



Bioethics and History¹

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ABSTRACT

Standard bioethics textbooks present the field to students and non-experts as a form of “applied ethics.” This ahistoric and rationalistic presentation is similar to that used in philosophy of science textbooks until three decades ago. Thomas Kuhn famously critiqued this self-conception of the philosophy of science, persuading the field that it would become deeper, richer, and more philosophical, if it integrated the history of science, especially the history of scientific change, into its self-conception. This essay urges a similar reconceptualization for bioethics, arguing that the analysis of moral change ought to be integral to bioethics (and to ethics generally). It proceeds by suggesting the sterility of the ahistoric, rationalist applied ethics model of bioethics embraced by standard bioethics textbooks. It also suggests the fecundity of alternative conceptions of the bioethics that focus on the history of successful and failed attempts to negotiate moral change, and the history of multifaceted relations between moral philosophy and practical ethics.

History, if viewed as a repository for more than anecdote or chronology, could produce a decisive transformation in the image of [bioethics] by which we are now possessed . . . The aim of [contemporary text] books is persuasive and pedagogic; a concept of [bioethics] drawn from them is no more likely to fit the enterprise that produced them than the image of a national culture drawn from a tourist brochure or a language text. This essay attempts to show that we have been misled by them in fundamental ways. Its aim is a sketch of the quite different concept of [bioethics] that can emerge from the historical activity itself. (Kuhn, 1970, p. 1; the word “bioethics,” has been substituted for “science,” “scientific”)

I. STANDARD BIOETHICS TEXTBOOKS

Despite their utility, or, perhaps, because of it, textbooks get little respect. Yet, as Kuhn has remarked, “both the layman’s and the practitioner’s knowledge of

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[the field] is based [primarily] on textbooks” (Kuhn, 1970, p. 137). Textbook formats, prefaces and tables of contents tell us a great deal about a field’s self-definition. Bioethics textbook prefaces are thus revealing when, as they typically do, they characterize the subject as a branch of ethics addressing “developments in the fast-moving areas of medicine and the biological sciences” (Kuhse & Singer, 1999, p. 60) or “complex situations in biology and medicine that require moral reflection, judgment, or decision” (Beauchamp & Walters, 1994, p. xi). These “developments” and “complex situations” are further specified in tables of contents, which catalogue a series of on-going debates about abortion, allowing death, cloning, euthanasia, and similar subjects. Thus the editors of one widely used textbook remark that essays “have been arranged in a debate-like format so that the reader may explore the strengths and weaknesses of alternative positions on an issue” (Beauchamp & Walters, 1994, p. xi).

Anyone familiar with ethics pedagogy will appreciate that the controversy-centered format of applied ethics and bioethics textbooks represents an invigorating alternative to the desiccated metaethical musings that, until fairly recently, dominated the field.² As Martha Nussbaum has eloquently observed, such textbooks contribute to the “production of a community that can genuinely reason together about a problem, not simply trade claims and counterclaims” (Nussbaum, 1997, p. 19). Yet, despite the debate format’s virtues for instructing students in reasoning, and in engaging their attention, it is a mixed blessing. What makes it problematic is that it insinuates the rationalist presumption that the most cogent argument, the position that wins the intellectual debate, should be awarded the prize of implementation. Worse yet, since textbook editors balance positions pro and con, students have a proclivity to see the outcome of bioethical debates as deadlocked. The debate format favored by bioethics textbooks thus tends to teach the next generation of bioethicists to think of bioethical problems as deadlocked debates, rather than as problems that are soluble, and that have, as often as not, actually been resolved.

One reason why bioethics textbooks inculcate presumptions of insolubility is that, in spite of a few admirable exceptions, such as Gregory Pence’s *Classic Cases in Medical Ethics* (1990, 1995, 2000) and Wanda Teays and Laura Purdy’s *Bioethics, Justice & Health Care* (2001), they are adamantly ahistoric. Like pre-Kuhnian philosophy of science texts, they dismiss the past as prologue. They may genuflect at the alter of the Hippocratic Oath and reverence the Nuremberg Code, but they seldom engage in serious historical reflection. Today, clinical ethicists take it as a matter of course that patients

can be allowed to die, that persons can be declared brain dead, that their families can consent to have their organs removed for transplantation, and that recipients remain normal persons. In bioethically active American and Europe, but not in bioethically quiescent Japan, the public accepts clinical acts – from allowances of death to organ transplantation – that only a few decades earlier were considered debatable, and perhaps even unacceptable (Baker, 2001). Yet the tale of this remarkable transformation is seldom remarked, much less seriously analyzed, in bioethics textbooks. To paraphrase Kuhn, bioethics textbooks thus seriously “mislead” students, the public, and perhaps even the profession itself, in “fundamental ways.” Like Kuhn, my purpose is to “sketch the quite different concept of [bioethics] that can emerge from the historical activity itself.”

II. DEBATING VERSUS NEGOTIATING: ROE v. WADE VERSUS DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT

Why are bioethics textbooks indifferent to history? Why do they ignore even famous cases in which bioethicists negotiated moral change *successfully*? To judge from the textbook prefaces, the most significant factor would appear to be a rationalist conception of ethics. Bioethics textbooks typically characterize their subject as “applied ethics,” specifying that their subject “assumes” a background “theory of normative ethics and a linking principle or principles by which the ethical principles . . . [that] can be applied in real life situations” (Boylan, 2000, p. 1). They thus presume a rationalist model of ethics that conflates the intellectual process of argumentation with the complex social process of “negotiating moral change.”

A. Negotiating Moral Change Versus Winning the Argument

By, “negotiating a moral change,” I do not mean passing a law or changing a policy; I mean the process of consciously altering moral norms to create or to change the social evaluation of character or conduct. Morality may be said to have changed if what was once morally questionable, or impermissible, comes to be considered permissible, or, even exemplary – or vice versa. Moral negotiation differs from argumentation. Argumentation proceeds by debate and aims at convincing others to accept one’s position. Negotiation, in contrast, aims at consensus on some conflict resolving solution, or norm; it

often involves compromising with others, rather than convincing them of the correctness of one's views. Argumentation can be an effective aspect of negotiating conflict in contexts where values and presumptions are shared. It can be glaringly ineffective, however, if parties do not share common values or presumptions, but nonetheless seek to resolve a conflict (see my discussion of negotiating moral norms between nudists and puritans in Baker, 1998b, pp. 235–237).

Two historical cases may help to differentiate the two processes, even as they challenge the rationalist presumption that argumentation should be the preferred means of negotiating moral change. The two cases are: *Roe v. Wade*, a 1973 Supreme Court decision, and *Deciding to Forego Life-Sustaining Treatment*, a 1983 report by The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Roe* famously declared that a woman's constitutionally protected right to privacy can override the state's interest in protecting potential human life, especially in the first trimester of pregnancy. *Deciding to Forego Life-Sustaining Treatment* declared the moral right of a terminal patient to refuse life sustaining treatment, legitimating, among other things, Do Not Resuscitate (DNR) orders. Both *Roe* and *Deciding* were efforts on the part of branches of the federal government (the judiciary and the executive) to change policy/law, and both did so successfully. Both were also efforts at negotiating moral change, i.e., they attempted to legitimate moral norms permitting physicians to perform actions that would lead to death (in one case, of an embryo/fetus, in the other of a patient). Both thus entailed the delegitimation of traditional, comparatively absolute prohibitions forbidding physicians to perform actions leading to death (abortion/withholding cardiopulmonary resuscitation). Moreover, both employed similar tactics to negotiate change – they attempted to bypass traditional prohibitions by substituting process for substance. In *Roe*, a procedure for weighing fetal, maternal, and state interests and rights overrode state laws prohibiting abortion (although, from 1970 onwards, Hawaii, New York, Colorado, North Carolina, California and 14 other states had liberalized their abortion laws); in *Deciding*, a process of shared patient/family-physician decision-making was substituted for laws prohibiting actions allowing patients to die.

