CHAPTER ONE

A Map of the Terrain of Ethics

Case 1: The Boy Who Ate the Pickle

A 9-year-old youngster named Yusef Camp who lived in inner-city Washington ate a pickle that he had bought from a street vendor. Soon after eating it he went into convulsions and collapsed on the sidewalk. A rescue squad took him to the nearest emergency room where his stomach was pumped. Tests revealed that the pickle contained traces of marijuana and PCP. The boy suffered severe respiratory depression and was left unconscious, unable to breathe for an unknown period.

The emergency room personnel restored respiration by putting him on a ventilator, but they were unable to restore him to consciousness or get him breathing adequately on his own.

The physicians concluded that his brain function was irreversibly destroyed and that there was no possibility of recovery. They might have simply pronounced him dead and then stopped the ventilator, but the situation soon became more complicated. Two of the attending neurologists were convinced that the patient’s brain was totally dead, but one believed that he had minor brain function still in place. So they were incapable of pronouncing the patient dead based on loss of brain function. Now the question became, what should they do? Their patient was still living but permanently unconscious, breathing only because he was on a ventilator.

The physicians pointed out that there was nothing more they could do except keep the ventilator running, perhaps indefinitely and maintain the boy in a persistent or permanent vegetative state. (The longest case on record of maintaining a patient in what is called a permanent vegetative state is over thirty-seven years.) The parents were Muslims, members of the Nation of Islam, who firmly believed in the power of Allah. They believed that Allah would intervene if it was his will, and that it was the physicians’ job to give Allah that opportunity. How should the physicians respond?
The physicians, the parents, and everyone else involved in this case face some difficult and controversial ethical choices. They need to determine the proper definition of death, the role of parents and other surrogates in deciding about medical care for a minor, the proper ethics of terminal care, the morality of using scarce medical resources, and what the role of minority religious perspectives ought to be in modern, secular medical care. In order to sort out these disparate and complex ethical issues we need a map of the ethical terrain: an overview of the kinds of ethical issues at stake and the terminology for labeling the disputes. This chapter will provide a basic map of that terrain. Once that overview is in place, we can begin sorting out the issues facing Yusef Camp’s parents and physicians.

THE LEVELS OF MORAL DISCOURSE

The Level of the Case

Often in biomedical ethics, the discussion begins with a case problem. Someone faces a concrete moral dilemma or two people disagree about what in a specific situation is the morally appropriate behavior. The analysis begins at the concrete level of the individual case. Some people may mistakenly think that ethical choices do not occur all that often in medicine. In fact, they occur constantly, but, fortunately, in almost all situations the ethically correct course is obvious. The decision can be made with little or no conscious thought. Ethical choices have still been made—even if the decision maker does not even realize it. He or she can rely on well-ingrained moral beliefs and get by quite adequately. Occasionally, however, the choice does not come as easily. As in the case of Yusef Camp, the choice requires more careful, conscious thought. The physician faced with a choice may turn to colleagues or to a hospital ethics committee for advice. A lay person may turn to friends or to a trusted religious or secular group for guidance.

One kind of advice may come in the form of mentioning other cases that seem similar, cases that have been resolved in the past. They may be in the form of a Biblical story or a legal case about which the culture has reached agreement. These agreed-upon cases are sometimes referred to as “paradigm cases.” Most people can agree that, in matters of ethics, similar cases should be treated similarly. In fact, one of the identifying characteristics of an ethical judgment (as opposed to a matter of mere taste or preference) is this awareness that if the relevant features are similar, then cases should be treated alike. As long as people can agree on what should be done in the paradigm case and can agree that the new case is similar in all relevant respects, they will be able to resolve their problem. This approach relying on paradigm cases is sometimes called casuistry. As seen in Figure 1, this is the lowest or most specific level of what can be considered the four major levels of moral
discourse. This figure is a simplified version of the more elaborate map of the ethical terrain that appears on the front and back inside covers of this book.

