INFLATIONARY BIOETHICS: ON FACT AND VALUE IN THE PHILOSOPHY OF MEDICINE

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Abstract

This critical notice argues for the existence of a new trend in bioethics, a complex and dynamic field of philosophical enquiry that goes beyond applied ethics and professional deontological codes. This trend supplements their traditionally "minimalist" ethics—and its concern with harm, rights or justice—with "inflationary" positions open to an integration of medicine with the humanities. By comparing and contrasting the views of two quite different philosophers, Diego Gracia and Alfred Tauber, and placing them within the theoretical background delineated by George Khushf, I argue that the main contribution of this "inflationary bioethics" is an understanding of health and disease as intrinsically normative concepts, which in turn brings about a blurring of the distinction between facts and values. By refusing to construe the distinction as a dichotomy, a post-positivist philosophy of medicine must become more epistemological in order to help us clarify concepts (such as that of "need for health care") in which the evaluative and the factual are impossible to separate. As a result, the "language of principles" in standard bioethics is being substituted by a more encompassing "language of values"; health and disease are increasingly understood as biopsychosocial phenomena; and the field is open to a process of moralization that challenges traditional models of patient autonomy and physician responsibility.

In a recent interview, Ronald de Sousa differentiated between "minimalist" views of ethics, restricting moral concerns to the prevention of harm and injustice, and those that he described as "inflationary". Aristotle's ethics is an example of the latter kind, in which no emotion or value is irrelevant to moral philosophy in the broadest sense of the term, because "all human potentialities contribute to making life worth living" (de Sousa 2008, p. 7). In what follows I analyse and discuss a trend towards such inflationary positions in contemporary

bioethics, relating it to recent debates in the field of philosophy of medicine, and describing its influence on the work of prominent bioethicists on both sides of the Atlantic.

Philosophy textbooks typically treat bioethics as a form of "applied ethics"—an attempt to apply a given ethical theory to controversial moral issues in biology and medicine. However, this view has been criticised on several fronts (see, for instance, Baker and McCullogh 2007), generally by arguing that in bioethics there is a bidirectional, dynamic process of "appropriation" or exchange between theory and practice. After all, many important authors in this field have combined careers in medicine and philosophy. This is the case with the two authors I would like to address here, Diego Gracia and Alfred Tauber. Today, Gracia is a Professor of History of Medicine and Bioethics at the Medical Faculty of the Complutense University of Madrid, but he began his career as a psychiatrist, keeping in close touch with philosophers such as Xavier Zubiri and medical humanists such as Pedro Laín. Tauber is a Professor of Philosophy and Medicine at Boston University, and Director of its Centre for Philosophy and History of Science; a qualified haematologist and biochemist, his interest in basic immunology prompted him to embark on a critical examination of modern biology and medicine. I would like to argue that in their mutually independent work, both Gracia and Tauber are representatives of a global trend that—correctly—sees values as integral to health concepts; their bioethics are therefore open to a bidirectional integration of the descriptive and the evaluative, the medical and the non-medical, the old and the new (Casado and Menéndez 2008). In this sense, and as we shall see now, both are *normativist* philosophers of medicine.

In his agenda for a philosophical debate about basic concepts of bioethics, such as health and disease, George Khushf (2007) describes how, in the philosophy of medicine, the concepts of health and disease function somewhat like demarcation criteria in the philosophy of science, i.e. they mark out the jurisdiction of scientific medicine. According to Khushf, this debate is crucial to any response to current developments in healthcare, and should be framed philosophically as one between what he calls weak and strong normativists. Of course here, "strong" and "weak" represent only different philosophical positions, and should not be read as "better" or "worse" forms of normativism, a term first used in the philosophy of medicine by Christopher Boorse in 1975.

In this context, to be a normativist means to deny that judgments about human health and disease are simply factual or descriptive. Boorse defined the strong version of normativism as a view of health judgements as "pure evaluations without descriptive

meaning", and the weak version as a view allowing such judgements "a descriptive as well as a normative component" (2004 [1975], p. 79). He rejected normativism in general, amongst other reasons (against de Sousa 1972) because "philosophers of science have made too much progress in giving biological function statements a descriptive analysis" (2004 [1975], p. 89). As Khushf notes, there is now a broad consensus against this view, even if "nearly everyone feels the need to return to Boorse and criticise him again" (2007, p. 19). The reason for this return, Khushf argues, is that modern medicine involves a "thought style" that presupposes at multiple levels the fact/value dichotomy implicit in Boorse's antinormativist position; in their everyday practice, most doctors think that they deal primarily with clinical facts, upon which decisions concerning values are to be subsequently made; but those facts are "biological function statements" susceptible to "descriptive analysis", and therefore not value-laden.