As it happens, *Deciding* effectively negotiated the Commission's intended change in the acceptance of moral norms, whereas *Roe* was only partially successful in negotiating the changes intended by the Court. Today, attitudes toward medical allowances of death have changed. Americans no longer

regard DNR orders, or the withdrawal of life support, as the *moral* equivalent of murder, or as, in any sense, impermissible or morally problematic. Allowances of death are not challenged in the courts, or on the streets. In contrast, although the Supreme Court successfully changed American *legal* norms, for many Americans abortion is still the moral equivalent of murder. Unlike DNR orders, abortion is contested on the streets, in the legislatures – and in the courts. *Deciding* is thus a paradigm case of the successful use of public reasoning to negotiate moral change in a pluralistic, multi-ethnic, multi-religious, secular democratic society. By contrast, *Roe* is a classic case of a failed attempt to negotiate moral change.

What intrigues about this comparison is that *Roe* provides a consistent, if complex, argument for the unconstitutionality of laws prohibiting first trimester abortion, whereas *Deciding* is beset by inconsistency. Had reality hewed to the rationalist model, were moral change a matter of winning the intellectual argument, *Roe* should have negotiated moral change more effectively than *Deciding*. Yet *Deciding* was not only plagued by an underlying existential inconsistency, this inconsistency contributed to its success.

B. The Treachery of Tradition: Killing Versus Allowing to Die

In 1983, when the President's Commission issued *Deciding*, neither the public, nor public prosecutors, (nor many Commission members) were prepared to accept norms that would legitimate *killing* patients. The Commission could thus legitimate norms permitting physician *allowances* of patient deaths, but it could do so only if the public (and public prosecutors) believed that such norms were conceptually and morally *different* from norms permitting killing patients. Differentiating between the norms might have been unproblematic, had not many on the Commission believed that the distinction in question – the distinction between acting/allowing and omitting/permitting – invalid. Complicating matters further they stated their position in the Commission report. Here is the passage:

Although the Commission believes that most omissions that lead to death in medical practice are acceptable, it does not believe that the moral distinction between that practice and wrongful killing lies in the difference between actions and omissions per se. (President's Commission, 1983, pp. 64-65, see more generally, pp. 60-89)

The Commission staff had thus placed itself in an awkward position. If, as the report claimed, there is no moral difference between allowing death and kill-

ing, then neither the public, nor public prosecutors, nor many members of the Commission could accept allowances of death as legitimate.

Dan Brock, who served as staff philosopher for the President's Commission during the 1981–1982 academic year, characterized this dilemma as follows.

I believe that on common understandings of the kill/allow to die distinction, the difference is not itself morally important, and that stopping life-sustaining treatment is often killing, though justified killing. Needless to say, many of the Commissioners did not share this view. They believed that killing was far more seriously wrong than allowing to die, and that stopping life support was allowing the patient to die of his disease, not causing his death and killing. [However] we shared the conclusion that stopping life-sustaining treatment at the request of a patient was morally permissible My philosophical instincts urged me to attack the confusion and follow the argument wherever it led.

But what would be the consequences of convincing them that allowing to die is no different morally than killing and/or that stopping life support was killing? . . . this would throw into question their acceptance of the moral permissibility of stopping life support. Could one then responsibly attack what seemed confusions in their view when the results of doing so might well be to lead them to an unwarranted and worse conclusion – and a conclusion, it is important to add, that could produce important adverse consequences in suffering and loss of self-determination for real people? (Brock, 1987, pp. 788-789)

Brock's "philosophical instinct" was to win the debate, but he realized that winning the debate would lead to unacceptable results. Forced to choose between the rationalist objective of winning the intellectual debate, and the social objective of effectively negotiating moral change, Brock, appropriately, but apologetically, chose the latter.

Had Brock seen his function as negotiating moral change, he would have had no reason to apologize. Negotiation occurs when persons with different valuations and constructions of the world nonetheless create common constructions to serve shared goals. Unlike argumentation, negotiation does not require agreement on premises, or even conclusions. It only requires agreement on the means for attaining a common goal: in this case, the common goal of legitimating physician allowances of death. In order to negotiate new norms for DNR orders and the withdrawal of life support – and technical matters, such as "brain death" – Brock and the other staff members had to construct the

problem in a way acceptable to all parties. They succeeded, and the rest is the history of a successful bioethical reform, a negotiation that changed the way in which people die, for the better.

Brock's regrets, his apology, is a consequence of a misleadingly rationalistic model of moral change. Moral norms are embedded in complex justificatory frameworks. Given the intricacy and interdependence of norms and explanatory frameworks, except in contexts of moral breakdown, prudence dictates a preference, if not for moral conservatism, than at least for reforms that can be accommodated with the fewest possible changes in explanatory frameworks. In the case in point, the killing-allowing death distinction is deeply embedded in our moral and legal conceptions of accountability and responsibility. These frameworks naturally place greater constraints on killings than on allowances of death because everyone alive is at risk of being killed, whereas, only persons dying preventable deaths are at risk of being allowed to die. Attributions of culpability in allowances of death are further limited by complex concepts of responsibility, so that persons are held accountable only if they allow a death that they had a responsibility for preventing. Brock was urging the wholesale revision of our moral and legal framework in order to allow the death of a few terminal patients. The same practical results could be achieved more economically, however, by revising our understanding of the conditions under which physicians were responsible for preventing death. Since radical reconceptualizations often have pernicious if unintended consequences, principles of moral prudence dictated, and the Commission ultimately accepted a more moderate reform.

C. Changing the Subject: Discourse and Paradigm Shifts

Even a moderate reform posed significant tactical problems. If the Commission's report relied on traditional moral distinctions – action versus omission, allowing-to-die versus killing – it would resurrect the traditional debate, and, traditionally, the debate ended in stalemate. So, the staff changed the subject. They turned away from the discourse that had deadlocked the traditional debate, re-centering the discussion around the new concept of “ethically sound medical decisionmaking.”

Good decisionmaking about life-sustaining treatments depends upon the same processes of shared decisionmaking that should be part of health-care in general. The hallmark of an ethically sound process is always that it enables competent and informed patients to reach voluntary decisions about care. (President's Commission, 1983, p. 89)

By deploying the new discourse of “ethically sound decisionmaking,” the staff side-stepped stalemate. The new discourse allowed the Commission to focus on the pivotal question: under what conditions would it be “ethically sound” for practitioners, patients and families to decide to forego medical treatments, including, as it happened, life sustaining treatments. So reformulated the Commission could develop a series of scenarios in which decisions to forego life-sustaining treatments could be considered “ethically sound.”

In many respects the Commission’s strategy of substituting process for content, and its attempt to deploy new forms of discourse, is rather like the strategy employed by the Supreme Court a decade earlier in *Roe*. The Commission, however, was able to do something that had eluded the Supreme Court. The Commission marshaled traditional authority to support the new norms it favored. An appendix citing cautiously worded statements by the AMA (President’s Commission, 1983, p. 300) and the Vatican, endorsing the position that physicians were permitted to forego treatments “that would only secure a precarious and burdensome prolongation of life” (President’s Commission, 1983, p. 306), suggested authoritative endorsements of the proposed model of shared end-of-life decisionmaking. It mattered not that the positions staked out by the AMA and the Vatican were more restrictive than that endorsed by the Commission. By refocusing discussion on ethically sound *decisionmaking*, the Commission effectively co-opted the legitimating authority of organized medicine and religion.