![Diagram of the four levels of moral discourse]

Figure 1 The Four Levels of Moral Discourse

Rules and Rights (Codes of Ethics)

But what if the basic ethics we learned as children does not settle the problem? What if we cannot agree on a paradigm case or cannot agree that our present problem is like the paradigm case in all relevant respects? We may, at that point, move to a second level of moral discourse, the level of rules and rights. Sometimes rules and rights tell us what is legal, but they may also describe what is ethical. Since not everything that is legal is also ethical (and not everything that is illegal is necessarily unethical) it will be important to note the difference. If a rule or a right is considered ethical, it will be seen as grounded in a moral system, an ultimate system of beliefs and norms about the rightness or wrongness of human conduct and character. Groups of rules or rights-claims are sometimes called codes of ethics.

Yusef Camp’s physicians may consult the Code of Ethics of the American Medical Association to see whether that group considers it ethical to stop treatment in such cases. His parents might consult an Islamic code. Some of the parties in the dispute may bring out the Hippocratic Oath or a “patients’ bill of rights.”

Sometimes the parties to an ethical dispute may cite a rule-like maxim, “Always get consent before surgery” or “a patient’s medical information must be kept confidential” are examples of such maxims. These rule-like statements are usually quite specific. A large number of them would be needed to cover all medical ethical situations. But if there is agreement on the rule that applies, then the case problem might be resolved at this second level.

Sometimes these maxims are stated not as rules but as rights-claims. The statement, “a patient has a right to consent before surgery” would be an example. So would the statement “a patient has a right to have his or her med-
ical information kept confidential.” Rules are expressed from the perspective of the one who has a duty to act; rights-claims from the vantage point of the one acted upon. Often rules and rights express the same moral duty from two different perspectives. “Always get consent before surgery” expresses from the health provider’s point of view the same moral notion that is expressed from the patient’s vantage point as “a patient has a right to consent before surgery.” They are then said to be “reciprocal.” If one person has a duty to act in a certain way toward another, that other person usually can be said to have a right to be acted upon in that way.

Medical professional, religious, cultural, and political organizations sometimes gather together collections of rules or rights claims. When they do they “codify” them or produce a code of ethics. They can also take the form of oaths as in the Hippocratic Oath or directives as in the “Ethical and Religious Directives for Catholic Health Facilities.” When the statements are made up of rights claims, they are often called bills of rights as in the American Hospital Association’s “Patient’s Bill of Rights.” Chapter 2 looks at the alternative oaths and codes, sees what their implications are for cases like Yusef Camp’s, and discovers how controversial these codifications are. Proponents of such codes not only have to determine what rules and rights are appropriate, but also which humans (and non-humans) have the moral standing to have claims based on these rules and rights. Chapter 3 takes up this question of who has moral standing. Here we address the question of whether Yusef Camp has the moral standing of a living human being or is already dead—according to a brain-oriented definition of death. We will also see the implications for the moral status of fetuses and non-human animals.

These rules and rights claims may provide enough moral guidance that the problem being disputed can be resolved. They rest, however, on the authority of the groups creating the codes (or on the inherent wisdom of the maxims themselves).

One of the controversies in ethics is how seriously these rules and rights must be taken. At one extreme an ethical theory could include the view that there are no exceptions to the rules or rights. This view, which almost no one actually holds, is sometimes called legalism. At the other extreme, someone might hold that every case is so unique that no rules or rights can ever be relevant in deciding what one ought to do in a specific situation. This view, which is as implausible as legalism, is called antinomianism. Two intermediate positions are more plausible. Situationalism holds that moral rules are merely “guidelines” or “rules of thumb” that must be evaluated in each situation. The rules of practice view holds that rules specify practices that are morally obligatory. In this view the rules are stringently binding on conduct. Exceptions are made only in very extraordinary circumstances—much less easily than in the situationalist position. The continuum is represented in Figure 2 and in the more complete map of the ethical terrain (inside the front and back covers).
Figure 2  Rules and Rights

Normative Ethics

If the citing of various rules or rights claims cannot resolve the matter at controversy, a more complete ethical analysis may be called for. The parties may have to move to a third level of moral discourse, what can be called the level of normative ethics. It is at this level that the broad, basic norms of behavior and character are discussed. It is in these basic norms that rules and rights claims will be derived and defended. It is also at this level that the norms of good moral character are articulated. The key feature of these norms is that they are general: They apply to a wide range of conduct and character. As such only a few norms will be expected or needed in a "normative ethical theory."