As we shall see now, both Gracia and Tauber move away from this traditional, largely positivist understanding of medicine, in order to embrace slightly different forms of normativism.

Gracia on deliberation and method

In 1979, the first edition of the *Principles of Biomedical Ethics* (Beauchamp and Childress 2008) unleashed the four principles of respect for autonomy, nonmaleficence, beneficence, and justice on the newly emerging field of bioethics. These principles were argued to be mid-level norms mediating between high-level moral theory and low-level common morality, and they immediately became popularised by many other authors. Ten years after Beauchamp and Childress published their book (which is now in its 6th edition, and remains a classic, standard text in the field), Gracia published his own *Fundamentos de bioética* (2007 [1989]), a book that introduced the four principle approach to Spanish bioethics. Arguably the most prominent and influential philosopher of medicine in Spain, he is also considered a paradigm of a "peripheral bioethicist", playing a decisive role in the introduction and dissemination of contemporary bioethics in Latin America (Rodríguez del Pozo and Fins 2006; Garrafa et al. 1999).

Gracia agreed with Beauchamp and Childress in that the content of traditional ethical theories is too abstract to explore practical ethical problems within medicine and the life sciences. In order to establish an agent's actual duty in the face of conflicting obligations, a process of moral deliberation is required. Gracia proposed moral deliberation as a tool

by which we examine our considered judgements and contrast them with principles that are central to bioethics across cultures, and with the anticipated outcomes that they might bring about. By embracing this broadly Aristotelian concept of moral deliberation, Gracia expanded the scope of bioethics beyond the limits of the traditional doctor-patient relationship:

> Bioethics deals necessarily with the values involved in health and disease, the life and the death of human beings. Therefore, bioethics is a process of deliberation about the individual and collective ends of human life. Consequently, it cannot be constrained to the limits of Hospitals and Schools of Medicine. The goals of human life are primarily social and political. And because the ends of medicine are derived from these goals, it is necessary to conclude that bioethics is engaged inevitably in matters that occur out of the hospitals and out of the healthcare professions. Bioethics is not only a professional ethics, but also and principally a part of political philosophy.[1]

Here the focus of bioethics is not the conduct of the healthcare professional alone, but rather society at large (including, of course, the patient). The facts and values we uphold when making health-related decisions are not natural, in the sense that they cannot be described or distinguished without appeal to norms and cultural standards; rather, they belong to the polis, and as such are inextricably linked to political life (Casado and Menéndez 2008). With quotes such as the previous one, it seems clear that Gracia is a normativist in the sense favoured by Khushf, and that his vision of ethics is inflationary in the sense described by de Sousa, i.e. it does not exclude minimalist concerns with justice and nonmaleficence, but strives to include comprehensive conceptions of the good life that go beyond the clinical realm.

However, according to Gracia, not all values are equally relevant for bioethics. He has defended that duties pertaining to a minimalist ethics are more limited or restricted than those of an inflationary (or, as he puts it, "maximalist") ethics, but also that the former are publicly compulsory standards, and therefore in case of conflict they usually take priority. In a paper published in 1995, Gracia sees correct moral reasoning as a process with three different stages. The first one is a Kantian absolute, but merely formal, command of respect for all human beings, while the other two are more *prima facie* and context-relative. In the first of these, deliberation deals with the four bioethical principles (divided into two levels, one private, including the principles of autonomy and beneficence, and the other public, including those of nonmaleficence and justice); and in the second, deliberation deals with the specific case at hand, requiring an analysis of the circumstances, possible courses of

1 Gracia (2005, p.38)

action and their consequences (Gracia 1995, pp. 204-5).

