherentism allows subjective and local beliefs to take on the credibility of established norms, because there is no absolute requirement to admit a universal overriding principle that might force a bigger worldview to prevail. Scanlon sees that coherentism could "seem that I am endorsing a complacent reaffirmation of whatever we happen to think" (70). The only way to elevate the process above the customary is to follow a Rawlsian dynamic process of case-driven, reflective revision of principles to overcome established beliefs and judgments and traditional moral principles. In other words, Scanlon's "dynamic process" is a form of reflective equilibrium. The main difference in the two methods of deliberation is that Scanlon adds his organizing principle as a constraint on the process: that is, the criterion that any principles under deliberation must be non-rejectable by the supposedly reasonable people involved, if they are to be defended at all. Since all members must cooperate in locating these non-rejectable and reasonable principles, a higher level of critical and social analysis is reached, discouraging personal or culturally biased outcomes.

Scanlon has a similar answer to the objection of relativism. Coherentist accounts cannot rule out the possibility that alternative moral schemes might produce similarly good results, undercutting the grounds for one approach to be ranked superior to others in making value judgments. In fact, because it is a necessary component of Scanlon's version of coherentism to take seriously the varied and unique experiences, knowledge, and relationships that might produce different inputs for moral reasoning, one might wonder how the method can avoid total relativism. Scanlon not only requires diverse moral inputs, but allows for multiple yardsticks or standards by which to appraise moral actions, so as to ensure that it doesn't fail the test of being bound by customary norms. For him, this is a strength, not a weakness, for his version because it allows for the details and the contexts of individual cases to be appreciated. Thus relativism is made acceptable, and even desirable, but at the same time, the relativism implied is "benign," because the overall organizing principle wherein all moral actions are held up to one universal requirement, that of being justifiable to others, necessitates that universal human values agreed upon by all members lies at the heart of the method (338). Although universal, it is not exactly an objective standard, but it allows him to escape a more malignant version of relativism in which, for example, a group could use the method to claim a right to harm or enslave some of its members by asserting their own special moral standpoint. It is basic to his theory that good reasons be provided for disputable actions, and the reasons are the sort that can't be rejected by others, unless they are unreasonable, so that immoral exploitation of people could not occur without their own reasonable consent, which is of course unlikely. Scanlon said: "What [my view] takes as fundamental is not what people actually think or want, but

what they have *reason* to want" (341). Relativity of goals and desires can exist, but without radical consequences since the diversity of the group ensures the fundamental inclusion of all affected in the decision-making, as long as they are reasonable. This leads to a need for a fuller account of what it is, in his scheme, to be reasonable, because the use of reason is the only way to avoid either of the objections listed so far, conservatism and relativism, but also to elevate the whole process beyond mere intuitionism.

Scanlon believes that to seriously evaluate one's moral judgments is to avoid habit or custom, so that an examination of our intuitions to see if any of them "best stands the test of careful reflection" is always advisable (98). This is a slightly different approach than to insist on the availability of a broad or wide array of information in the dynamic process (as used by Rawls for his version of wide reflective equilibrium), because Scanlon wants to achieve something more than mere diversity. In the Rawlsian scheme, wide reflective equilibrium is one way to move from a simplistic reliance on one's prior moral intuitions to a higher and broader level of possibilities, and to test intuitions against broader principles. In Scanlon's work, intuitionism is not defended as a starting place by any metaphysical claim; rather he depends on "good reasons," as a common-sense product, to be preferred to some "unanalyzable, non-natural property" (11). He asserts that it is the use of "reasons," thought of as an everyday process of providing explanations to others, that brings intuition to earth and gives credibility to the practical ability of considering the pros and cons of actions. As in Rawls, this back and forth procedure of testing one's beliefs against others, and against higher principles, creates a procedure to provide a check at each step of moral

deliberation, so that subjectivity, relativism, and intuitionism aren't allowed to run wild.