Action Theory  As illustrated in Figure 3, normative ethics involves at least three kinds of questions. An ethical theory at the normative level, therefore, must address three separate issues. Much of recent biomedical ethics has dealt with the question of what the principles of morally right action are. The central normative ethical question has been "what principles make actions

Figure 3  Three Questions of Normative Ethics
moral right?" The answer involves some list of moral principles such as beneficence, nonmaleficence, respect for autonomy, or justice. These are proposals for what characteristics of actions make them morally right. Someone might claim, for example, that doing good (beneficence) or respecting autonomy will tend to make an action (or perhaps a set of actions) morally right. The principles of right action were almost the entire focus of bioethics in the 1970s and '80s and remain a dominant part of the discussion. They will be considered in more detail in Chapter 4, when we take up the principles that concentrate on producing the best possible consequences, and in Chapters 5 through 8 when we consider some additional principles that do not deal with maximizing good outcomes. The figures in these chapters and inside the front and back covers of this book expand the map of the terrain of ethics by providing charts of possible consequence-maximizing principles and of ones that attempt to identify certain moral duties that do not deal with producing good consequences.

If a bioethic includes more than one ethical principle, the action theory portion of normative ethics will have to address the question of how to resolve the conflicts that arise among them. There are several different possibilities for resolving these conflicts. They will be explored in Chapter 9.

Value Theory Since beneficence (or producing good consequences) is one possible principle of right action and nonmaleficence (or avoiding producing bad consequences) is another, a second question that has to be addressed in a full normative theory is the question: "What kinds of consequences are good or valuable?" This branch of normative theory is therefore called value theory. Some of the questions of value theory are taken up in Chapter 4, where the principles of beneficence and nonmaleficence are discussed. The map of the options for this part of normative theory is expanded in that chapter in Figure 9. Just as there are disputes about what the proper list of principles is, so there are disputes about what kinds of things are valuable. Some kinds of things, like money, seem to be valuable, but only instrumentally—because it will buy something intrinsically valuable. The real question here is what kinds of things are intrinsically valuable. Among the standard answers are happiness, beauty, knowledge, and—importantly for biomedical ethics—health. Some people also consider morally good character to be among those things that are intrinsically valuable.

Virtue Theory That brings us to the third question of normative ethics: "What kinds of character traits are morally praiseworthy?" A morally praiseworthy character trait—such as compassion or benevolence or faithfulness—is usually referred to as a virtue and, hence, this part of normative ethics is referred to as virtue theory. For a fuller list of the virtues and a discussion of their role in bioethics, see Figure 21 in Chapter 11 and the discussion of virtue theory in that chapter.

It is critical that the virtues be understood as referring not to the character of actions, but to the character of the people who engage in the actions.
Benevolence and beneficence should be contrasted. Benevolence is a virtue, the virtue of willing to do good. Beneficence is a principle of actions, the principle of actually acting in such a way that good consequences result. One can of course will the good (show the virtue of benevolence) but end up not doing the good (being beneficent). One can also be malevolent, but nevertheless beneficent. (This person would not be of good will, but would nevertheless act in such a way that good results are produced, perhaps because the malevolent one has calculated that it is in his or her self-interest to produce the good consequences.)

This means that normative ethics involves questions of ethical principle (action theory), intrinsic goods (value theory), and good character (virtue theory). Depending on the question asked and the situation, one may be more interested in one of these questions than another. In the 1970s and 1980s, for example, most biomedical ethics concentrated on the principles of right action. Theorists of the time wanted to get straight on whether an action by a physician was morally right if it was designed to produce good consequences, but simultaneously violated respect for autonomy or involved telling a lie. The bioethicists of that time did not really care very much about the character of the physician; the issue was what made his or her external conduct morally right, not whether the physician had a virtuous disposition. Ethicists who attacked the mainstream medical paternalism of the day in the name of the principle of autonomy were concerned that the benevolently paternalistic physician was acting immorally by violating the principle of autonomy even if his heart was in the right place. Only in the late 1980s did biomedical ethics return to the more traditional interest in the virtuous character of the health provider. Since then, there has been more of a balance between ethics concerned about actions and ethics concerned about the character of the actors.