If we look at the development of Gracia's work over the years, it is easy to see a shift from a "language of principles" to a "language of values". This shift is especially evident in his proposals of a method for moral deliberation. In a programmatic paper published in Spanish, Gracia (2001, p. 20) proposed the following basic steps for analysing cases, so as to ensure a proper balance between principlism and contextualism:

1) Presentation of the case by the person responsible for making the decision.
2) Discussion of the clinical aspects of the medical record.
3) Identification of the moral problems that arise.
4) The person responsible for the patient chooses the moral problem that concerns him or her and that he or she wishes to analyse.
5) Determination of the possible courses of action.
6) Analysis of the best course of action.
7) Final decision.
8) Selection of arguments for and against this decision that we are ready to defend in public.

Two years later, Gracia (2003, p. 230) reformulated the second half of his checklist, giving more weight to the consideration of the values at play in the case:

5) Determination of the values in conflict.
6) Tree diagram of courses of action.
7) Analysis of the best course of action.
8) Final decision.
9) Decision control consistency: check the consistency of the decision made by subjecting it to the legality test ("is this a legal decision?"), the publicity test ("would you be prepared to defend it publicly?"), and to the consistency in time test ("would you arrive at the same decision in a few more hours or a few more days' time?").

This might seem a minor change, but it is representative of this trend which introduces into bioethics values other than those traditionally associated with the four principles. However, the trend does not prompt Gracia to go as far as to reject the distinction between

facts and values. He is keen to repeat that they are interlinked, but his methodology still presupposes a distinction between them: "Ethical problems are always connected to conflicts of value, and values are supported by facts. Therefore, the procedure must start with a detailed study of the clinical facts. The clearer these are the more accurate the identification of value conflicts will result." (2003, p. 230)

Why inflationary?

What we have just seen is an example of an influential author in the field of international bioethics whose views are becoming inflationary. Others could be used, as critics of the role bioethics plays in public debate point out when warning about "the almost indiscriminate way in which the rubric of morality is now being used" (B. Hoffmaster, quoted by Herrera 2008, p. 238). However, instead of providing more evidence, let us tackle the question—why is this happening?

One answer is that healthcare systems in the Western world are increasingly pluralistic, and values connote pluralism and difference in a way that principles cannot; therefore an inflationary constellation of values seems to provide a better description of contemporary moral life than a set of limited yet congruent principles. Since it is pursued elsewhere (Casado and Menéndez 2008), I will not expand on this kind of answer here. Instead, I would like to explore the question further by using arguments from Tauber. It makes sense to put these two authors together because they have much in common, even if they belong to different social and cultural environments. Both share an emphasis on the role of humanism in the training of healthcare professionals. Both want to match clinical skills with the acquisition of a moral education. And both understand the legitimate place of patient autonomy in relation to an ethics of responsibility (Gracia 2004; Tauber 2005a).

My hypothesis here is that inflationary views of bioethics go hand in hand with the blurring of the fact/value distinction, which in turn is associated with a holistic, biopsychosocial approach to health and disease. This approach attempts to address elements of personhood that have no firm and delineated objective basis—the social, the emotional, the moral—because the organism is an integrated, functioning entity, and thus "medicine is, by its very character, holistic in orientation" (Tauber 2005b, p. 51). Even though the influence of a fact-driven clinical science has prevailed as medicine's dominant ethos, the biopsychosocial approach has been widely adopted by primary care providers (Tauber 2005b, p. 45). And primary care, with its focus on chronic disease, is an area of medicine where practice

must go beyond the simplistic idea of "fixing bodies" and view patients as people with stories of their own; as Gracia suggests, the language of principles might be adequate for other situations in medical practice, but in primary care the language of values (which we apprehend by means of narrative) is more useful and adequate.

In addition, primary care and its focus on chronic disease place us in a domain where causation is multidimensional, complex, and difficult to understand; where lifestyle can be easily invoked as a contributor to health and disease. The health care relationship is thus open for what Paul Rozin has described as "moralization", the process by which something (in this case, health and disease) that was previously outside the moral domain enters into it (1997, p. 379). In such a process, "the development of the idea of risk factors, treated as if they themselves are diseases, provides ample opportunities to invoke individual responsibility and hence moral factors in the aetiology of this newly expanded notion of disease". As both "physicians and nonphysicians dislike multicausation and probabilistic accounts" (Rozin 1997, p. 396), concepts of health and disease are increasingly more encompassing, and bioethics becomes inflationary.