Important to Scanlon's scheme (like Rawls) is his concept of what it is to be a rational moral agent. He values "reasonableness" over rationality, because he defines the quality of being reasonable as an ability to formulate good reasons for one's actions, reasons that are defensible to others, whereas rationality is better described as people forming judgments that conform to their actions. To Rawls reason embodies "reciprocity" and "social cooperation" (1980, 316). Good reasons are derived from one's ability to create plans to further his or her own goals, although unlike Rawls, Scanlon does not think of these goals as primarily self-regarding, but as more constituted by our inherent sociality, so that sometimes we desire to please others over ourselves. They require an attitude of "judgment sensitivity" if they are to achieve social approbation. To be judgment- sensitive is to have the ability to apply evidence and/or objectivity to moral problems, to take the perspectives of others, and to "take responsibility," to be willing to be "held responsible" for one's choices, and ultimately to define them in ways others can accept (23). To those who are skeptical about the intelligibility of reasons developed in this complex fashion, Scanlon responds that critics should not let the abstractions of argument cause them to lose sight of how real-life reasoning and deliberation processes actually work:

> Objectivity of such claims [reasons people have] lies not in the metaphysical reality of some subjective matter independent of us, that they describe, but rather in the fact that there is such a thing as thinking about such questions in the right way - a process that yields stable results in which we have no good reason not to have confidence (354-355).

For Scanlon, the quality of "reasonableness" includes a complex set of information and relevant choices applied to problems. Reasons are not 'strategies' put forth to reach certain ends (as is implied by the concept of rationality), but are the sort of judgments where objections and disagreements for certain actions are considered and taken seriously. Having added the ultimate requirement, for reflective equilibrium, of taking into account other people's objections when formulating reasons, one is as likely to achieve moral agreement as can be found outside of deductivist approaches, according to Scanlon's justificatory framework (192-194). Reason, according to Scanlon, "is not a judgment about what would be most likely to advance their interests or to produce agreement in their actual circumstances or in any more idealized situation, but rather a judgment about the suitability of certain principles to serve as the basis of mutual recognition and accommodation" (194). But it is those "principles" that become problematic, because, as I have shown, they are not always easy to identify. What he means by asserting the usefulness of "certain principles" is not to deductively apply some at-hand set of external principles to the problem, but to use those developed as part of the dynamic process in his style of reflective equilibrium. Principles are derived from the process, and then used to test the judgments pertaining to them. The approach avoids total circularity because of the requirement of providing grounding reasons (mutually derived), and defending and gaining assent to them, as part of the process of ensuring that the best particular principles for the problem are being used. This qualification adds a useful component to the reflective equilibrium method in bioethics, both because of the importance Scanlon attributes to diversity in the deliberative relationship, as it has been portrayed, but also the way this method seems to jibe more realistically

with actual group processes, at least in my observations of actual case-driven problem-solving. The ethics committee at ARM Clinic sought out principles by attempting to offer reasons for action that were pushed and prodded and tested in the process until sometimes a sort of overall consensus could be achieved.

But the fact that such a process approximates reality doesn't mean it offers justifiability to the method overall. One test for Scanlon might be to see if he can actually deliver "objective" results; that is, results in which all parties, despite different starting places, are moved to agree as a result of a process of refining and revising having brought them to some stable position. Frustratingly, he cannot claim any such success. He admits that because the authority of moral judgments are derived from reasons developed by people, their objectivity "lies not in the metaphysical reality of some subject matter, independent of us, that they describe, but rather in the fact that there is such a thing as thinking about such questions in the right way." The problem is that "different inquirers" can arrive at "incompatible but quite stable" conclusions (354-355). Overall objectivity remains unachievable.

How can this be so, if the process is to be taken seriously as an actual method for action? As Scanlon has said, such differences in outcomes imply that using a correct method isn't enough to move even like-minded groups into consensus, when basic goals, aims, attitudes, and commitments are too various and dissimilar. As products of different cultures, we approach moral issues with different experiences, circumstances, and values, not only cross culturally, in the larger sense, but even from our localized situations. One only has to notice the persistence of disagreement about abortion, with its associated differences in how to value and respect human life, to realize that when

premises are vastly different, any moral methods might fail to achieve stable outcomes. Scanlon takes this sort of disagreement in stride:

> Persistent disagreements about right and wrong have a similar character: they are disagreements about how complex sets of conflicting reasons should be understood and reconciled, and they are most likely to persist when people's differing interests and commitments lead them, in different ways, to concentrate on certain of these reasons (and on certain ways of understanding them) and to neglect others (358).