Metaethics

Sometimes if people can get clear on which principles or virtues or intrinsic goods are at stake, they can then resolve lower-level moral disputes. They might agree on the principle of autonomy (or beneficence) being dominant, for example, and then be able to settle disputes about which moral rules or rights are legitimate. In the more interesting and complicated cases, however, the disagreement may remain intractable. The parties to a dispute may not be able to determine which principles should prevail. One person, for example, might give priority to the principle of beneficence while another might believe that autonomy should take precedence (even if respecting autonomy will lead to less good consequences, that is, be less beneficent). Or they may not agree on whether principles or right action or virtuous character is more important. When disputes of this sort linger, the discourse must move to a fourth and final level, the level of metaethics.
Chapter One

Metaethics deals with the most basic questions of ethics: the meaning and justification of ethical terms, how people know which principle or virtues are the correct ones, and the ultimate grounding of ethics. Here we are no longer interested in the substantive questions of which actions are morally right or which traits of character are morally praiseworthy. Rather we are dealing with even more basic issues of where to look to get answers to these questions and how we can know when we have the right answer.

Religious ethics has, by now, fairly standard answers to these metaethical questions. To the religious person, claiming an action is right means it would be approved by the deity or is in accord with laws created by the deity. For them, to say that a character trait is virtuous is to say that it would be approved morally by God. Religious people also have well-worked-out notions of how humans can know something is ethical: by revelation and reason, by reading the scriptures, and by religious authorities such as the pope, church councils, Islamic fatoos, or Talmudic law. More mystical religious people may rely more on direct spiritual revelation.

Secular people are not satisfied with these positions, but have analogous answers of their own. The grounding of ethics may be in natural law or in some contract (actual or hypothetical) among people. Traditional secular ethics have shared with monotheistic religions the notion that ethics is universal, that is, for a specific moral case at a specific time and place, all people ought to reach the same ethical judgment about whether the behavior involved is morally right or wrong. Of course, universalists recognize that not all people actually will agree on such judgments, but they believe that there is some universal standard (such as the divine will or reason or natural law) against which people’s judgments can be tested. If two people disagree, say, about whether a particular abortion in a particular set of circumstances is immoral, then at least one of them must be mistaken.

Other secular theories share with polytheistic religion the notion that there is more than one standard of reference for moral matters. These metaethical positions are called relativist because they hold that moral judgments are relative to the multiple standards or authorities that exist. For example, for believers in polytheistic religion, different cultures may have different deities. One culture’s god might approve of a merciful killing of a suffering patient while another culture’s, while considering exactly the same case, might disapprove. Likewise, a secular ethic might be relativist if it holds that the ultimate standard of reference for moral judgments was the norms agreed upon in a particular culture. These alternative answers to the question of the source of ethical judgments are summarized in Figure 4 and in the chart on the inside of the front and back covers of the book.

Metaethics also deals with a related question of how we can know the content of these moral norms. While for religious ethics the divine will or divine law is known through revelation or reason, scripture, or church tradition, in
**Figure 4  Metaethics: The Meaning and Justification of Ethical Judgments**

In secular ethical systems it is known through reason or through empirical experience. The German philosopher Immanuel Kant based knowledge of ethics in reason; the British empiricist David Hume in the experience of sympathy. These religious and secular answers to the question of how we can know what is ethical are also included in Figure 4 and inside the front and back covers.

These metaethical questions take us well beyond what bioethics normally addresses. Fortunately, many have found that even if there is serious disagreement at this most abstract level, those who cannot agree on matters of religion and secular philosophy can nevertheless reach some converging consensus at the lower three levels of moral discourse. They can agree on normative ethical matters of principles, virtues, and intrinsic goods. They can agree on many moral rules and rights. Therefore, they can sometimes agree on what is morally right in a particular case, even if they have no agreement in metaethical matters. This is what is sometimes referred to as a common morality, an agreement on many, indeed most, ethical matters across cultures, religions, politics, and time periods. Fortunately, reasonable people can often agree on these matters at the lower levels of moral discourse.
A Full Theory of Bioethics

Even though we need not spend much time in bioethics going all the way up the “ladder” of the levels of moral discourse, a full theory would need to climb all the way to this top level. In fact, some people would claim that traveling up this ladder from the case through rules and rights to normative theory and finally to matters of metaethics is traveling the wrong way. They hold that, in matters of ethics, one must start at the top and work one’s way down. One would then first get clear on the meaning and justification of ethical claims—on metaethics; then identify principles of right action, traits of good character, and intrinsic goods at the normative level; which would, in turn, lead to identifying lists of rules and rights; which would finally tell us how to act and what character traits one should have in particular cases. They claim one should reason from top to bottom rather than from case to the more abstract levels.

