

INDIVIDUAL GOOD AND COMMON GOOD

a communitarian approach to bioethics

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ABSTRACT The field of bioethics emerged in the late 1960s and early 1970s. Among its early issues were the protection of human research subjects, the rights of patients, abortion, and reproductive issues. Partly as a reflection of the times, and of those issues, the field became focused on autonomy and individual rights, and liberal individualism came to be the dominant ideology in the 1980s and 1990s. Communitarianism, as an alternative ideology focused more on the common good and the public interest than on autonomy, was a neglected approach. But many bioethical issues can not reasonably be reduced to questions of individualism and choice only. Issues of genetics and reproduction will of necessity touch on the society as a whole, its values, and its social institutions. Serious ethical analysis must take the social implications seriously and not simply assume that they should be left to autonomous choices of individuals. Human beings are social animals and our nature is distorted if we think of ourselves only as co-existing social atoms. Various approaches to communitarianism are outlined, and the question of the relationship between individual good and common good is confronted.

WHEN THE FIELD OF BIOETHICS began to emerge in the late 1960s and early 1970s, one of the first questions to surface was that of its ethical foundation. The earlier, historical field of medical ethics rested either on a theological

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base, stemming from various religious perspectives, or, much further back in time, on the professional obligations of the physician to the patient and to the profession, embodied in what we think of as the Hippocratic tradition.

The new bioethics, however, needed to find a way to speak in a secular culture, drawing on nonreligious premises, and to encompass a far wider range of medical and biotechnology issues than that of the doctor-patient relationship. The question then became: what ought to be the foundational principles, premises, and perspectives of this new venture? Two answers were quickly forthcoming. One was that the ethical foundations of the field should not be idiosyncratic to its particular issues but should be understood simply as an arena for the application of more general ethical principles and analysis. The other was just the opposite: bioethics should have its own moral basis, suitable to its particular subject matter.

That debate sputtered out by the end of the 1970s, never formally resolved but de facto influenced by the growing number of philosophers drawn to bioethics and prone to import into it the modes of reasoning common to the moral philosophy of the era. Most textbooks and classroom readers in bioethics came to open with an introduction to philosophical ethics, which usually turned out to be an inventory of the familiar philosophical theories of utilitarianism, deontology, natural law thinking, and the like. The idea that there is distinctive biomedical ethic all but disappeared from the inventory.

Two important developments since that time bear on the foundations of bioethics. The first is a general decline of interest in foundational matters—even though, for those who remain interested, there have been new theoretical models added to the older ones, such as feminist and narrative ethics. By “foundational matters,” I mean broadly comprehensive theories of a kind symbolized by the arguments between utilitarians and deontologists. There nonetheless remains, at a somewhat lower level, a lively interest in the place of rules and principles, the balancing of universality and contextuality, and the virtues pertinent to patient care.

Although textbooks and readers still have introductions to ethical theory, it is striking how the majority of articles selected for inclusion in the readers are in fact devoid of the direct employment of any of those theories. They may be there tacitly, but it is rare to find them openly used to solve ethical problems. An examination of, say, the case studies carried for over 30 years now in the *Hastings Center Report* reveals a similar phenomenon. In both instances, the main characteristic is the lack of a conspicuous theory. The articles and case studies are, in that respect, all over the place in their analysis, marked by many strengths and charms (if any good at all), but theory is rarely prominent. While “principlism” (the view that four moral principles—autonomy, non-maleficence, beneficence, and justice—are sufficient to deal with most moral problems in medicine) still raises its head now and then, its numerous critics have taken much of the wind out of its sails (Beauchamp and Childress 2001).

The second development is not unrelated to the first, but moves in a different direction. It might best be characterized as the almost complete triumph of liberal individualism in bioethics. I call this an ideology rather than a moral theory because it is a set of essentially political and social values brought into bioethics, not as formal theory but as a vital background constellation of values. If it does not function as a moral theory as philosophers have understood that concept, it is clearly present and pervasive as a litmus test of the acceptability of certain ideas and ways of framing issues. As a familiar constellation it encompasses a high place for autonomy, for biomedical progress with few constraints, for procedural rather than substantive solutions to controverted ethical problems, and for a strong antipathy to comprehensive notions of the human good.