Settling such differences is not accomplished by adding more discussion, more education or technical advice, more uncovering of self-interest, more imagination, more moral points of view, and so on, as some suggest in bioethics. These strong moral disagreements can be incorrigible even when self-interest is not a factor, and even when knowledgeable and thoughtful attempts to understand the other side have taken place. More likely it is that our grasp of moral truth does not result from "something analogous to direct perception" as Scanlon insisted (359). We can recognize moral significance, (sometimes by the yuck factor) but it is far from clear what form this significance takes.

One way to avoid moral disagreement is to work within small, like-minded groups, thereby escaping dissent, but of course that approach is only temporary. When decisions are made public, different points of view are brought to bear adding more dimension to problems. Defenders of wide reflective equilibrium, in general, believe that the more diverse and inclusive the process, the more valid. As Buchanan et al insist, "It is very important to understand how diverse the types of beliefs are that are included in wide reflective equilibrium, as well as the kinds of arguments that may be based on them" (2001, 377). Only by allowing a wide diversity do we insure the con-

siderations of varying beliefs, motivations, moral development, commitments and so on to be taken seriously in particular instances. To Scanlon moral criticism is (or should be) a system of "co-deliberation" to "work out principles" that we would each accept as a "basis for criticism" (1998, 268). This implies that not only is diversity useful in moral deliberations but that opening group deliberations to public scrutiny and criticism is necessary.

It would be interesting to see this applied in the deliberations at ARM Clinic. Occasionally some members have compared their own fertility issues to those of their patients exhibiting empathy for their desires, but as I pointed out, their desire to avoid unwanted publicity and stake out new ground in the field can quickly lessen any desire to assist in the more unusual cases, such as in Example 29. In that case, a woman wanted to maintain a genetic link to her family by using her father's sperm to inseminate a donor egg that she would carry through a surrogate pregnancy. The committee quickly denied this case with little sympathy for the fact that the applicant was the last in her genetic line. One can only wonder what alternative points of view and additional public input might have meant to this outcome. Some cultures value genetic bloodlines, and the idea of carrying on the family name, more than others, for instance, while others might be as shocked as these committee members were at the notion of a woman bearing her father's child, even though no sexual relationship occurred. Only by holding up such novel cases to wider and more diverse perspectives will some kind of more reasoned thinking prevail.

Attaining wide diversity in viewpoints seems very difficult to ensure in the private setting, especially when public scrutiny is unacceptable for privacy reasons. The

best solution for the small private ethics committee is to look to their professional association as a more objective and broadly based group, who set up the sort of policies that can prove useful to private ethical deliberations as guidelines. Broad and wide publicity can be achieved when professional groups make their discussions public whenever possible. Bioethics discussion at the commission level is to some extent, public, their activities reported in the press at times, and sometimes open to testimony from the public. However, the "wideness" of public input is variable. It might only consist of members of the profession whose issues are at stake, it may take place in a somewhat private venue, or by disdaining "political correctness" it may accidentally or even purposely screen out members of special groups, minorities, women, or political opponents. Of course, inclusion of these groups does not guarantee moral decision-making, but in the case of reproductive decisions, where eugenics-type decisions are sometimes feared, those concerns could be allayed if minorities, or other widely affected groups, are represented in the overall deliberation, or are able to add public commentary.

Scanlon is not alone in advocating the inclusion of public criticism and diversity as an important means of providing support to procedural methods. In a method like reflective equilibrium, where process is given status over content, it is imperative that the rules and procedures be as open as possible, so that overall fairness is not compromised, particularly in large scale institutional or governmental decision-making. Buchanan et al point out that principles are given credibility by public support:

> Principles are needed to evaluate existing institutions and to guide institutional design; reliance on the judgment of virtuous individuals (even if we could identify them without recourse to principles) is no substitute for principled public debate about the ethical character of our common institutions (2000, 378).

