

Two Models of Ethical Consensus, Or What Good Is a Bunch of Bioethicists?

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Contemporary bioethics is a peculiar creature. What was once a subdivision of moral theology and philosophy tended mainly within the confines of schools of arts and sciences or seminaries has now become a quasi-profession whose practitioners come from a wide variety of disciplines. Perhaps still more intriguing is that the “members” of this discipline routinely engage the public at the hospital bedside, in the institutional boardroom, and through public policy consultation. Bioethicists have actively embraced these roles as the natural outgrowth of their research and study. Contemporary bioethics is thus a “demi-discipline.”¹ It is study and research but completes itself in public engagement.

The publics that bioethicists engage in the United States comprise a pluralistic liberal democratic society. In general, such a society values personal choice and the opportunity for each person to pursue his or her own vision of happiness. The imposition of an ethic on an unwilling minority by the majority is contrary to the overarching ethos. As a result, many bioethicists embrace consensus as the telos or goal of their efforts. They seek areas of widely shared agreement on which policy can be based. In other words, consensus makes potentially controversial and divisive issues manageable within a pluralistic society.²

Bioethics is especially known for the production of consensus in at least two major areas of decisionmaking: forgoing life-sustaining treatment³ and the ethical conduct of biomedical research.⁴ These are general societal consensuses as can be seen from the fact that many state laws and federal regulations stem from their basic tenets. The way in which each was produced is similar, but there are also some important differences. Each consensus is at least partially the result of the deliberations of a blue ribbon commission that articulated the framework behind these areas of decisionmaking. Furthermore, each is an effort to balance some competing values—that is, respect for patient autonomy and respect for human life, respect for subject autonomy and the clinician’s duty to avoid harming the subject. However, the consensus on forgoing life-sustaining treatment was also developed through a series of court decisions, whereas the conduct of research has been articulated mainly in federal regulations.

It is natural to ask what bioethicists should do when it is obvious that they have a stable consensus among themselves regarding an issue but this consensus has had little, if any, impact on social policy. For instance, universal health insurance is one such issue. It is very likely that an overwhelming majority of those who call themselves bioethicists believe that our current system of

leaving millions of citizens uninsured is immoral. The current insurance system largely denies access to the uninsured for all but emergency care. Furthermore, the system creates incentives for healthcare institutions and insurers to shift the costs for care delivered to the uninsured, to seek out the healthiest patients among the insured, and to shun the sick or high-risk populations.

Nevertheless, the details regarding what kind of insurance system is optimal and should replace our current schema tend to create lively debate among bioethicists as well as other kinds of policy analysts. Similarly, what particular kinds of treatment and for exactly what conditions should be covered by a guaranteed package of benefits will always be contentious. But that any serious attempt to provide health insurance to all our citizens is morally preferable to the current system is a proposition that clearly has widespread assent among those who work in bioethics.

Of course, in our nation at the present time, there is no serious debate within the halls of power concerning how to provide insurance to all those who are uninsured. Does this mean that bioethicists have a moral responsibility to take a public stand as a group? Should bioethicists attempt to speak with one voice on such issues in an effort to influence the nation's policy agenda or at least to tear away the veneer of moral respectability from opposition to universal coverage?

I believe the answer to these questions is yes. But, some qualifications in addition to justification are needed. First, some will question whether bioethicists have a legitimate role in advocacy. I support the claim that we do. Second, we must be careful regarding how we arrive at consensus. Our conclusions need to be of a certain kind for us to be genuine advocates and not merely one more special interest group.

Bioethics as a Public Calling

When one talks about the role of academics in public life, it is difficult to know whether the discussion should be a normative or a descriptive one. It is easy to say that academics do academic things such as publish their conclusions in journals rather than advocate for their conclusions in the public square. But, does this description imply that this is all that academics should do? Whether or not it should be something that all academics do, bioethicists also routinely engage in discussion in the public sphere. Does this have any normative implications?

Whether all academics who study social issues should seek to influence public policy is an interesting question. One could frame an Aristotelian argument based on the premise that the end of practical knowledge is "to do," not simply "to know."⁵ It may be that when one studies practical matters, the end of such study is action. As Alasdair MacIntyre has emphasized, when one describes practical matters, the descriptions will naturally contain evaluations of whether those matters were conducted well (i.e., good as judged by the aims of that activity).⁶ For instance, if one is describing the United States' system of healthcare finance and delivery, one cannot help but note that it does not meet the aim it has set for itself of delivering healthcare in an efficient and equitable manner. Furthermore, no matter what we academics think we are doing and why we are doing it, society probably supports the social and human sciences precisely because it wants the benefit of its findings in the public debate.