As a practical matter, the triumph of liberal individualism has led to a systematic marginalization of religious and conservative perspectives, often treated with disdain and hostility; and it has brought to bioethics the cultural wars from which it had earlier been spared. Bioethicists are increasingly labeled as “liberal” or “conservative,” and the nastiness and partisanship of the broader political scene has begun to make its appearance (though mainly from the conservative side; liberals seem too indifferent to conservatives to care what they say). It is exceedingly rare to find ethical conferences or symposia that are not dominated by one side or the other, usually unwittingly (our congenial crowd), but sometimes consciously.

Many liberals were distressed that a conservative, Leon R. Kass, was appointed in 2001 to direct President Bush’s Council on Bioethics, and that most of the Council members were of a similar persuasion. But each of the three earlier national bioethics commissions had liberal directors and predominantly liberal members, though that had been hardly noticed in the press, much less complained about, presumably because it was taken for granted. As it turned out, the Bush Council showed far more ethical variety and lack of consensus in its work on cloning than had been true of any of the other commissions; more than lip service has been paid to diversity (President’s Council on Bioethics 2002). I was not proud of my field when I heard the first question of a prominent science reporter who called me in the summer of 2001 about the stem cell debate. “Why is it,” she asked, “that everyone in bioethics is in lock step on stem cells?” A good question, to which I had no ready answer—at least none I was prepared to be quoted on.

I have tried to briefly lay out this historical background in order to set the stage for the two central points I want to make in this paper. The first is the contention that bioethics needs no formal foundations, if for no other reason than that it is, and ought to be, an interdisciplinary field, drawing upon many disciplines for its intellectual resources. No one discipline, whatever its foundation, can claim a privileged place. Of course, it is the lack of formal foundations that dooms interdisciplinary fields to the frowns of disciplinary purists, but that can be survived if some other traits are in place. The traits I believe are most important for bioethical inquiry are, on the one hand, determining the right set of

questions to ask and issues to pursue; and, on the other, pursuing them with rationality, imagination, and insight. If that is done, people will listen and progress can be made.

My second contention is that liberal individualism needs a strong competitive voice, one that can be found in communitarianism. In addition to fomenting cultural wars, liberal individualism does not have the intellectual strength or penetration to deal effectively with the most important bioethical issues. Its “thin theory” of the good is a thin gruel for the future of bioethics.

ASKING THE RIGHT QUESTIONS

Contemporary bioethics took its rise from the advances in biomedical knowledge and technological innovation that marked the postwar years and that showed the inadequacy of the older medical ethics to encompass the new issues. I have found it helpful to categorize the issues into three parts, reflecting the impact of the new developments. Each category suggests some fundamental questions for bioethics.

First, scientific knowledge and its practical applications have forced a change in our vision of the goals and purposes in medicine, not simply moving from care to cure, and from palliation to the saving of life, but also showing the possibility of using medical knowledge and techniques only indirectly related, if at all, to the preservation of health traditionally understood; and, at the outer edge, bringing the possibility of an enhancement of human nature and traits into view. That has left us with the question: what are the proper goals and uses of medicine?

Second, scientific knowledge and its applications have led us to reexamine the meaning of health. As a concept, “health” has always had a descriptive component, referring to various biological characteristics of the body and mind and the pathologies that can affect them, and a normative component, referring to the human desire for good health and the related fear of illness and disease. While it would be stretching things to say that health has been redefined recently (debates about its meaning are old and well developed), it does seem evident that the practical standards for what counts as good health, and the attendant expectations for it, have considerably escalated of late.