Henry Richardson is another who has noticed how the absence of public deliberation can skew even the most well-intended ethical process, so that even good decisions are invalidated by a lack of public backing. To buttress his early form of coherentism, he later added the new requirement of publicity, as a means of further strengthening his method. His plan is directly related to Scanlon's approach:

> Justification is a matter of making arguments in both directions…to be justified in overriding one of the moral rules, one must have grounds that a rational person can impartially and publicly advocate. Putting these two aspects together, reflective equilibrium and publicity – we arrive at Rawls' idea of public justification, in which each rational (and reasonable) individual accepts as reasonable the basis on which each other person supports them (2000, 294).

In Richardson's scheme, similar to Scanlon's, broad principles are specified down into more specific ones and the structure is supported by the coherence of the total set of norms involved, their argumentative support, and their practical consistency with actions. This form of coherence only escapes relativism and conservatism by adding a broad array of public input.

Norman Daniels has argued that too many health care decisions are seen as illegitimate and unfair to those who are affected, but he believes that improved outcomes can be obtained when features of what he calls "deliberative democracy" are integrated into the deliberative process. For Daniels, like Scanlon and Richardson, a key feature is "the provision of publicly accessible reasons, that is, a public rationale, for decisions" (1997, 307). He acknowledges that publicity has costs, but the gain is a

sense that outcomes are fair and legitimate. Another key feature to Daniels is the inclusion of "mechanisms for considering challenges to decisions that are made for revisiting those decisions in light of counter-arguments" (307). Leaving moral judgments open to challenge seems to be reasonable, and yet the possibility causes discomfort among deliberators who are seeking principles, rules, or definitive solutions to problems. Members of ARM Clinic valued consistency and disliked making "exceptions to the rules." A good way to respond to that problem comes from Daniels's final condition: that decision-makers accept some sort of "voluntary regulation" of the deliberative process to ensure that the other conditions, "public accessibility" and a "mechanism for challenge," are met (323). The addition of voluntary regulation seems to a worthwhile impetus to encourage an occasional overview of past decisions to see how they fare over time.

In a fascinating example of how broadly public discourse can reset or respecify the grounds for certain decisions, ARM Clinic recently changed one of their most strongly endorsed internal rules: their policy against "baby creation" or no donor egg/donor sperm (discussed in detail in Chapter Seven). Over time, the physicians began to question the policy as they interacted with disappointed patients whose only recourse to parenthood lie in access to both donated sperm and egg. Furthermore, the disappointment was exacerbated by being confronted during treatment; it could not always be predicted in advance, such as when a husband's sperm was found deficient just as an egg was ready for fertilization causing the donor to suffer unnecessary preparatory treatment. The refusal to resort to donor sperm at this stage began to seem arbitrary and lacking in empathy to the patients; it seemed to violate principles of

beneficence and autonomy. Physicians hated to stop treatments and face the anguish at this stage.

The original policy had been erected due to the "yuck factor;" the reasoning emerged out of vague feelings that it wasn't right to create a baby with no genetic link to either parent. For some, it had conjured a mental picture of a commercialized product, a supermarket of embryos to be picked over and discarded if they didn't match expectations. Nobody wanted parents to purchase an embryo for its characteristics, like a commodity. But in the cases confronted in the clinic, these factors were not realistic. In one sense, the egg or the sperm donation were already available as a market choice since prospective parents could sort through facts about donors to pick the one that beset fit their needs (usually physical resemblance), but in allowing for the donation of both egg and sperm, the clinic was not exactly putting out embryos for sale. The full slippery slope had not been instigated.

More importantly, opinions were changing at a higher level. Other clinics for assisted reproductive medicine were not so firmly opposed to the procedure, causing ARM Clinic to doubt the point of their adherence, and the specialty organization had not found it totally objectionable.

Recently, the physician/owners took the problem back from their own ethics committee and discussed it among themselves. The result was the adoption of a less restricted policy allowing for the use of both donor egg and donor sperm in certain medically necessary situations. This modification was akin to their "backing into" a decision, because the new policy would only affect those patients whose need was dis-

closed during treatment. The change in policy is not intended to be advertised or made easily available as a marketing device for new patients.

This example seems to me to illustrate how public and professional debate at a higher, in this case a national level, served to produce a new guideline at the lower level, one that differed from their own locally produced viewpoint. The way was softened by the contextual issues that had arisen in particular cases leading to a relaxation of the formerly stringent rule previously taken. However, one cannot overlook the possibility that market considerations (losing patients to competitive practices) had an effect here, so that reflective equilibrium was not purely an ethical deliberation. If so, that problem could nevertheless be mediated by more publicity.