Perhaps of more immediate import for our discussion than a philosophy of practical knowledge is the fact that bioethicists are consistently engaged in the “public square.” This was originally by invitation as philosophers and theologians were added to newly formed government commissions and were increasingly asked to join in bedside deliberations in hospitals.⁷ In the intervening years, bioethics has become more institutionalized and bioethicists are now routinely included in a variety of regulatory deliberations. That such academics have this role has two implications: (1) the telos of bioethics has become action even if we do not believe that practical sciences implicitly have that goal, and (2) bioethicists as a group have a responsibility to take positions on certain issues.

As Albert Jonsen, one of bioethics’ founding fathers has noted, the kind of deliberation that came to characterize bioethics has a certain form. Namely, bioethical issues require the gathering of facts, the sorting through of public opinion, and the creative development of options, and these issues ultimately come to closure in recommendations for policy or action.⁸ Certainly, when bioethicists are on commissions or consulting at the bedside, those who ask for our help desire recommendations. Even if the bioethicist conceives his or her job as clarifying alternatives, the bioethicist is asked to accurately depict the options, not to conspire to make them all seem equal. When matters are studied closely, some options reveal themselves to be objectively better than others. Bioethicists are, therefore, called to the influencing of public policy by the matters themselves.

Second, when the calling of bioethicists leads them into the public square, it implicitly confers a responsibility on the profession of bioethics. When bioethicists testify before Congress or some other deliberative body, they are, in effect, “expert witnesses.” That is, they are bringing their expertise to bear on particular questions at the request of those who summoned them. Of course, in every field, it is important for those who receive such testimony to have some idea how widely shared the opinion provided is among similar experts. Only a society of ethicists can answer this question for the field.

In other words, it is simple to portray any ethical issue as having two equally valid sides. One produces a well-spoken expert for the pro side and a similar expert for the con side. Casual observers then simply conclude that there is no consensus among experts. Of course, this may not be the case. For instance, it is easy to have a debate on the free market’s ability to provide a just and equitable healthcare system for the United States. However, it would be wrong to conclude from that debate that there is no consensus concerning the free market’s ability to provide such a system among bioethicists. The fact that the literature may contain some articles supporting a strictly free-market approach tells you nothing about the prevalence of the opinion.

If a professional society is meant to foster, support, and uphold the quality of the activities of its members, it will need to take stands when a clear consensus is to be found. To say that a professional society of bioethicists is simply meant to foster debate does not support and uphold the quality of one-half of the demi-discipline, the part that is about engagement in the public square.

Two Kinds of Consensus

My discussion of the need to put the considered opinion of any particular bioethicist within the context of the larger bioethics community begs us to ask

in what such expertise consists? In other words, are some kinds of consensus more congruent with the bioethicist's calling than others? Surely, it cannot be that there is something important simply in the preferences of the majority of bioethicists. Such personal preferences would have no inherent claim upon the attention of the public. If the opinions of bioethicists are to count for anything, they must be developed in a particular way. However, bioethicists do not always recognize this, and they sometimes lapse into being defenders of a kind of "mere autonomy" rather than working in a model that prescribes balancing the competing values within the community.

One model of bioethical reasoning takes its cue from a libertarian interpretation of democracy. On a libertarian view of government, the individual's particular pursuit of happiness is the only value that truly matters. It is important to safeguard every individual's right to pursue his or her dreams, and society must make laws that punish individuals who harm others. Furthermore, society must not only protect the individual from other individuals, it must also provide for such things as the common defense. But, society's roles end there. Government should avoid getting in the way of each member's pursuit of his or her own particular vision of the good life. On a libertarian account, the state is ultimately seen as a necessary evil and should remain extremely limited in power and scope.

Of course, libertarianism so conceived leads to some rather extreme conclusions that are rejected by average persons of common sense and the vast majority of bioethicists. A libertarian view rejects the idea that government should advance the opportunities of its citizens and increase their aggregate happiness. Government must remain limited because of a presumed epistemic relativism that underlies the theory. That is, a thoroughgoing libertarianism claims that each and every view of the good life must be considered equal to every other. Therefore, government must be careful not to do anything that aids or abets any particular view of happiness lest it implicitly enlist the aid (e.g., via tax dollars) of those who do not share the vision or crowd out another vision.

Bioethicists are often rightly sympathetic with this vision. It is supported by the common observation that happiness is many different things to many different people and that it can be difficult to say that some of these visions of the good life are superior to others. Furthermore, this philosophy justifies the deeply felt American value of the separation of church and state. Particular religions express specific visions of the good life, and our nation is founded on a belief that the state should establish no official religion.