Just as importantly, the Commission aligned itself with comparatively new but on-going initiatives within the medical community – advance directives, brain death, DNR orders, ethics committees – and, by offering its endorsement, used the imprimatur of its presidential authority to legitimate them. Proponents of these reforms were thus inclined to embrace *Deciding*, its new paradigms, its discourse of shared decisionmaking and its correlative rejection of the old discourse and its distinctions. As they urged moral reform they thus naturally disseminated the new paradigm and its attendant discourse throughout the medical community, which would ultimately internalize it.

Kuhn remarked that since revolutions succeed by becoming mundane, science textbooks provide an on-going quotidian measure of the success of once revolutionary laws and theories. Similarly, in American medical ethics, the AMA’s Code of Medical Ethics is an important measure of the success of medical ethics reform. Evidence of the medical community’s internalization of the norms and discourse promulgated by the Commission in *Deciding* was soon evident in the AMA’s Code of Medical Ethics:

Withholding or Withdrawing Life-sustaining Medical Treatment: . . . The principle of patient autonomy requires that physicians should respect the decision to forego life-sustaining treatment of a patient who possesses decision-making capacity. . . .

There is no ethical distinction between withdrawing and withholding treatment. (American Medical Association, 1999, pp. 45-46, § 2.20)

What is noteworthy here is that the AMA has accepted, *as its own*, the Commission's construction of the issue. Like the Commission, the AMA now views the issue in terms of ethically sound decisions, to "forego life-sustaining treatments" – echoing the title of the Commission's report in its statement. The AMA also accepted, at least in part, the Commission's dismissal of traditional distinctions, specifically, the distinction between "withholding" and "withdrawing." Thus, the most prominent medical organization in America has internalized the core of the *Deciding* report, and by so doing, legitimated the Commission's normative reforms.

D. Bioethics Textbooks' Rejection of Moral Progress and its Philosophical Analysis

Unlike the AMA's Code of Ethics, unlike science textbooks, and unlike clinical ethics textbooks, bioethics textbooks seldom reflect the progress of the field. Bioethics textbooks, which are typically written for and ordered by philosophy professors (for purchase by their students), refuse to treat an issue as closed or settled, even for practical or operational purposes. Old debates never die – although some are crowded out of the table of contents to linger on in the half-life of footnotes. Thus while the debate over killing and allowing death may be extinct on the clinic floor it lives on in bioethics textbooks – almost as if the President's Commission had never negotiated a successful moral compromise. Here, for example, is how philosopher Michael Boylan opens the section on Killing and Allowing to Die in *Medical Ethics*: "no valid distinction, many argue, can be made between killing and letting die, or between an act of commission and one of omission" (Boylan, 2000, p. 199). The validity of the distinction is here treated as an open question, subject to on-going debate.

In striking contrast, clinical ethics textbooks (e.g., Ahronheim, Moreno, & Zuckerman, 2000; Jonsen, Siegler, & Winslade, 1997), which are typically written by practicing clinical ethicists for the instruction of health care professionals, present the revolutionary achievements of the past as *fait accompli*.

Thus in *Ethics in Clinical Practice*, clinical ethicists, Judith Ahronheim, Jonathan Moreno, and Connie Zuckerman treat the debate over the validity of the distinction as closed.

In its most recent decision examining physician-assisted suicide, the Supreme Court also found important distinctions between allowing patients to die . . . versus actions intended to bring about the death of the patients. . . . In subsequent case discussions [in this volume] the distinction between killing and letting die is taken as logically valid and morally relevant. (Ahronheim, Moreno, & Zuckerman, 2000, pp. 53-54)

The point to appreciate is that unlike philosophically-oriented bioethics textbooks, and like science textbooks, clinical ethics textbooks recognize that debates must be operationally settled so that the field can move on to tend to its practical concerns. As Albert Jonsen has remarked, “a philosophical argument can roll on eternally; a [clinical] ethical problem is a problem that must be resolved at a certain time and place” (Jonsen, 2001, p. 43).

Clinical ethics texts thus mark the progress of the field, they reflect which issues are operationally open and which are provisionally considered settled – subject, of course, to reopening, should a pressing reason present itself. Bioethics texts, in contrast, ignore the movement and progress of the field by keeping virtually all debates open. In doing so, they not only embrace a rationalist debaters’ model of moral change and misrepresent the progress of the field, they also obscure pivotal questions that are fundamental to bioethics and to moral philosophy generally – questions, for example, about how debates come to be accepted as settled. Thus by failing to recognize that the killing/allowing death distinction has been operationally closed, bioethics textbooks prevent bioethics teachers and their students from analyzing the phenomenon of moral closure. Also, by keeping open closed debates, they blind their students – and perhaps themselves – to moral change. Thus some of the most significant questions in bioethics, and in moral philosophy generally are never addressed: questions about how moral change is negotiated, and how moral progress possible.

It would appear that these philosophical questions are not being addressed because the philosophers who author and edit bioethics textbooks are enamored with the pedagogy of debate, and because, perhaps unwittingly, they embrace a rationalist model of moral philosophy. Students educated on such texts, nurtured on ahistoric rationalist models, having never analyzed the negotiation of moral change or the moral progress of their field, will naturally

be insensitive to moral change and moral progress. To invert Santayana's dictum, by being kept ignorant of the past, they may be unable to repeat it. The bioethics revolution has been a spectacularly successful exercise in negotiating moral change. Yet, by ignoring its own past, bioethics textbooks not only fail to analyze the successes and failures of bioethics itself, they risk creating a generation of students ignorant of the fundamentals of bioethical successes and thus unable to duplicate them. Whatever else a textbook should do, it should not ignore the fundamentals of the field whose knowledge it aims to disseminate; nor, for that matter, should a philosophy text ignore core philosophical questions. It is time to revise standard bioethics textbooks and teaching.

III. TRANSFORMING BIOETHICS' SELF-IMAGE

In my paraphrase of Kuhn I stated that my objective was "a decisive transformation in the image of [bioethics] by which we are now possessed." Bioethics textbooks characterize the field as a branch of ethics; implicitly, and often explicitly, they construct the relationship between ethics and bioethics in terms of what Arthur Caplan has dubbed the "engineering model." The relationship between ethics and bioethics is thus envisioned as paralleling the relationship between physics and engineering. Bioethics textbooks invoke this model, not only in their prefaces, but when they employ such phrases as "go[ing] from ethical theory back to real world problems and . . . us[ing] ethical theory to help us wrestle with those problems" (Zucker, Borchert, & Stewart, 1992, p. 10). Ethical theorists are here portrayed as supplying the conceptual apparatus, the discourse, and the theoretical principles that bioethicists, and other applied ethicists, "apply" to moral problems in biology and medicine.

A. Problems with the Engineering Model

Despite its popularity in introductory bioethics textbooks, the engineering model is problematic on its face. In striking contrast to physics textbooks, ethics textbooks do not reflect a consensus on a single standard theory. Indeed, as the bioethics textbook editors fully appreciate, "There are competing [ethical] theories . . . and . . . none of these theories has achieved acceptance by everybody" (Zucker et al., 1992, p. 8). Leading postmodern critics of the foundations of bioethics, also remark the same problem, albeit at a more elevated level of theory and discourse (Engelhardt, 1996).