The example shows how a process of reflective equilibrium can work to assist in producing localized ethical guidelines and perhaps in specifying (in Richardson's terms) a norm down for practical application. It also shows how opening up background assumptions and non-moral concerns can cast light on moral questions. The procedural approach keeps the options open for new information to add useful information to the inquiry. The example also shows how principles develop out of novel cases. Information flows in both directions, from the details of particular cases up and from more abstract deliberation down. The public process of reflective equilibrium allows new principles to become accepted as public policy. Richardson tried to show how his specifying approach was superior to Beauchamp and Childress's because it provided a means to move beyond the clashing of principles thought to be inherent in their method.

However, in Richardson's emphasis on publicity, it is not clear whether he intended the "initial" principles in his method to be taken from the well-known list already publicly accepted, such as Beauchamp and Childress's, or should be attained otherwise. It is also unclear whether they are supposed to be "action-guides" which must be able to stand up to public debate, or simply be guides for reflection. Furthermore he noted that there is a difference between "potential public expressability" and "actual public expressability" (286). Only when actually expressed, can reasons garner the diversity and publicity necessary.

However, a criticism of the publicity requirement is that in general, such a process may not get off the ground in a public arena without some common background assumptions or premises among the participants, the sort implied by a common membership in a procedural public arena. As Moreno has pointed out, the moral consensus developed by a group is "extended" into a broader "overlapping consensus," but this can only occur when the participants share such fundamental background values as "respect for the personal autonomy of those who disagree and a willingness to consider alternative points of view" (1995, 62-62). When decisions are made in a vacuum they are less likely to achieve validity because of the suspicion that they are thrust onto, rather than developed out of, public discourse. Moreno insisted that the stability of principles depend on the liberal values of the society from which they emerge. He believes they must include "nonviolent methods, mutual respect, and a willingness to entertain new evidence and alternative points of view. These are standards that are themselves objects of an overlapping consensus in a liberal, pluralistic society" (63-64). If these standards are not taken seriously, then the principles, al-

though accepted, might not be morally correct. Some decisions made in government settings to create public policy might not be specific enough or realistic enough to reflect the goals of particular citizens.

An important point to be taken from this perspective is that bioethical decisions can vary in their acceptance depending on whether they are applied to public or private settings. For example, the Bush administration policy to restrict stem cell research to a small number of already developed lines was intended to apply to only publicly funded research, but did not impact private research. This is probably because our culture has a strong adverse reaction to government interference with private behavior, especially scientific exploration. The distinction between private and public helps to explain why reproductive research in the private sector remains mostly unregulated, and perhaps why the abortion debate seems to have mostly ceded to the side of abortion rights. Buchanan et al suggest that the heart of the values that back up reflective equilibrium as a method include moral individualism, equality of persons, and similar typical values generally thought to be at the heart of democracy (2000, 379). They said:

> Institutions that reflect a recognition of moral individualism, the moral equality of persons, and the capacity of persons to be critical choosers of ends will create and protect a significant private sphere in which individuals, either as individuals or as members of communities, can freely pursue and critically revise their own conceptions of the good. (And hence there are significant limitations on the use of public authority and the power of the state, including, on some accounts, the requirement of state "neutrality" (379).

Retaining the freedom to conduct scientific and ethical choices in the private sphere does not entail a repudiation of public deliberation and debate about those choices, or

presume they shouldn't be moderated by controversy. In two fairly recent examples, publicity, in the sense of public scrutiny, but also in the sense of obtaining more diverse representation to supply criticism of scientific research, has forced a revamping in some scientific procedures. In the first, feminists challenged the scientific validity of research in which women were not included, pointing out that the findings of research projects that excluded women impaired the generalizability of that research and denied women the benefits that should apply to them. In the second, homosexuals, as research subjects, but also as full participants in critiquing the administration of AIDS research, asserted their political power to both reorganize and control the format of the scientific agenda.[54] Research conducted privately might or might not be acceptable ethically, but it cannot be determined so without admitting public deliberations into the process. Even though many scientific practices remain private, as in the reproductive clinical activities that I have presented here, publicity provides a means to audit, oversee and perhaps put a check on more radical practices. But even more, this is the arena in which the policies and mid-level principles are created to assist the private practitioners in making justifiable local decisions.