What was tolerable health earlier—or if intolerable, then fatalistically accepted—is increasingly often now rejected. Why should we suffer from old age, or cancer or heart disease, or simply a less than perfect face? If research can be brought to bear on what ails us, or even just displeases us, then it ought to be pursued; and, best of all, past research success is taken to guarantee future success (exactly the opposite of the Security and Exchange Commission’s required warning on the purchase of stocks and bonds). Since the reality of, and expectations about, health are a significant determinant of our overall sense of well-being, we are then left with the question: what are realistic expectations for our health and what kind of research should we support to achieve it?

Third, the technological developments have led us to what seems to me the most important matter of all: we have been led to reconsider, in the light of biomedical progress, what it means to live a life and to think about the nature of our human nature. Effective contraception has helped change the role of women, the procreation of children, and the significance of sexuality. Advances in the health of the elderly have meant changes in the place of old age in the individual life cycle (and what counts as “old”) and in the place of the elderly in our social order. Genetic technologies open up new prospects for choosing the traits of our children, and thus affect both the parent-child relationship and the meaning of parenthood. What do we want to make of ourselves as human beings, and what kinds of lives ought we aspire to live?

I don't mean to suggest here that biomedical developments will be the sole determinants of how we may shape our ideas of medicine, health, and the ordering of our lives. Not only will those three categories interact with and affect each other, but they will also take place in the context of developments in information theory, environmental trends, bioterrorism and new natural pathogens, economic and urban life, and so on. Predicting the outcome of so complex a mix is next to impossible, and predicting the mix of moral, social, and political values that will animate them is no less difficult.

At the same time, it is not a threat to liberty to say that liberal individualism is poorly equipped to help us as human communities develop the moral perspectives to deal with the resulting complexity. Liberal individualism's greatest weakness is what is often thought its greatest strength: eschewing a public pursuit of comprehensive ways of understanding the human good and its future. But it takes an act of arbitrary imagination to see how the principle of autonomy, at the core of individualism, or that of market values as its ideological conservative twin, can provide any helpful guidance. Only if one believes in some version of an “invisible hand” shaping our individual goods into a common good, can that view be made plausible. The inescapable reality of the kinds of changes that biomedical progress introduce is that they affect our collective lives, our social and educational and political institutions, as well as those tacitly shared values that push our culture one way or the other.

As an individual, I need to make choices about how I will respond to those changes. But more important, *we* have to make political and social decisions about which choices will, and will not, be good for us as a community, and about the moral principles, rules, and virtues that ought to superintend the introduction of new technologies into the societal mainstream. Only if we believe that there will be no socially coercive or inadvertent culture-shaping consequences of present and forthcoming medical technologies can we deny the need to take common, and not just individual, responsibility for the deployment of a biomedicine that can change just about everything in our lives.

ANALYTICAL VIRTUES

Bioethics can survive and even flourish in the absence of any formal or agreed-upon foundations. But it cannot do without a set of intellectual skills that will enable its leading questions to be approached in the richest and deepest way possible. My list of such skills would include rationality, imagination, and insight. Rarely will any one of them be adequate by itself; typically, each should come into play to enhance the possibility of a comprehensive judgment. Although I cannot do justice to each of those skills here, I will try to indicate a general direction for each of them.

Rationality

While rationality is obviously important for those of us who think of ourselves as rational animals, it is a complex idea. Nothing is less helpful, I have observed, than moralistically urging people to be rational, as if that is the definitive answer to prejudice and wayward emotions. Rationality is often, of course, taken to be synonymous with the use of scientific knowledge (positivism, long moribund, never quite dies); or with being objective (more easily said than done, and almost always morally contestable); or with thinking consistently (as if that guarantees anything other than consistency); or with making logical moves from premises to conclusions (which anyone of ordinary intelligence can do).

The great problem in bioethics as elsewhere is getting the right premises and points of rational departure, and no one has ever proposed good procedures for doing that. In any case, it is by no means easy to think well, especially about those bioethical issues that are new and whose understanding cannot readily draw on accumulated human experience. Nor is it easy for any of us to see how our tacit political and social ideologies, lurking just below the surface, are pulling the strings of our "rational" thought. Being right and being rational are not necessarily synonymous. The careful and painstaking analysis characteristic of good philosophical work is no guarantee of reasonable outcomes, though it can certainly (and sometimes misleadingly) give that impression. Some very bad ideas have been elegantly argued. Nonetheless, with all those qualifications in mind, rationality remains important. Reason can, on occasion, cut through to some truths not reducible to the passions.