Some normativists (like Gracia, to a certain extent) see values as integral to health concepts, but still share with the prevalent medical ethos a confidence in our ability to tease out facts from values. This may prove a problem, especially as the classical distinction between clinical and socioeconomic aspects of healthcare is now being challenged by new realities in the practice of medicine, such as the overlap between administrators and clinicians, or the shift of focus to systems-based interventions (manifest in the rise of "organisation ethics"). On the other hand, stronger normativists are sceptical of the drive to differentiate between science and other social activities, and believe that facts and values cannot be disentangled. This, I believe, is Tauber's case. "The basic question concerning the future of biology", he wrote in 1999, is "where to draw the boundary between science and other social activities and applied moral judgement" (p. 485). But the boundary, he added, is ultimately drawn by human choices based on human values:

> The epistemological and moral domains are not easily separated because we integrate them as informed opinion on a complex continuum between the search for "what is" and our aspirations for "what ought to be." On the social playing field, these two philosophical goals meet somewhere beyond their theoretical origins and thereafter cannot be divided again.[2]

If fact and value—"is" and "ought"—cannot be separated, bioethics cannot restrict itself

2 Tauber (1999, p.485)

to the prevention of harm and injustice, i.e. to its minimalist view. Strong normativists, with their mistrust of the fact/value dichotomy, are bound to favour inflationary views on bioethics. The fact that socioeconomic conditions unavoidably influence how pathology is understood is often described as a problem, and even as a crisis, in healthcare. But it is only a problem inasmuch as we work with an allegedly value-free concept of health, in which clinical science has no underlying moral agenda (Tauber 2005b, p. 43). As put forth by the normativists, the lesson of inflationary bioethics is that human health has to do with values, and that those values are not always medical or economic. Tauber's way of looking at medicine, his proposal of an integrated epistemology of facts and values, might look at "the economic and political issues currently dominating public debate from a different perspective, one that shifts dollar-dominated choices into a different currency" (2005b, p. 51). For instance, Tauber argues that the category of need, one of the key concepts in this public debate, inextricably combines facts and values, and therefore the aspiration to rigidly separate them collapses when medical practice begins to view patients as people. Thus, "the fact-value distinction has a particularly pernicious quality when applied to the ill" (2005a, p. 54).

Actually, focusing on this concept of need provides an illustration of how inflationary bioethics goes hand in hand with blurring of the fact/value distinction. John Harris (1998) has argued that, when allocating resources at the micro level (for instance, when deciding what patient should be treated first), in many cases it is unlikely that consensus about the degree of need for health care can be achieved. In those cases, principle-based approaches (such as that of maximizing QUALYs, quality adjusted life years) are not of much help. The lack of consensus is typically inflationary, being the result of conflicting ideas on what criteria should we follow in order to ascertain what is "greater need" for health care. This concept is not transparent, as the degree of need for health care presents itself in multiple dimensions. Should we take into account factors such as moral worth, number of dependants, the individual's utility to society? "Ultimately", Harris concludes, "we will be comparing different moral priorities" (1998, p. 304).

In other words, and despite that much of the rhetoric of modern medicine advocates the utility of separating fact from value, the science from the ethics, health care need is not a fact, and should not be analysed as one. Although medical students are typically taught to be "neutral" and to avoid making value judgements about their patients, the attempt to produce "value-free" analyses of the concept of need often produces the most biased and moralistic results. Instead of relying only on a set of principles, attention should also be put on the multiple ways

in which facts-and-values are introduced in medicine and health care.

I have tried to argue that the current debate on concepts of health and disease strengthens the "inflationary" trend in bioethics, which is moving away from a former biomedical model foundation, in which facts and values were neatly separated, towards a competing biopsychosocial model of healthcare and, ultimately, towards construing health needs as biopsychosocial (Schaffner 2001). This movement is especially visible if we look at how values are increasingly playing a role in the conceptualisation of health and disease, and therefore in the methodology of medical ethics, such as the one proposed by Gracia. In his approach, the role of values in the definition of health and disease is emphasised, and nonmaleficence and justice are ultimately defined by a public deliberation process involving all members of society (1995, p. 198), so his position is clearly a normativist one—but not as strong as Tauber's, because for methodological purposes Gracia maintains a clear-cut distinction between facts and values.