When bioethicists find themselves thinking like libertarians, they elevate the value of individual autonomy to a paramount position. The central question that bioethicists then ask regarding any technology is whether it will cause some obvious injury to identifiable parties who have not given full and free informed consent. If the answer is yes, the technology must be regulated. If that harm is not clear or full and free informed consent to it can be given, then the technology proceeds. Some communitarian philosophers have decried this situation and noted that this stance cannot impede the advance of suspect technologies. Daniel Callahan expresses this "libertarian proposition" in this way: "if someone wants something that medicine can give them, they have a right to it unless immediate and demonstrable harm to others can be proved."⁹ One can interpret the consensus regarding biomedical research along these lines.

A libertarian bioethics would construe the federal regulations governing research as aimed at promoting respect for autonomy. Researchers must be free to pilot new treatments, and patients must be able to give their free and informed consent to obtaining the potential benefits of biomedical research by participation in clinical trials. As subjects may not be in an ideal position to evaluate the technical information that goes into a risk-benefit calculation, the regulations would be characterized as aimed at enhancing the potential subject's autonomy by ensuring that the scientific basis of the research is sound and ready for trial and that the information provided to the patient is clear and complete.

On this view of bioethics, consensus is a consensus on individual autonomy. Every proposal is subjected to a kind of "thumbs up or thumbs down" vote. If the proposal directly harms persons without their free and informed consent, then bioethicists should agree that the proposal is to be rejected. If it does not harm individuals or places them at risk but has procured their due consent, then bioethicists should approve the proposal. And, as this kind of test is seen to accord with the American emphasis on the value of freedom, societal consensus should be easy to promulgate. What more could anyone want from an ethical consensus?

We can interpret the same phenomenon—that is, the successful production of a societal consensus on biomedical research—in a way that emphasizes differing elements. For instance, clinical trials are part of a large communal enterprise, not a matter of individual investigators and individual patients. Modern biomedical science requires too many resources to be able to be sustained by individuals and must feed at the trough of our collective efforts. Although government funding directly underwrites only some clinical trials, virtually every part of the biomedical enterprise has been subsidized indirectly by taxpayer funds. As a result, society can ask how the conduct of research reflects the values of the public at large.

When members of society ask this question, bioethicists respond that, in fact, we have a stable societal consensus that reflects our common values and this consensus is reflected in the federal regulations. Biomedical science is a collective project that tries to advance the health and well-being of the general public. The regulations that stem from the consensus ensure a peer-review scientific process so that the science is as good as any system can guarantee. The consensus balances the demand by victims of particular diseases for rapid progress against the need to develop treatments that are scientifically verified as safe and effective. In general, the consensus can be viewed as reflecting a concern for the integrity of the biomedical enterprise as a societal institution. This is clearly a more communitarian vision of a bioethical consensus than the libertarian model. Of course, calling it communitarian makes it sound as if one must subscribe to a particular ideology or philosophy of the good life. In fact, this is simply a view of consensus that represents the pragmatic politics that characterize the United States.

Some philosophers, such as Norman Daniels, are quick to point out that from a liberal democratic perspective, the government should safeguard a number of goods such as education and healthcare. These goods are essential to equality of opportunity. Society need not select a particular vision of the good life but should guarantee access to the conditions that provide an opportunity to pursue a vision of the good life that is part of a reasonable range for members

of the society.¹⁰ Daniels's line of reasoning is quite plausible and can explain why an issue such as public support for improving the educational system is so popular. But, clearly, our thinking as Americans about education and health goes beyond mere instrumental reasoning and, in fact, narrows the collective vision of the good life.

When looking at healthcare and education, "how much" questions must be answered. That is, how much healthcare, how much biomedical research, and how much education are necessary to ensure equality of opportunity? These questions cannot be answered directly by appeal to the notion of equality of opportunity. These must ultimately be political questions in which these goods are balanced against competing goods and demands on resources. Of particular interest is that the answers to these questions cannot be seen as completely neutral regarding visions of the good life. The particular answers to these questions will necessarily have an impact or restrict the kinds of lives that are available as realistic choices. For instance, by simply choosing one particular number of years of education over another, whole lifestyles may become possible or be diminished. For instance, if one decides 12 years of public education are required, becoming a Web designer is enhanced as a prospect whereas being a practicing member of the Amish community is diminished.¹¹ If the prescribed years of mandatory education are capped at 7, the reverse may happen. It has generally been the American way to try to arrive at a compromise that holds both opportunities open. However, when push comes to shove, Americans do directly and indirectly foster some kinds of opportunities at the expense of others. In this way, Americans are generally pragmatists and are willing to sacrifice ideological consistency to this pragmatism.