Imagination

I reveal myself as a consequentialist by holding that any form of reasoning that does not reflect on the possible consequences and implications of a chain of reasoning is likely to be blind and illusory. Unfortunately, in bioethics it is often almost impossible to know the likely consequences of new technologies or even, at the clinical level, the likely medical outcome of many procedures with individual patients. That is where imagination comes in. We will have to project a future that is little grounded in past experience, or one in which the experience

is too limited to be wholly reliable. Nonetheless, if we must act, we will have nothing better to go by. A comprehensive imagination is needed, beginning with the question of the kind of world we want to live in, and how the various imagined scenarios or alternatives will or won't contribute to that world. If a scenario will not contribute, then there should be a presumption against it, not to be overridden because some individuals, or some market considerations, might make it appear attractive. Knowledge of the outcomes of other technologies can be helpful in that exercise.

Insight

In using the term *insight*, I have two dimensions in mind. One of them is self-insight, attempting to understand one's biases and proclivities and how either might interfere with good judgment by pushing our reasoning and emotions one way rather than another. The other dimension is that of insight into the context of, and cultural background of, the ethical problem. Where did it come from; how is context shaping it; what is its cultural meaning?

While careful personal observation can sometimes do the necessary work here, the social sciences provide a useful source of insight. A memorable instance of that for me, while working on the care of the dying, was an anthropological study of their care by medical residents. The study concluded that patients "died" for the residents when therapy was no longer effective. Death was a function of the available technology, not something that happened to bodies (Muller and Koenig 1988). That insight helped me to grasp the meaning of the "technological imperative" in a clearer way.

A COMMUNITARIAN PREDILECTION

While I believe that liberal individualism is, in excessively large doses, a poor ideological base for bioethics, it is too much a valuable part of our culture to simply throw out in favor of an alternative ideology, even communitarianism. Instead, the challenge is to put them in tension with each other, understanding that on some occasions prudence and good judgment will decisively go one way or the other, and on other occasions there will be a compromise blend. The main point though is that communitarianism must be allowed to be a strong competitor—permitted, in fact, to make the opening bid in framing the issues. By the "opening bid" I simply mean that the *first* ethical question always to be raised should bear on the potential societal and cultural impact of a possible decision. While this approach is most evidently important with new technologies that can have major social implications (e.g., germ line therapy), it is no less applicable with the classical problems of individual patient choices and doctor-patient relationships. The fact that they present themselves as individual problems does not mean that they do not, in reality, have social implications. Those implications

should always be sought out. Moreover, it is important to be able to interpret some principles assumed to be individualist in a communitarian way, as I will shortly try to show with “principlism.”

Let me define what I mean by *communitarianism*. In fashioning a definition, the dominant image is one I take from ecology. The important question for ecologists when new species are introduced into an existing environment is not just how well they will flourish individually, but what they will do to the network of other species. Will they live in harmony with them, perhaps improving the whole ensemble, or will they prove destructive? Or will they perhaps do a little of both? The function of communitarianism is to force us to ask the ecology question, now brought into the realm of ethics. While I will use the example of new technologies and their dissemination as my main examples, a more extended analysis would encompass the full range of the ethical problems of contemporary medicine.

Communitarianism, as I construe the term, is meant to characterize a way of thinking about ethical problems. It is not meant to provide a formula or a set of rigid criteria for solving them. That is why I opened this essay with an emphasis on “analytical virtues” and on asking the right questions rather than on ethical theory as ordinarily understood. Communitarianism might best be understood as a stance or a way of framing issues. Thereafter, the analytic virtues I sketched above will come into play, offering no sure guide to good decisions, but instead the ingredients of a prudential richness that the mainline philosophical theories usually overshadow.