While the theorists defending the top-down approach fought bitterly with the bottom-up clinicians for the last decades of the twentieth century, there is now something of a rapprochement. More and more there is agreement that what is critical is that, for a full and consistent approach to bioethics, eventually all four of these levels must be brought into “equilibrium.” It seems less and less important where one starts. If one begins with a case intuition and discovers that that intuition cannot be brought in line with firmly held beliefs about moral rules and principles, then something must give. Either one adjusts the case intuition or, if the case judgment is firm and unrelenting, then maybe the commitments at the higher levels will have to be adjusted. One will move up and down the ladder of the levels of moral discourse. Hence, in Figure 1, the arrows moving from one level of discourse to another are shown pointing in both directions. If one wants a full and consistent position in bioethics, eventually a stable equilibrium needs to be obtained. The result is what is now often called a reflective equilibrium. Chapter 9, illustrates how questions at all four levels of moral discourse can be brought together to develop a set of judgments that rest in an equilibrium. In that chapter we examine the current controversies over genetic engineering and new birth technologies: in vitro fertilization, surrogate motherhood, and cloning. In these debates we are witnessing the tensions during the process of the emergence of a stable or equilibrium state in the moral debate.

In the case of Yusef Camp, the boy who ate the pickle, it appears that the physicians and the parents are not yet in such a stable state. If they were to start going up the ladder of the levels of moral discourse, they might turn to various codifications of moral rules and rights. Some of their options are presented in Chapter 2.
KEY CONCEPTS

**Action Theory**: The branch of normative ethics pertaining to the principles of morally right behavior (as opposed to virtuous character, cf. Virtue Theory, Value Theory).

**Antinomianism**: The position that ethical action is determined independent of law or rules; cf. Situationalism, Rules of Practice, Legalism.

**Casuistry**: The approach to ethics that addresses case problems by applying paradigm or settled cases attempting to identify morally relevant similar and dissimilar features.

**Contract Theory**: A type of metaethics that maintains that the source of moral rightness or the way of knowing what is moral stems from actual or hypothetical social agreement.

**Legalism**: The position that ethical action consists in strict conformity to law or rules; cf. Antinomianism, Rules of Practice, Situationalism.

**Metaethics**: The branch of ethics having to do with the meaning and justification of ethical terms and norms. cf. Normative Ethics.

**Moral Principles**: General and abstract characteristics of morally right action. The main elements of part of normative ethics called action theory; cf. Action Theory, Moral Rules.

**Moral Rules**: Concrete statements specifying patterns of morally right conduct, sometimes believed to be derived from more abstract moral principles or, alternatively, created as summaries of patterns of individual case judgments.

**Normative Ethics**: The branch of ethics having to do with standards of right or wrong; cf. Metaethics.

**Relativism**: In metaethics, the position that there are multiple sources or groundings of moral judgments such as the approval of various cultures to which any correct moral judgment must conform; cf. Universalism, Situationalism.

**Rights**: Justified moral or legal claims to entitlements or liberties often seen as taking precedence over ("trumping") considerations of consequences. Rights normally stand in a reciprocal relation with moral or legal rules, i.e., if someone has a rights claim against some other party, that other party is duty-bound by a rule requiring that the right be respected.

**Rules of Practice**: The position that rules govern practices such that actions are normally judged by rules; cf. Antinomianism, Situationalism, Legalism.

**Situationalism**: The position that ethical action must be judged in each situation guided by, but not directly determined by, rules; cf. Antinomianism, Rules of Practice, Legalism.
Universalism: The position in metaethics that there is a single source or grounding of moral judgments such as the divine will or reason to which any correct moral judgment must conform; cf. Relativism.

Value Theory: The portion of normative ethics having to do with rational conceptions of the desirable. Value theory addresses the question of which outcomes are considered good consequences of actions.

Virtue Theory: The portion of normative ethics having to do with virtues, i.e., persistent dispositions or traits of good character in persons.

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