Scientific practices in general are an example of how publicity provides credibility. Scientific results take their validity more from coherentist standards than from foundationalist platforms. When research results earn the attribute "objective," it is more likely because they survived a procedural and public process, earning their

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[54] See Sandra Harding's classic *The Science Question in Feminism*, Cornell University Press: (1986), for examples of how the inclusion of women into scientific disciplines has promoted change in research outcomes; also see Courtney Campbell's "Ethics and Militant AIDS Activism," in *Aids and Ethics*, ed. Frederick G. Reamer, Columbia University Press, (1991), for examples of how scientific activities in AIDS research changed due to the activist inclusion of interested and affected members of society.

credibility from the process of experimentation and production of evidence. Helen Longino, the feminist philosopher of science, has argued that even the best scientific results would be considered "hopelessly subjective" without some set of external criteria to support them. She named the familiar historical criteria— consistency, simplicity, fruitfulness, scope, and accuracy—to be virtues long associated with giving credibility to some scientific theories over others, but she maintained that an overall ability to withstand publicity ought to be a virtue added to the original list, because in the modern world it provides the most consistent way to test the truth standards of science. Historically, criteria like these have provided standards and constraints to scientific projects so that they are credible to others:

> Among values the standards can include are such elements as empirical adequacy, truth, generation of specifiable interactions with the natural or experienced world, the expansion of existing knowledge frameworks, consistency with accepted theories in other domains, comprehensiveness, reliability as a guide to action, relevance to or satisfaction of particular social needs. Only the first of these constitutes a necessary condition that any research program must meet or aspire to meet, and even this requirement may be temporarily waived and is subject to interpretation (1990, 77).

But Longino goes on to point out that without public debate and criticism, the traditional demarcation between projects thought to be scientific and those considered non-scientific are left undetermined. It is in publishing scientific results, allowing for attempts to replicate them, opening the way for them to receive peer criticism, and subjecting them to public discussion that the activities of science are distinguished from other endeavors, so that the findings of the former are seen to be superior to any competitor. In science, participants accept common styles of reasoning and assumptions about nature that allow for open deliberations about their meaning and usefulness, just

as ethical deliberations are said to do through the process of reflective equilibrium.

Longino suggests that scientific inquiry attains credibility over other forms of knowledge because publicity allows for wide levels of criticism "in

a way that is not possible, for instance, for descriptions of mystical experience or expressions of feeling or emotion." The only way to accept the testimony of others about their emotions is to experience the same feeling, although even then we cannot be positive. However, producing evidence, testing, and opening ideas to peer review gives authority to critics and credibility to outcomes. As Longino says, "It is the possibility of intersubjective criticism, at any rate, that permits objectivity in spite of the context dependence of evidential reasoning" (1990, 70-71)

When an idea can withstand peer review, publicity and criticism, then its grounds to be taken seriously are secured. Just as some scientific ideas have historically lost validity after public criticism (their inability to be replicated, their overall characteristics, or their inability to stand up to evidentiary challenges), so can some moral ideas stand or fall when put under public scrutiny. This is the crux of the coherentist approach to bioethics: that inclusiveness, diversity, publicity, and open deliberations provide the most reasonable solutions to both everyday and to novel problems, and that well-founded mid-level principles can emerge from the process so as to cover similar cases and problems.

It is my contention that the best way to deliver valid bioethical decisions at the committee or local level is to create useful mid-level principles at a higher and more public level. By putting the procedure of reflective equilibrium into practice at the

higher levels of deliberation, especially at the professional association level, practical rules are made available to the practitioners at local levels who do not, by themselves, have the necessary tools to build a substantive process of reflective equilibrium. In this way, reasonable and useful maxims, principles and paradigms can be passed on to users who will continue to add justification to them as they work to solve real cases or dispose of them if they do not. This can only happen when open public procedural deliberations occur, among inter-social deliberators, over time, using reasonable arguments that, in a Scanlonian way, "can not be reasonably rejected by others, similarly motivated."

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