The absence of agreement on moral theory was actually one of the most vexing theoretical issue faced by founders of bioethics. Yet textbook writers (except those who are numbered amongst the founders) usually ignore the founders' response to this problem: the claim of convergence. The idea of convergence was clearly articulated in such foundational works as the Belmont Report (National Commission, 1978) and in the first several editions of Beauchamp and Childress's *Principles of Biomedical Ethics* (1979, 1983, 1989). Beauchamp and Childress discuss convergence in terms of the following diagram.

4. *Ethical Theories*
- ↑
3. *Principles*
- ↑
2. *Rules*
- ↑
1. *Judgments and Actions*

“According to this diagram,” Beauchamp and Childress remark, “judgments about what ought to be done in particular situations are justified by moral rules, which in turn are grounded in principles and ultimately ethical theories” (Beauchamp & Childress, 1979, p. 5; 1983, p 6). “Mid-level convergence” (a concept fleshed out in the second and third editions of *Principles of Biomedical Ethics*) occurs with respect to level 3 principles. The claim is that, however much philosophers may differ at the level of ethical theory (4), in practice, given sufficient time to reflect, they can and will tend to agree on the principles of level 3. Thus a Kantian (like Childress) and a Rule Utilitarian (like Beauchamp) can, will, and in point of historical fact, actually did agree (in crafting the Belmont Report) on the principles of respect for persons, helping them, and treating them justly.

Beauchamp and Childress's anti-engineering model liberated bioethics from interminable philosophical debates over ethical and metaethical theory. For it mattered not which philosophical theory of ethics/metaethics was in vogue at level 4, consensus on principles at level 3 would provide everything needed to address the issues of policy and conduct arising at levels 2 and 1. Moreover, to reiterate the historical fact that informed the foundation of bioethics, on the clinic floor and in the closed chambers of innumerable committees and commissions, bioethicists found themselves repeatedly able to effect consensus. Since Hamlet has no role to play on commissions, or on

the clinic floor, had the new field been hostage to philosophical indecision, it would undoubtedly have been stillborn. Convergence worked. Yet, ironically, now that bioethics has achieved a measure of practical success, today's textbooks propagate the very engineering model of applied ethics that its founders had to reject in order to launch the field.

Another less noticed aspect of Beauchamp and Childress's diagram is that it inverts the presumptions of the engineering model by representing the flow of ideas upwards, from practice to theory. The engineering model inverts this by presuming a unidirectionally downward flow of concepts and principles from theory to practice. Bioethical experience again undercuts the engineering model. Skip past the opening remarks on theory and turn to the index of any standard bioethics textbook. It will immediately be evident that Beauchamp and Childress's upward pointing arrows describe the field. The terms indexed are drawn promiscuously, not merely from ethical theory, but from the clinic, the courts, the sciences and the mass media. Concepts such as "brain death," "capacitation," "surrogacy," and "informed consent" did not originate in ethical theory: neither, for that matter did the concept of "non-maleficence." The very language used in bioethics textbooks thus subverts the engineering model propagated in most of their prefaces.

B. Historical Models of Applying Philosophy: Bacon, Gregory, and Percival

The Kantian dictum, *percepts without concepts are blind*, helps to explain the curious perpetuation of the engineering model in bioethics textbooks, in spite of the evident mismatch between the model and the known facts of bioethics. Textbook editors and writers lack a viable alternative, so they invoke the engineering model in their prefaces for want of a better alternative. History, however, provides alternatives to the rationalist model of applying ethics. In this section I attempt to expand conceptual horizons by discussing a few alternative models of the relationship between ethics and biomedical ethics. Two prefatory remarks are needed. First, I use the expression "biomedical ethics" to designate both the interdisciplinary field of bioethics that emerged in the 1970s, and its precursor, medical ethics – an ethic of doctoring, devised by doctors to regulate their interactions with their patients, their peers, and the public. Second, as a professor at the first college in America to offer an engineering degree, I must protest the disservice that my friend Arthur Caplan inadvertently did to engineering. The rationalist model of applied ethics that Caplan correctly targets for critique has little to do with engineering as it

was actually practiced by such paradigms of engineering as Edison and Steinmetz.

I shall consider, in historical order, three examples of moral philosophy being “applied” to create new forms of medical morality: Baconian blueprints, Gregorian reforms, and Percivalean revolutions. In his 1605 essay, “The Advancement of Learning,” Francis Bacon (1561–1626) drew a blueprint for modern medicine and for its ethics. Bacon recognized that, as practiced in his day, medicine was a feckless occupation capable of little that would prevent, alter, or ameliorate the course or consequences of illness. He had a vision. A more effective medicine that might be achieved, if practitioners were willing to abandon traditional medical and moral practices by basing their art on empirical science and their conduct on moral precepts devised by their peers. Bacon believed that the new scientific medicine should aim at preventing and curing illness, extending human longevity, and relieving suffering in sickness and in death (an idea encapsulated by Bacon’s neologism “euthanasia”³). His vision for a new medicine also encompassed professional self-discipline, and hence a new ethics for medicine based on peer self-regulation.

Bacon’s blueprint was a vision – not theory, not principles, not rules. Yet this vision was extraordinarily influential. It inspired eighteenth-century medical practitioners to create medical colleges and teaching hospitals in places as diverse as Edinburgh, Boston, Leiden, and Philadelphia. Following Bacon’s blueprint, in the course of two centuries, visionary physicians transformed medicine from an ineffective tradition-bound practice to the more effective art predicated upon empirical science that Bacon had envisioned (Haakonssen, 1997). The creators of the new medicine were also inspired by Bacon’s blueprint to integrate the idea of professional self-regulation – which we now call “medical ethics” – into the curriculum of their new medical colleges. It is no accident therefore that medical ethics and modern medicine developed in tandem, since both were integral aspects of Bacon’s blueprint and both inspired the medical enlightenment of the eighteenth century. The point of this example is that one of philosophy’s greatest contributions to medicine, the very idea of modern medical ethics itself, was rooted, not in an argument, or a theory, or a set of principles, but in a philosopher’s vision. Visions, however, are too ethereal to be encompassed by the thin rationalism of the applied ethics engineering model.

John Gregory’s (1724–1773) medicalization of Hume’s (1777, 1902) moral sense theory comes closer to the engineering paradigm case of “applying”

philosophical ethics to medical practice. Yet even in this case, “applying” moral philosophy is more complex than in the rationalist portrayal. Gregory lectured at the Edinburgh medical school (Gregory, 1770, 1772, 1998), offering what are probably the earliest English-language lectures on the subject that we would today characterize as “medical ethics” (that expression would not be coined until 1803 (Percival)). He was a Baconian who expounded on the goals of medicine, the duties of practitioners, and the physician–patient relationship, extolling the ideals of humanity and sympathy. Although the stoic ideal of respecting humanity, in all its forms, had threaded its way through a few of the canonical texts of Western medical morality, Gregory was the first to yoke it to the concept of sympathy.

Marrying humanism to sympathy is a paradigm case of applied ethics; for, as the leading Gregory scholar of our generation, Laurence McCullough, has shown (McCullough, 1998), Gregory’s concept of sympathy was drawn directly from the work of his friend, David Hume (1711–1776). Hume had modeled all moral conduct on emotions, such as sympathy. Gregory borrowed Hume’s concept of sympathy, yoked it to Stoic concepts of humanity and Baconian ideas of science, creating a new ideal: the humanistic physician who balances science with sympathy.

This may be a paradigm case of the engineering model, yet the example also underlines the innovative nature of “applied ethics.” For Hume never wrote about medical ethics, and he never envisioned a connection between sympathy, humanism, and Bacon’s blueprint for medicine. In drawing on Hume’s theory, therefore, Gregory reshaped Hume’s concepts in ways that were novel to Hume and which Hume himself might well have rejected. Hume, for example, nowhere envisioned sympathy as the basis of the physician–patient relationship. His own personal physician, William Cullen (1710–1790), was Gregory’s polar opposite and a partisan, not of sympathy, but of *dispassionate*, scientific medicine.