When bioethics engages with actual medical practice, it is forced to give up the fact/value dichotomy and accept that medical science never escapes its underlying moral agenda. Once this is done, bioethics ceases to be an ontological discipline, focused on the status of norms, principles and values, and becomes an epistemological discipline, one seeking to establish the conditions for a proper debate in medicine so that its moral agenda is made explicit, and the "is" and the "ought" can be reconciled with each other. Tauber's work does not usually cover developments outside American medicine and bioethical theory (Irvine 2007, p. 338). However, as I have tried to show in this brief commentary, his call for a moral epistemology for medicine (Tauber 2008) is consistent with current trends in Europe, and makes a valuable contribution to the ever expanding field of international bioethics.

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References

Baker, R. and L. B. McCullough, 2007, 'Medical Ethics' Appropriation of Moral Philosophy: The Case of the Sympathetic and the Unsympathetic Physician', *Kennedy Institute of Ethics Journal* 17(1), 3-22.

Beauchamp, T. L., and J. F. Childress, 2008, *Principles of Biomedical Ethics* (6th edition). New York: Oxford University Press.

Boorse, C., 1975, 'On the Distinction between Disease and Illness', *Philosophy and Public Affairs* 5, 49-68. Reprinted in: A. L. Caplan, J. J. McCartney, D. A. Sisti (eds.), *Health, Disease, and Illness: Concepts in Medicine*. Washington: Georgetown University Press, 2004; 77-89.

Casado da Rocha, A., and A. Menéndez Viso, 2008, 'Fact and value in bioethics: How to get rid of the dichotomy', *Praxis Filosófica* 26, 245-261.

de Sousa, R., 1972, 'The Politics of Mental Illness', *Inquiry* 15, 187-202.

-----, 2008, 'Interview with Ronnie de Sousa', *Praxis* 1(1), 2-14.

Garrafa V., D. Diniz and D. B. Guilhem, 1999, 'Bioethical language and its dialects and idiolects', *Cadernos de Saúde Pública* 15(suppl.1), 35-42.

Gracia, D, 1995, 'Hard times, hard choices: founding bioethics today', *Bioethics* 9(3), 192-206.

-----, 2001, 'La deliberación moral: El método de la ética clínica', *Medicina clínica* 117(1), 18-23.

-----, 2003, 'Ethical case deliberation and decision making', *Medicine, Health Care and Philosophy* 6(3), 227-233.

-----, 2004, *Como arqueros al blanco. Estudios de bioética*. Madrid: Triacastela.

-----, 2007 [1989], *Fundamentos de bioética* (2nd edition). Madrid: Triacastela.

Harris, J., 1998, 'Micro-allocation: deciding between patients', in H. Kuhse and P. Singer (eds.), *A Companion to Bioethics*, Oxford: Blackwell.

Herrera, C., 2008, 'Is it time for bioethics to go empirical?', *Bioethics* 22: 137-146.

Khushf, G., 2007, 'An agenda for future debate on concepts of health and disease', *Medicine, Health Care and Philosophy* 10(1), 19-27.

Rodríguez del Pozo, P., and J. J. Fins, 2006, 'Iberian influences on Pan-American bioethics: bringing Don Quixote to our shores', *Cambridge Quarterly of Healthcare Ethics* 15(3), 225-38.

Rozin, P., 1997, 'Moralization', in A. M. Brandt and P. Rozin (eds.), *Morality and Health* (eds.), London: Routledge.

Schaffner, K. F., 2001, 'Biopsychosocial Foundations', *The American Journal of Bioethics* 1(2), 26-7.

Tauber, A. I., 1999, 'Is Biology a Political Science?', *BioScience* 49(9), 479-486.

-----, 2005a, *Patient Autonomy and the Ethics of Responsibility*. Cambridge, Mass: The MIT Press.

-----, 2005b, 'Medicine and the Call for a Moral Epistemology', *Perspectives in Biology and Medicine* 48(1), 42-53.

-----, 2008, 'Medicine and the Call for a Moral Epistemology, Part II: Construting a Synthesis of Values', *Perspectives in Biology and Medicine* 51(3), 450-463.7