Our vision of the United States has never been truly libertarian. Libertarianism accepts the random outcome of dividing society into winners and losers. In the case of our nation, that could mean enormous, perhaps overwhelming, corporate monopoly winners that drive out all alternative life opportunities. In contrast, our society has usually embraced a vision of opportunity such that one can select a vision of the good life. Thus, the state has a role in preserving a variety of life options. For instance, the arts and humanities receive some public subsidies lest they disappear as forms of life. Of course, this is a political theorist's justification.

In real life, the U.S. political system is one of interest-group politics. We provide some public subsidy to the arts and humanities because those who like such things have been successful at lobbying those in power. Of course, sometimes they are not successful enough. Nevertheless, that there are a variety of goods and that those who manage the public trough should weigh and balance support of competing constituencies is fairly well accepted. In this way, we truly are a pluralistic society.

Perhaps we have unlocked the key to the kind of consensus bioethicists seek. The United States may have moments of extremism but, in general, is a genuinely pluralistic society in which our most stable policies balance competing claims. On this interpretation, the consensus on the regulation of biomedical research is a way of balancing goods, not the triumph of individual autonomy. Similarly, the consensus on forgoing life-sustaining treatment is successful because it balances competing claims such as respect for patient autonomy, the responsibility of the physician for the patient's well-being, the integrity of the medical profession, and the state's interest in preserving life.

For it to be a genuine and stable consensus, it likely must maintain such a balance and not simply become a stage in the march of the triumph of one of these values.

When a Consensus of Bioethicists Is Good

A majority of bioethicists sharing the same opinion is of no intrinsic value. However, when bioethicists parse the facts of an issue and devise a set of proposals that balance the competing considerations, their arguments can be important. Although any one bioethicist can devise policy proposals that balance competing goods, the critical scrutiny of other bioethicists is important for obvious reasons. That is, any one person can be biased in his or her deliberations, and the validation of others is an important factor in determining objectivity. When bioethicists reach consensus among themselves via an even-handed balancing approach, their conclusions should not be hidden but should be set forth for consideration by society.

If a particular consensus of bioethicists truly reflects a balancing of important values, the proposals should not seem foreign to the average American. In a sense, what bioethicists are putting forward is not a completely novel proposal but something that reflects the values of the members of our society. What is sought are proposals that capture what most Americans would think if they had sufficient time and resources to consider the matter. Such a consensus reflects “what I would think if I thought about it.” A genuine consensus must not assume that everyone is the same. It is what I think given that I am a member of this society and must consider what is also important to others. In other words, consensus should reflect “what I’d think if I thought about it as it affects me and my community.” Thus, a well-formed consensus can encompass elements of compromise but is not necessarily a mere political compromise.¹²

For instance, one cannot look simply at an issue such as physician-assisted suicide, do public opinion polls, and create a consensus by balancing the competing opinions. Opinions are often reflective of misinformation and superficial. In such cases, bioethicists must go below the surface of the opinions and make sure that the relatively stable values of the society, not uninformed impulses, are reflected in the consensus. To follow the example of assisted suicide, many persons may favor its legalization if simply asked a question. But, once the distinction between assisted suicide and forgoing treatment is clarified via public information campaigns, the support for legalization of physician-assisted death drops precipitously.¹³

Many bioethicists tend to favor legalization of assisted suicide because it passes their “thumbs up or thumbs down” approach to consensus. Societal interests in prohibiting assisted death tend to be expressed as preventing future harms that, of course, may not occur. Such reasoning may seem insufficient to outweigh the respect for the autonomous choice of patients to partake of an assisted death. This earns the “thumbs up” of many ethicists. However, the current consensus on life-sustaining treatment goes beyond this thumbs up approach. The consensus respects the right of patients to be free from unwanted medical treatment but also balances this right with societal concerns for the integrity of the medical profession and the preservation of human life. Of course, this consensus does not place as high a premium on individual autonomy as some would wish. (Nor, conversely, does it make prolongation of biological existence the only value worth

considering as others might wish.) Sustainable consensus is often likely to be a moderate approach reflecting such deep values.