Make no mistake, Gregory’s fusion of Humean concepts of sympathy to Stoic concepts of humanity was new to Hume and to the Western world. It has no precursor in the entire history of medical ethics. Yet Gregory’s invention is the reason why, even today, we still expect our physicians – but not our accountants, our dentists, our lawyers, or our professors – to have an empathic relationship with us when acting in their professional capacity. In creating this novel concept Gregory did not deduce or specify some principle in Hume to apply it to medical morality. Much as Edison’s did in inventing the light bulb and as Steinmetz did inventing alternating current (AC), Gregory’s “applica-

tion” involved the creation of something entirely *novel*. Thus even in a paradigm case of applying ethics, the applied or practical ethicist turns out to be an innovator whose creations are novel and perhaps even unimaginable by the moral philosopher whose works are “applied.”

An even better illustration of the limits of the engineering model of applied ethics is the creation of “medical ethics” itself. By the end of the eighteenth century, Bacon’s vision had been actualized in the birth of the modern hospital and the concomitant development of clinically based medical education. These innovations fundamentally challenged the received ethic of gentlemanly honor. Like its precursor, Hippocratic ethics, the ethics of honor had served admirably to regulate solo-practitioners. Yet, despite the best efforts of reformers like Gregory, when practitioners tried to collaborate using norms suited to solo practice, they became embroiled in disputes and duels. Individualistic ethics collapsed. Faced with tangible evidence of a breakdown in individual ethics – a staff feud that closed a fever hospital in the midst of an epidemic – Thomas Percival (1794, 1803), a philosopher and physician, suggested an alternative conception, which he dubbed “medical ethics” (Baker, 1993).

In two tracts published in 1794 and 1803, Percival proposed that informal codes of honor predicated on personal character be replaced by formal codes of ethical conduct, predicated upon the concept of professional duty. Since the specifics of professional duty were to be determined by, interpreted by, and enforced by the medical profession acting *collaboratively*, Percival dubbed his new form of ethics, “professional ethics”; since the particular profession he was dealing with was medicine, he characterized his code “medical ethics.” When published in 1803, Percival’s *Medical Ethics; Or, A Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons* was the world’s first code of *medical* ethics and the first code of *professional* ethics; it would serve as the prototype for all later codes of professional and medical ethics (Baker, Caplan, Emanuel, & Latham, 1999b).

Like the authors of standard biomedical ethics textbooks, Percival thought of medical ethics as “applied ethics,” or, more accurately, as “applied moral philosophy.” He appears to have been the second person in the world to have employed the expression “applied moral philosophy.” He borrowed it from his young friend, the Reverend Thomas Gisborne (1758–1846), whose *Principles of Moral Philosophy Investigated and Briefly Applied To the Constitution of Civil Society* (1789) seems to contain the first use of the expression “applied . . . moral philosophy.” In a later work, *An Enquiry into*

the Duties of Men in the Higher and Middle Classes of Society in Great Britain Resulting from their Respective Stations, Professions and Employment (1794), Gisborne adopted a popular literary form, the gentleman's handbook, to the more serious task of envisioning the implications of a Lockean social compact for the moral duties of persons according to their "stations, professions and employment": magistrate, justice of the peace, lawyer, and physician. The *Enquiry* was thus a systematic attempt to work out the practical implications of a philosophical theory, specifically John Locke's (1690) social compact, for the morals of "men in the higher and middle classes of society." Gisborne was clearly "applying" an idea drawn from Locke. However, much like Gregory's adaptation of Hume, Gisborne "applied" Locke's idea of a social compact in areas and in ways that Locke himself had never envisioned (and may not have agreed with).⁴

In drafting *Medical Ethics*, Percival was following the precedent laid down by his younger colleague Gisborne. However, while Gisborne was self-consciously attempting to "apply" Locke's social compact to develop a practical account of class/professional duties, Percival, while drawing inspiration eclectically from Cicero, Gregory, Gisborne, and John Aiken (1747–1822), was *not* applying any particular principle, idea, concept or theory from their works. Like many contemporary bioethicists, and unlike Gregory and Gisborne, Percival's medical ethics was thus "applied" not in the sense that he was attempting to put some moral philosopher's ideas into practice, but only in the sense that it dealt with *practical* issues rather than with theory. From birth, therefore, medical ethics was *not* an attempt to "apply" any specific concept, idea, precept or principle (e.g., the concept of sympathy, or the idea of the social contract) drawn from moral philosophy to the practical questions of medical ethics, it was rather an attempt to devise a systematic account of an alternative to the then received concepts of medical morality.

Percival's *Medical Ethics* also departed from earlier precedents in its codified format, and its voice. The voice of Gisborne's *Enquiry* is the first and second person singular, the traditional voice of the gentleman's handbook and of medical morality. In his codes, however, Percival writes about "physicians" in the third person singular and plural, abandoning the first and second person voice in which medical morality had traditionally been articulated from the Hippocratic Oath through Gregory. Percival's shift was not required by codification, since codes can be written as a matter for "I," "thou," "you" and "we." He appears rather to have sought a voice that would fit the idea of collaborative ethics that was emerging from the new forms of communal

moral life necessitated by hospitals. His use of the third person thus fits with his efforts to legitimate norms of collaborative decision-making by ethics committees, institutional review boards, medical records, outcomes analysis, and rounds (all of which are discussed in his 1803 code). And, not unnaturally, since collaborative forms of life continued to dominate modern professional medical practice, the voice of professional medical ethics has continued to be the third person.

Despite Percival's innovations in voice and format, an adherent of the engineering model might suggest that, insofar as Percival was influenced by Gisborne, he was really "applying" Locke, second hand, so to speak. The problem with this reading is that, as mentioned earlier, Gisborne's "applied moral philosophy" drew on precepts never expressly stated by Locke (much as Norman Daniel's writings (1985) are inspired by Rawls' theories, but extend them in directions Rawls himself never envisioned). Percival was thus inspired by the innovations of his applied ethicist peer, *not* by anything directly in Locke, or in any other philosopher. The point to appreciate is that, from its inception, "applied ethics" appears to have been a self-reinforcing activity, sometimes inspired by, but nonetheless independent of, moral philosophy *per se*.

Much the same relationship obtains between bioethics and moral philosophy today. Peruse the bibliographies in the latest volume of this or any other leading bioethics journal. It will immediately be evident that, while there are abundant citations of other bioethics journals and of medical, legal and public policy journals, there are remarkably few citations from *Ethics*, *Philosophy and Public Affairs* and other leading ethics or philosophy journals. The absence of references suggests that bioethicists today—much like Percival, the founder of "medical ethics"—tend to be influenced more than by the work of their applied ethicist peers than by moral philosophers or ethical theorists. Whatever the sense in which biomedical ethicists "apply" ethics and philosophy, it appears that it never was the simple, direct sense of "application" envisioned in the engineering model.

The complex interconnections between Locke, Gisborne, and Percival, or between Bacon, Hume, and Gregory, or between Gregory and Percival (or between Rawls and Daniels, or—since this essay is also a form of "applied philosophy"—between Kuhn and Baker) elude the rigid rationalism of the engineering model. They need not, however, elude the authors and editors of introductory bioethics textbooks, who can and should discuss how visionary philosophical blueprints can inspire, how applied ethicists innovate using

philosophical models, and how they influence each other to envision, to propose, to critique, and to experiment with alternative forms of moral life. These are the sorts of discussions that should enliven the prefaces and introductions of bioethics textbooks and bioethics pedagogy – but they are notoriously absent at present.