Here are some key categories to flesh out my understanding of communitarianism:

Human nature. Human beings are social animals. They always exist in a network of other people and within the social institutions and culture of their society.

The public and the private. No sharp distinction can be drawn between the public and private spheres. The private sphere is a fluctuating social construct with few if any intrinsic contents of its own. Although it is important that there be a private sphere, to protect against undue encroachments of public pressure and to acknowledge the diversity of human tastes, values, and ways of life, what counts as private will be a societal decision.

The welfare of the whole. Just as a sensitive ecologist will take the whole of a natural environment or landscape as the point of departure, so too a communitarian will begin with the welfare of a society as a whole as the analogous starting point—understanding “welfare” in the broadest sense, as encompassing the traditions, political institutions, characteristic practices and values, and culture commitments of a society.

Human rights. Every society needs a set of recognized individual rights, both negative and positive. They are imperative as a solid source of resistance to the power of government or public opinion when it goes awry. They also establish

the moral standing of individuals, and thus serve to provide a sense of security in their thoughts and actions. At the same time, few human rights are unlimited. They can come in conflict with each other, requiring a choice or efforts at achieving some kind of reasonable balance. For example, some claims of reproductive rights, such as cloning, can threaten the right of a child to its own genetic future. A right to health care without limits in the face of scarce resources can threaten the health needs of others.

Democratic participation. When biomedical developments, theoretical or applied, are likely to affect the community as a whole, including its traditional values, then it is appropriate to initiate a community discussion of the human good, understood comprehensively. A society that avoids confronting the nature of the human good sets itself up to be influenced by the biomedical developments in ways beyond its control and direction. Every member of the community ought to have a part in these discussions, and allowed to speak the language most congenial to their religious or secular values. The notion that “public reasons” only should count in the public square amounts to empowering groups whose culture easily make that possible at the expense of those which don’t. In any case, wholly sectarian positions, though they should have an accepted place in democratic decision-making, are not likely to be efficacious in pluralistic societies.

Individual good and common good. The relationship between individual good and common good is an old issue. When analyzing the introduction of new technologies or the deployment of old ones, a communitarian predilection will require that the very first questions be asked from a communitarian perspective. What will the technology mean for all of us together? The next questions will address what the technology’s meaning for individuals will be, and whether (1) the technology is sufficiently compatible with the common good to permit its use, and (2) if the technology is not wholly compatible, whether it should nonetheless be permitted on the grounds that a good society may on occasion permit potential harms to itself in the name of accommodating the special needs of some of its citizens.

Such an approach to biomedical technology would effectively turn upside down the working presumption of liberal individualism when evaluating technology. That presumption can be formulated as a general if not always articulated rule: if a new technology is desired by some individuals, they have a right to that technology unless hard evidence (not speculative possibilities) can be advanced showing that it will be harmful; since no such evidence can be advanced with technologies not yet deployed and in use, therefore the technology may be deployed.

This rule in effect means that the rest of us are held hostage by the desires of individuals and by the overwhelming bias of liberal individualism toward technology, which creates a presumption in its favor that is exceedingly difficult to combat. Such an argument has been used by some supporters of reproductive cloning, who invented heart-wringing scenarios designed to show that it would

help some infertile people or help make up for the death of a loved one. Speculative objections were at first put aside, and it was only with the appearance of considerable evidence of harm to animals that even early proponents gave way. At no point, however, was a case advanced that cloning would make a contribution to the overall welfare of our society or any other—only the supposed good of some would-be parents was at stake, and not even their children.

CONVERTING INDIVIDUALISTIC PRINCIPLES TO COMMUNITARIAN PRINCIPLES

I want to propose, in closing, that many well-accepted principles reflecting a commitment to liberal individualism can be converted into communitarian principles, and that they will be the richer for it. Principlism, for example, has been one of the most widely used methodological tools for the resolution of ethical dilemmas. It has been presented as a set of middle-level principles, of more utility than high-level principles such as deontology and utilitarianism. While much criticized over the years, principlism has managed to survive, and it has been particularly popular with clinicians and others who want a relatively clear and simple way of thinking through ethical problems. Principlism has seemed to meet those needs, and it is usually presented as a non-ideological methodology.