Of course, even if ethicists take such a moderate approach, the proposals bioethicists put forth as a group may not always win easy acceptance. The process of creating a consensus is often as important as the values contained in a proposal. For instance, the consensus regarding end-of-life decisionmaking is one that is only partially the conclusion of the deliberations of bioethicists and health-care professionals. It is also the product of appellate court decisions, clinical practice, state statutes, and referenda. As a result, the consensus revolves around a certain constellation of principles but cannot be said, in practice, to be identical to particular principles, given that the instantiation of the consensus is always in a "more or less" fashion in any given state of the United States.¹⁴

The specific role that bioethicists have played in any given consensus varies quite a bit. The deliberations of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research played a large and direct role in the consensus on the protection of human subjects of biomedical research. Bioethicists had only a cameo role in the commission that devised the President's Health Security Act (1992). This latter group can be thought to have arrived at many of the right conclusions but to have failed to utilize effective consensus-building processes to facilitate its passage.¹⁵

I am arguing that bioethicists deliberate in a way that is useful when they facilitate a stable consensus for the community and society. There is no infallible way to arrive at such a consensus. On the one hand, substance is extremely important. We must seek solutions that balance the important consideration of various constituencies within our society. However, we cannot always expect our solutions to be accepted wholesale. The process of arriving at consensus or promulgating it will also be important. However, it is not possible to determine a priori how to foster a consensus for a particular issue. But, this should not deter us from seeing such a goal as the telos of bioethics.

When Bioethicists Agree

Bioethicists are always in the public domain. It is, therefore, disingenuous to argue that we are simply scholars who should not take part in political activities. The question is how to participate responsibly. My answer so far has been that we must follow the path that we have evolved of "qualified facilitation."¹⁶ When we are at our best, we are facilitating a widely acceptable consensus that is within the parameters set by sound ethics.

A professional society of bioethicists has the responsibility to reflect and support the range of activities of its members. Therefore, I argue that by occasionally reflecting the considered judgments of its members, the society can help to document when particular bioethicists are expressing novel opinions that are not representative of the field. Furthermore, it can provide a vehicle for the membership to express health policy prescriptions that reflect the values of the general public, a public that does not always have the opportunity and resources to study an issue and to separate rhetoric from reality. In this way, we supply the answer to what the public would think if they thought about it. Of course there is no guarantee that ethicists can put an issue on the public agenda and make sure people actually do think about it.

What would constitute a consensus among bioethicists? As I have noted, there are really two requirements for consensus. One is that the vast majority of bioethicists hold an opinion. The second requirement is that the opinion be one that attempts to balance the values prevalent within our society and those held by significant subcultures. Only the first requirement can be guaranteed. The second must be maintained by the consciences and good will of the members of the society.

A “supermajority” of approximately two-thirds of a membership may be sufficient, although a professional society may choose a higher percentage such as 70% of returned ballots on an issue, to ensure that an opinion is widely held and offset the possible variation that will result from a selection bias of those persons who choose to return ballots. Clearly a majority of such magnitude ought to be able to create a position for its organization.

The much more difficult issue will be determining when an issue is one on which a stand should be taken. For instance, bioethicists will be speculating on when a question really is of a nature such that the citizens of our society would widely reach a similar conclusion if they thought about the matter in a calm manner and considered all of the facts available to the ethicist. For instance, some matters, such as those involving interventions with persons whose behavior involves the use of illegal drugs, alcohol, or promiscuous sexuality often generate great public controversy. In considering a public position on such matters, bioethicists will have to determine when they are faced with a genuine clash of values among the public and when the matter is a factual one that can be resolved by data collection. For instance, debates may concern whether an intervention will inadvertently increase an undesirable behavior (e.g., do needle exchange programs promote intravenous drug use?) or have unintended negative health consequences (e.g., will addiction-intervention strategies prevent addicts from seeking beneficial medical care?). These are empirical, not value, questions. Bioethicists should take positions when data sufficiently answer these questions and make clear what policy will promote the general welfare. However, this is quite different from questions in which the fundamental values in question are at stake and no data can be gathered to answer the questions. In these latter instances, bioethicists should refrain from seeking to put forward a united agenda.

Conclusion

Bioethicists cannot have their cake and eat it too. We cannot constantly engage the public and then run from the responsibilities that accompany this role. We must own up to the idea that we need to develop our own “standard of care”¹⁷ in regard to the directions in which we attempt to lead the public. When you study important questions, sometimes you find answers. We must be clear when there are answers on which most reasonable observers agree and when we are exploring uncharted territory or murky waters. And, above all, we must not let persons subvert the public interest by putting forward the biased conclusions of particular interests as if these were the studied conclusions of bioethicists.

However, the main issue for the future of bioethicists will be whether we will resist the temptation to become mere partisans and remain in our proper role of qualified facilitation. This outcome cannot be guaranteed in advance. It will

require constant vigilance and respectful debate on issue after issue. But, there is no good alternative. As we attempt to influence history, we must accept that we are historical beings and cannot be saved from this by an eternal principle or a feigned position of neutrality and impartiality.

Notes

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