IV. RATIONALISM'S REPLY: SOME FURTHER CONSIDERATIONS

To paraphrase Kuhn, I have been urging “a quite different concept of [bioethics that] can emerge from the [analysis of the] historical activity itself.” Someone wedded to a rationalist model of ethics might object that the historically grounded conception of bioethics that I propose would turn the field away from its foundational core in philosophical ethics. Bioethics should be a form of *ethics*; thus, a critic might contend, bioethics ought properly to be about “oughts,” not about what is, much less about what once was and “has been.” In replying, I offer a few pedagogic exercises to suggest how historical exploration can deepen our appreciation of ethics, even as it assists bioethicists to navigate safely between the twin shoals of rationalism and historicism.

A. Transcendent Rationalism and the Challenge of Moral Change

As Friedrich Nietzsche remarks in the ur-text for all historical investigations of morality, *The Genealogy of Morals*, norms may persist through the ages, but their justification characteristically changes to suit the style of each era.

There is no set of maxims more important for an historian than . . . that everything that exists, no matter what its origins, is periodically reinterpreted. . . in terms of fresh intentions. . . in the course of which earlier meaning and purposes are necessarily either obscured or lost. . . . The whole history of a custom, [thus] becomes a continuous *chain* of reinterpretations and rearrangements

I have emphasized this point of historical method all the more strongly because it runs counter to our current instincts and fashions. (Nietzsche, 1967, pp. 209-210)

One can teach Nietzsche's maxim to bioethics students by means of a simple exercise, which (I know from experience) is as well suited to junior

high school students, as it is to senior academic and medical faculty, including administrators, nurses, and physicians. The exercise requires “students” to track a single norm from the Hippocratic Oath, through the latest editions of the AMA Code of Medical Ethics, to Beauchamp and Childress’s *Principles of Biomedical Ethics*. The exercise thus permits students to discover for themselves the poles of Nietzsche’s maxims: the phenomenon of “normative conservatism,” and the related phenomenon of continuous reinterpretation.

Consider, for example, two of the most highly conserved norms in Western medical ethics: the prohibition of practitioner–patient sexual relations, and the norm of confidentiality. Intriguingly, while confidentiality is defended just as vigorously in the latest edition of Beauchamp and Childress (2001) as it was by the Hippocratics. As Nietzsche’s maxim suggests, the justificatory reasons adduced on behalf of the norm vary. Greek physicians justified confidentiality in terms of a pledge to their gods and an undertaking to live a pure and holy life. Beauchamp and Childress, invoke the principles of biomedical ethics – including autonomy/privacy, fidelity and various consequentialist concerns (Beauchamp & Childress, 2001, pp. 303–308). The norm is conserved, even as it is reinterpreted and as justifications advanced to legitimate it change over time.

The phenomenon of justificatory variation tends to subvert rationalist accounts of morality. As Nietzsche puts the point, “it runs counter to our current instincts and fashions.” This observation applies as readily to bioethics textbook prefaces, as it did to the rationalist accounts of morality in Nietzsche’s day. What unsettles rationalists is the implication that norms may be accepted on grounds that are *independent* of the reasons given to justify them. Norms may thus be primary and may be conserved by being “rationalized” in terms of *whichever* conception of ethics happens to be in vogue in a particular era. Justificatory variation thus threatens to undermine the rationalist’s instinct to make reasoned argument the focal point of morality. While this is a theoretically rich observation, the point being made here is that a simple historical exercise, easily conducted with bioethics “students,” at all educational levels, provokes fundamental questions about the nature of biomedical ethics – indeed, about the nature of ethical justification generally. Historical inquiry into medical ethics, properly conducted, does not distract from normative inquiry; it enriches it by contextualizing the abstruse, even as it provokes new avenues for philosophical inquiry.

B. The Philosophical Suggestiveness of History

Kuhn's observation that understanding history will alter our conception of the subject matter of philosophy is as apt for biomedical ethics as it is in the philosophy of science. Consider normative conservatism. The phenomenon could be read as evidence for moral realism (just as I.B. Cohen's analysis of the conservation of laws in scientific revolutions can support scientific realism⁵). Realists could claim that the norms are highly conserved just insofar as they approximate to moral truths. Truths may be justified differently in differing ethical frameworks, but truth remains truth nonetheless.⁶ Notice that even superficial historical analysis can suggest interesting philosophical possibilities. To reiterate, instead of leading bioethics away from philosophy, as the rationalists fear, historical analysis opens the door to new modes of philosophical reflection.

In my own work, I draw on the phenomena of norm conservation and normative reinterpretation to support a contractarian analysis of medical morality (see Baker 1998a, 1998b). On some contractarian perspectives, norms can be interpreted as negotiated resolutions to conflicts of interest or values that are mutually acceptable to the parties affected. Highly conserved norms can thus be viewed as representing effective mechanisms for resolving persistent conflicts. Consider again the norms of asexuality and confidentiality. These norms arose when Greek medicine turned from Aesclepiadic magico-religious healing, based on dream interpretation, to physical interventions based on physical examination of the body. Hippocratic physical examination techniques, such as palpation, breached norms of intimacy, not only between males and females, but also (given the prevalence of male homosexual relations) between males and males. A contractarian analysis suggests that norms of asexuality and confidentiality were thus invented to render permissible otherwise prohibited access to peoples' bodies and to the personal information found in their homes. These norms continue to persist because Western medicine still requires access to intimate spheres, and thus still confronts norms regulating intimacy.

One need not pursue these possibilities much further to appreciate the point that the integration of historical analysis into bioethics does not impoverish its philosophical foundations. History merely offers more robust phenomena for analysis, which have the additional advantage of being grounded in fact rather than rationalist imaginings. What virtue is there, after all, in philosophical, moral, or ethical theories that cannot be reconciled with the actual history of ethics and morality, medical and non-medical?

C. History as a Foil for Historicism

Integrating history into bioethics has a further virtue: it immunizes the subject against historicism. Justificatory variation poses a problem for rationalists because they embrace a conception of reason transcending time and culture. The classical foil for rationalism is historicism: the leap from the fact that legitimating reasons have historically changed over time to the fallacious conclusion that this variation impugns the validity or rationality of norms and/or of their justifications. Unfortunately, historians of medicine often advance historicist readings of medical ethics, deploying the phenomenon of justificatory variation for deflationary ends. They frequently suggest, for example, that the variable nature of reasons offered in justification of the norms of medical ethics means that a norm's real purpose is to serve as a fig leaf for professional power and privilege. Ethical reasoning is thus reduced to the role of rhetoric designed to gull the public into accepting the social power and privilege of the profession (see, for example, Berlant, 1975; Starr, 1982; Waddington, 1975).

In fact, the history of medical ethics provides scant support for historicism (see Baker, 1993, 1995, 1999; Baker & Emanuel, 2000). One need not accept the transcendent rationalism of bioethics textbooks to reject the irrationalism of historicism. Moral frameworks can be rational without being grounded in transcendent reasons. Contractarian philosopher, T.M. Scanlon, for example, characterizes a moral framework as *irrational* when "attitudes fail to conform to . . . judgments: when, for example, a person continues to believe something (continues to regard it with conviction and to take it as a premise in subsequent reasoning) even though he or she judges there to be a good reason for rejecting it" (Scanlon, 1998, p. 25). Thus, were the reasons cited in medical ethics mere propaganda directed at others, were they non-rational or irrational in the ways that historicists' suggest, one would expect medical practitioners to ignore these norms when it suited their interests. In point of historical fact, ethical reasons have typical constrained professional conduct.