In practice, however, principlism is an expression of liberal individualism. Its four principles are meant to cover the major ethical considerations that should bear on clinical and policymaking decisions. In reality, autonomy turns out to be king: all the other principles lead back to it, and the interpretation of the principles is classically liberal. Autonomy as interpreted by principlism enshrines the right to make one's own decisions, but assiduously avoids specifying a means of evaluating the ethical content of those decisions; nonmaleficence, aiming to protect patients from harm, is a variant of the autonomy principle, emphasizing negative liberty, the right of bodily noninterference; the point of justice as a principle is to ensure a sufficiently fair share of social and medical resources, such that individuals are free to make efficacious autonomous judgments in living their lives, unhampered by social inequities; and beneficence comes down to assisting people to be treated fairly and empowered to live their autonomous lives. It is no wonder that of all the principles, beneficence is the most neglected. For it to be taken with full seriousness would require coming to some judgment about what is actually beneficial to people. And that would mean crossing the brightest of all liberal lines, moving into the taboo territory of "the" human good, about which too many bad things can not be said.

Each of these principles admits of a communitarian translation. Autonomy should be broadened to encompass an analysis of what constitutes morally good and bad free choices. The claim that so-called private choices should be exempt from moral analysis is the death of ethics. Private choices can be right and

wrong, good and bad, and at the least, we benefit from the moral counsel and judgment of our fellow citizens. How ought I to live? That question is an ancient part of ethics, not to be neutered by designations of private choice. Those private choices will determine in great part our view of how we ought to live together.

Non-maleficence should encompass an analysis of those harms other than physical that can be done to people, threats to their values and social relationships, for instance—that is, the making of judgments about what truly harms people in the broadest sense of “harms.” Beneficence should include an effort, requiring community reflection and support, to determine just what constitutes the good of individuals, even if that means trespassing into the forbidden territory of comprehensive theories of the human good. Justice, finally, requires a judgment not only about what constitutes a fair distribution of health care resources but must—in the face of scarce resources—also determine just what constitutes appropriate resources, among those already available for distribution or those that could be created by research advances. If, for instance, we are interested in a fair allocation of future resources, what kind of a research agenda for what kind of medical progress would most promote it?

As these suggestions should make clear, I understand communitarianism to include a social rather than individual starting point for ethical analysis, but also a solid place for substantive reflection and judgment about ends and goals—and that is its greatest strength. Liberal individualism works overtime to avoid substantive analysis and judgment. Communitarianism goes in just the opposite direction, embracing the hardest and deepest questions about the right uses of medical knowledge and technology. Given their power to change the way we live our lives, and to understand our own nature, nothing else will suffice.

The greatest fear of liberal individualism is authoritarianism. But that fear, reasonable enough, fails to take account of the fact that the power of technology, and the profit to be made from it, can control and manipulate us even more effectively than authoritarianism. Moral dictators can be seen and overthrown, but technological repression steals up on us, visible but with an innocent countenance, and is just about impossible to overthrow, even as we see it doing its work on us. Liberal individualism makes this scenario more easily possible, and that is why it is not a tolerable guide to the sensible use of medical knowledge and technology.

It is just possible as well that a stronger place for communitarianism in our society will help to dampen the cultural war that has broken out in bioethics. A well-formulated communitarianism will not be indifferent to the rights and values of individuals; it will make room for them. In that respect, it need not worry political liberals as much as it does. A stronger appreciation of communitarianism could also hope to open up a stronger dialogue with conservative thought. Conservative thought is willing to take seriously the notion of a human good and of the need for substantive inquiry into the nature of good and evil in sci-

entific progress and technological innovation. The liberal individualism of much contemporary bioethics needs to take seriously that way of thinking. Without it, bioethics risks being empty and leaving everyone else at the mercy of biomedical developments that will have their way with us. It should be the other way around.

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