Consider fee splitting. Were medicine a trade, commissions, rebates, and referral networks would be irreproachable practices. The business world thrives on "fee splitting," in the form of commissions and rebates. Every automobile manufacturer recommends its own dealers and its own brand name replacement parts. When the American Medical Association adopted its Code of Ethics in 1847, however, it rejected the rule of *caveat emptor* and claimed instead to place patients' interests above practitioners' personal and financial advantage (Baker, 1995, 1999). Thus, one way to assess

historicist readings of medical ethics is to ask: Did the AMA's ethical commitments, actually constrain its members' conduct with respect to fee splitting?

Questions about commissions and secret fee splitting did not arise in American medicine until the end of the nineteenth century, when medical specialties became commonplace. The issue was first raised before the AMA in 1900. As if acting the role scripted by historicists, the AMA *rejected* a resolution to condemn secret "commissions or a division of fees under whatever guise it may be made." The stated reasons were practical. The AMA realized that members were fattening their bank balance at the expense of their patients but, as a practical matter, "it would be impossible for this Association to get at the truth. . . on all such questions" (House of Delegates, 1900a, 1900b, pp. 1553, 1557, 1559). Had the matter ended there, it would have provided strong evidence for the historicists' deflationary reading of professional ethics. Within two years, however, the AMA's House of Delegates devised a practical way of investigating complaints of fee splitting – turning the investigations over to county medical societies.⁷ However, fee splitting was a lucrative practice and eradication proved difficult. Ten years later, the AMA had to launch an in-depth multi-year investigation into commissions and fee splitting. The investigation led to new rules permitting the national society to expel "any member receiving commissions or rebates" from "instrument houses or houses dealing with medical supplies" (House of Delegates, 1912a, pp. 11, 45; 1912b, p. 1661). Yet this power was limited because the prerogative of investigating fee splitting remained with the local societies, which were reluctant to investigate their own members.

In 1924 the AMA cracked down on "county societ[ies] found to enroll so many fee-splitting, or otherwise unethical, members as to render it impossible for that society to enforce the ethical standards of the medical profession" (House of Delegates, 1924, pp. 21-22, 40). From this point onward the AMA extended the campaign against self-referral to encompass physician-owned diagnostic laboratories, healthcare appliance outlets, pharmacies, as well as hospitals, and home health agencies in which physicians had a financial interest. It also continued its campaign against the direct physician dispensing of drugs, traditional fee splitting, and commissions or rebates for "steering" patients to specific commercial organizations and laboratories (Baker & Emanuel, 2000). After the 1970s, in the post-Medicare, Medicaid, and managed care era, the revenue stream, and hence the more lucrative opportunities for misappropriating funds, lay elsewhere and the problem of "fee-splitting"

subsided (although, with the emergence of managed care the inverse problem of non-referral arose to take its place).

The question before us is whether the AMA's stand on fee-splitting was empty rhetoric, as historicists would contend. Measured by Scanlon's standard, it is clear that the AMA consistently acted in accordance with its proclaimed ethical standards, maintaining its commitment to this standard, even at the expense of its members' bank accounts. In this case – and similar cases are legion – the standard historicist reading of professional medical ethics is unsupported by the evidence. Although there is nothing transcendent about the AMA's ethics, it is clear that the ethical standards that the organization proclaimed acted as constraints on its own conduct and on that of those practitioners who were members. This is but one example of how a careful study of the history of medical ethics can serve as an anodyne to historicist skepticism about the role of medical ethics (and its heir, bioethics).

V. ON HISTORY AND ETHICS: SOME CONCLUDING REMARKS

In this essay I have argued that historical analyses of the “application” of moral philosophy are richer and more insightful than the rationalist imaginings of the engineering model presumed by most textbooks of applied ethics and of bioethics. I have, to paraphrase Kuhn, tried to sketch the quite different, deeper and richer conception of bioethics that can emerge from an historical analysis. The moral world of medicine sketched here is one of continual debate, of reformers and reactionaries, of revolutions and reactions, of progress and regress. It is a world that philosophers have played a pivotal role in shaping, and that they can shape best if they understand the historical contexts in which their ideas have proven influential and successful.

As I noted in the last section, some might object that ethics addresses the ideal, it deals with what ought to be, not with what is, much less what has been. Such outmoded professional shibboleths should be rejected. We do not consider anyone knowledgeable about ethics if s/he lacks a rudimentary acquaintance with the ideas of great ethicists of the past, Aristotle, Kant, or Mill. Why should not the same criteria hold in “applied ethics”? How can anyone claim to be knowledgeable about biomedical ethics if they are ignorant of Bacon, Gregory, Percival, Gisborne – or the Nuremberg Code, or the Belmont Report? If, as bioethicists, or applied ethicists, we claim to advise others about how to negotiate the “challenges of biomedical technology,” how

can we willfully cultivate ignorance of the success – and failure – of past attempts to negotiate moral change? If the unexamined life may not be worth living, then, in much the same way, advice given by historically uninformed bioethicists may not be worth having. Perhaps the best way to educate the next generation of bioethicists is to introduce them to the subject through textbooks that are well informed about the history of medical ethics and bioethics.⁸

NOTES

1. An earlier draft of this paper, “The Role of History in Teaching Biomedical Ethics” was presented at the session on “Philosophical Challenges in Teaching Bioethics,” at the Ninety-Sixth Annual Meeting of the American Philosophical Association (Eastern Division) in Boston, December 28, 1999. I am grateful to Laurence McCullough for inviting me to participate in the session. The current version of the paper has been refined in response to formal comments from my respondent, Rosamond Rhodes, and perceptive informal comments by Bernard Gert and Richard Momeyer.
2. The problem centered debate format became popular in ethics textbooks after the publication of Richard Wasserstrom’s *Today’s Moral Problems* in 1975.
3. Bacon’s neologism, “euthanasia,” was as vague as his vision. He never explained whether he meant hospice-style medically managed painless death, or Dutch-style physician administered life-terminating interventions.
4. Haakonssen (1997) dissents from this reading of Gisborne; her reading of Gisborne was challenged in Baker (1996).
5. Although Kuhn rejected the logical empiricist model of scientific theories, he inherited their conception of scientific laws as logical expressions of theories. Consequently, in his more radical moments, Kuhn tended to suggest radical discontinuities in scientific laws, holding that they were redefined during revolutionary changes in theory. In contrast, Cohen documented the historical continuity of laws – even through revolutionary change – thus supporting the argument that laws may be validated independently of the paradigms that justify them (Cohen, 1985). I am suggesting something similar in this paper.
6. Moral realism is “the view that moral statements are true or false, independently of individual or cultural opinions about their truth or falsity” (Boyd, 1998, p. 182). Moral realism has not been prominent in bioethics.
7. County medical societies were empowered to expel any members found “guilty of division of fees [i.e.] either the giving or receiving of part of a fee without the full knowledge of the patient” (House of Delegates, 1900a; 1912b, p. 1661).
8. To provide the foundations for a historical approach to bioethics, I am working with my friend Larry McCullough on a series of projects. The first of these (generously supported by the National Endowment for the Humanities Collaborative Research Division and by the Earhart, Greenwall, Littauer and Milbank Memorial foundations) is our co-edited *History of Medical Ethics*, a collaboratively authored global history of medical ethics to be published by Cambridge University Press in 2003.

REFERENCES

- Ahronheim, J.C., Moreno, J.D., & Zuckerman, C. (2000). *Ethics in clinical practice* (2nd ed.). Gaithersburg: Aspen Publishers.
- American Medical Association. (1999). *Code of medical ethics: Current opinions with annotations, 1998–1999*. Chicago: American Medical Association.
- Bacon, F. (1623, 1868). De augmentis scientiarum (Of the dignity and advancement of learning). In: J. Spedding, R. Ellis, and D. Heath (Eds.), *The works of Francis Bacon, Baron of Verulam, Viscount St. Alban and Lord High Chancellor of England* (Vol. IV). London: Longman.
- Baker, R.B. (1993). Deciphering Percival's code. In: R. Baker, D. Porter, and R. Porter (Eds.), *The codification of medical morality: Historical and philosophical studies of the formalization of medical morality in the eighteenth and nineteenth centuries* (pp. 179–212). Dordrecht: Kluwer Academic Publishers.
- Baker, R.B. (1995). *The codification of medical morality: Historical and philosophical studies of the formalization of medical morality in the eighteenth and nineteenth centuries*. Vol. II: *Anglo-American medical ethics and medical jurisprudence in the nineteenth century*. Dordrecht: Kluwer Academic Publishers.
- Baker, R.B. (1996). Recent work in the history of medical ethics and its relevance to bioethics. *American Philosophical Association Newsletters*, 96, 90–97.
- Baker, R.B. (1998a). Multiculturalism, postmodernism and the bankruptcy of fundamentalism. *Kennedy Institute of Ethics Journal*, 8, 210–231.
- Baker, R.B. (1998b). A theory of international bioethics. *Kennedy Institute of Ethics Journal*, 8, 233–274.
- Baker, R.B. (1999). The American medical ethics revolution. In: R.B. Baker, A. Caplan, L. Emanuel, and S. Latham (Eds.), *The American medical ethics revolution* (pp. 17–51). Baltimore: Johns Hopkins University Press.
- Baker, R.B. (2001). Transplantation: A historical perspective. In: W. Shelton (Ed.), *Advances in bioethics: Volume 7: The Ethics of Organ Transplantation* (pp. 1–42). London: Elsevier Science Publications.
- Baker, R.B., Caplan A., Emanuel L., & Latham S. (1999). Introduction. In: R.B. Baker, A. Caplan, L. Emanuel, and S. Latham (Eds.), *The American medical ethics revolution* (pp. xiii–xxxix). Baltimore: Johns Hopkins University Press.
- Baker R.B., & Emanuel, L. (2000). The efficacy of professional ethics: The AMA code of ethics in historical and current perspective. *Hastings Center Report*, 30, S13–S17.
- Berlant, J. (1975). *Profession and monopoly: A study of medicine in the United States and Great Britain*. Berkeley: University of California Press.
- Beauchamp T.L., & Childress J.F. (1979, 1983, 1989, 2001). *Principles of Biomedical Ethics* (1st through 5th eds.). New York: Oxford University Press.
- Beauchamp, T.L., & Walters, L. (1994). *Contemporary issues in bioethics* (4th ed.). Belmont, CA: Wadsworth Publishing Company.
- Boyd, R. (1998). How to be a moral realist. In: G. Sayre-McCord (Ed.), *Essays on moral realism* (p. 182). Ithaca, NY: Cornell University Press.
- Boylan, M. (2000). *Medical ethics*. Upper Saddle River: Prentice Hall.
- Brock, D.W. (1987). Truth of consequences: The role of philosophers in policy-making. *Ethics*, 97, 786–791.

- Cohen, I.B. (1985). *Revolution in science*. Cambridge, MA: Harvard University Press.
- Daniels, N. (1985). *Just health care*. Cambridge, England: Cambridge University Press.
- Engelhardt, H.T., Jr. (1996). *The foundations of bioethics* (2nd ed.). New York: Oxford University Press.
- Gisborne, T. (1789). *Principles of moral philosophy investigated and briefly applied to the constitution of civil society*. London: B. and J. White.
- Gisborne, T. (1794). *An enquiry into the duties of men in the higher and middle classes of society in Great Britain resulting from their respective stations, professions and employment*. London: B. and J. White.
- Gregory, J. (1770, 1772, 1998). *John Gregory's writings on medical ethics and the philosophy of medicine* (L. McCullough, Ed.). Dordrecht: Kluwer Academic Publishers.
- Haakonssen, L. (1997). *Medicine and morals in the Enlightenment: John Gregory, Thomas Percival and Benjamin Rush*. Amsterdam: Editions Rodopi.
- House of Delegates on the American Medical Association. (1900a, 1902a, 1912a, 1924). *Proceedings of the House of Delegates*. Chicago: American Medical Association.
- House of Delegates of the American Medical Association. (1900b, 1902b, 1912b). *Report*. Chicago: American Medical Association.
- Hume, D. (1777, 1902). *Enquires concerning human understanding and concerning the principles of morals* (2nd ed., L. Selby Bigge, Ed.). London: Oxford University Press.
- Jonsen, A. (2001). Beating up bioethics. *Hastings Center Report*, 31, 43.
- Jonsen, A.R., Siegler, M., & Winslade, W. (1997). *Clinical ethics* (4th ed.). New York: McGraw-Hill.
- Kuhn, T.S. (1970). *The structure of scientific revolutions*. In: International Encyclopedia of Unified Science (Vol. 2, number 2). Chicago: University of Chicago Press.
- Kuhse, H., & Singer, P. (1999). *Bioethics: An anthology*. Oxford: Blackwell Publishers.
- Locke, J. (1690, 1967). *Two treatises of government* (P. Laslett, Ed.). Cambridge: Cambridge University Press.
- McCullough, L.B. (1998). *John Gregory and the invention of professional medical ethics and the profession of medicine*. Dordrecht: Kluwer Academic Publishers.
- National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. (1978). *The Belmont report*. Washington, DC: DHEW Publication No. OS 78-0014.
- Nietzsche, F. (1967). *Birth of tragedy and on the genealogy of morals* (W. Kaufman, Ed. and Trans.). New York: Anchor Books.
- Nussbaum, M.C. (1997). *Cultivating humanity: A classical defense of reform in liberal education*. Cambridge, MA: Harvard University Press.
- Pence, G. (1990, 1995, 2000). *Classic cases in medical ethic: Accounts of cases that have shaped medical ethics, with philosophical, legal and historical backgrounds*. New York: McGraw Hill.
- Percival, T. (1794). *Medical jurisprudence; Or, a code of institutes and precepts, adapted to the professional conduct of physicians and surgeons*. Manchester, (UK): For private circulation.
- Percival T. (1803). *Medical ethics; Or, a code of institutes and precepts, adapted to the professional conduct of physicians and surgeons*. London: J. Johnson.
- President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. (1983). *Deciding to forego life-sustaining treatment*. Washington DC: U.S. Government Printing Office, 83-600503.

- Roe v. Wade (1973). *Supreme Court Reporter*, 93, 410 US 151.
- Scanlon, T.M. (1998). *What we owe to each other*. Cambridge: Harvard University Press.
- Starr, P. (1982). *The social transformation of American medicine*. New York: Basic Books.
- Teays, W., & Purdy, L. (2001) *Bioethics, justice, & health care*. Belmont: Wadsworth/Thomson Learning.
- Waddington, I. (1975). The development of medical ethics – a sociological analysis. *Medical History*, 19, 36–51.
- Wasserstrom R. (1975). *Today's moral problems*. New York: Macmillan.
- Zucker, A., Borchert, D., & Stewart, D. (1992). *Medical ethics: A reader*. Englewood Cliffs, NJ: Prentice Hall.