Toward a Postmodern Bioethics

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Abstract: In this article, postmodernism is presented as posing a challenge to the role of philosophy within bioethics. It is argued that any attempt to develop a postmodern bioethics must respond to arguments concerning power, relational responsibility, and violence. Contemporary work on the topic of relational autonomy and naturalized bioethics is interpreted as engaging with the postmodern challenge. This article proposes that the role of philosophy in bioethics should be not to provide moral guidance but rather to adopt a critical approach to the possible consequences of privileging any position or understanding over others.

Keywords: bioethics; postmodernism; power; violence; relational autonomy; relational responsibility

Introduction

Any suggestion that the role of philosophy within bioethics is not to provide justification or support for conduct is likely to be rejected by some bioethicists. If philosophical approaches fail to provide objective guidance for practice, the purpose of philosophical contributions will be questioned.[1] I aim to show that, in adopting a postmodern approach, the role of philosophy is to continually question the presuppositions of and accepted practices within healthcare. As such, a postmodern approach invites practitioners and philosophers to be accountable for what practices they support. For a postmodern bioethics, the ethical lies not in doing the proposed "right thing," whatever that may be, but in adopting a critical perspective toward healthcare, acknowledging that practices invariably privilege some people over others.

The adoption of a postmodern approach requires at first an acknowledgement of the difficulties postmodernism presents. Three specific difficulties—as outlined by David Wood, Michel Foucault, and Sheila McNamee and Kenneth Gergen, respectively—provide an opportunity to acknowledge (1) the potential for violence in philosophy, (2) philosophy's role in shaping subjectivity, and (3) the complex nature of identity. Two anthologies—*Relational Autonomy: Feminist Essays on Autonomy, Agency and the Social Self*[2] (referred to from here on as *Relational Autonomy*) and *Naturalized Bioethics: Towards Responsible Knowing and Practice*[3] (referred to from here on as *Naturalized Bioethics*)—call into question the privileged ideal of the autonomous self in bioethics and medicine. I suggest that these two works can be viewed as introducing a crisis, one that a postmodern philosophical approach would seek to maintain. The uptake of a postmodern philosophical approach is difficult, as it asks us to recognize that all understanding is perspectival and situated. In healthcare, the practitioners' work environment is shaped by conceptions of justice, health, and the individual that have been privileged over others. In bioethics, peers and institutions that privilege particular theoretical approaches over others are responsible for evaluating contributions. The novelty of a postmodern philosophical approach lies in acknowledging the limits of any perspective and calling for a stepping

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back from the offering of theories to guide practice. Instead, the imposition of particular theories on practice is identified as ethically significant, as to do so serves to exclude or relegate the importance of other perspectives. In seeking to question and disrupt accepted approaches and theories in healthcare, a postmodern approach attempts to acknowledge the limitations that healthcare practices impose on practitioners, while calling on theorists to take responsibility for their contributions.

Before advancing the argument, it is necessary to preface this work with a comment on language and method. First, any engagement with postmodernism succumbs to the difficulty of language usage, namely, the need to speak in the language of the audience one is seeking to address. In providing only a brief outline of postmodernism and deconstruction, a disservice of sorts is imposed on these two traditions. Second, the "toward" in the title of this article signals uncertainty as to whether a postmodern approach will ever be adopted in mainstream philosophical bioethics, as to do so challenges the role philosophy plays in bioethics.

Postmodernism

In his 1979 book *The Postmodern Condition*,[4] Jean-Francois Lyotard offers an account of postmodernity. At its most basic, postmodernism challenges or invites us to focus our attention on the conditions, production, and use of knowledge. This turn, referred to by Fredric Jameson as beckoning a "crisis of representation,"[5] offers an approach that postmodern bioethics seeks to maintain. Lyotard's understanding of postmodernity could be understood as involving three steps. The first stage occurs when we think about the conditions and requirements of knowledge claims. Underpinning a science or discipline of knowledge at any time is an already established source of legitimation, "meta-narratives."[6] The realization that these metanarratives are produced at a particular time in history undercuts their legitimacy, representing a fracturing of knowledge from justification. The second stage, in response, attends to the production of knowledge, identifying performativity and power as characteristics of science. To be afforded legitimacy, knowledge claims must conform to established practices, and if successful, the performer and the knowledge will gain "power."[7] The issue of the legitimacy of knowledge is accordingly inseparable from the legitimacy of the institution that maintains standards of legitimization. The third stage, that of crisis, acknowledges that individuals are a product of intersubjective contexts and that each of these contexts has its own language and rules. The issue of legitimation signals the condition of postmodernity, in which the subject is implicated in and can only be encountered through multiple language games, each with its own established set of rules. A person or a knowledge claim is already situated in a series of narratives.

Jacque Derrida's idea of deconstruction refers to a possible way of engaging with a text, one that seeks to draw out what has been obscured or silenced. Echoing Lyotard, Derrida's deconstruction is not a method exterior to knowledge that may be applied to a topic; rather, deconstruction, like postmodernism, is latent within the text or knowledge claims.[8] Deconstruction takes as its focus truth claims or objective—often metaphysical—descriptions. It is only in the disrupting of these truth claims, the realization that this truth is a production of a particular time

in history, that the opportunity to encounter or relate to people ethically opens up. The opportunity for ethics or justice emerges from the discrediting of any attempted universalizing description or imposed "homogenized whole."[9] Traditional moral theories that demand the observation of principles already presuppose a particular description of the world. These theories, however, in describing the world, omit or afford more importance to particular concepts than others. The possibility of ethics requires an acknowledgment that all our experiences are located in a particular situation and perspective, what Maurice Merleau-Ponty refers to as the most important lesson of phenomenology.[10] The construction of a moral theory based on a particular experience and then applied to or expected of others is an attempt to privilege one perspective over others.

In practice, postmodernism invites healthcare practitioners to recognize that the guidelines they work under, the knowledge that guides practice, and the protocols they follow have been developed in the light of particular theories, at a particular time in history and within a particular cultural setting. The perspective within which practitioners operate—based on guidelines, knowledge, and protocols—privileges some over others but also demands the adherence of practitioners. This may lead to dilemmas in practice.

Three Postmodern Challenges for Bioethics

Stepping Back

David Wood,[11] in examining the possibility of ethics after deconstruction, identifies the challenge confronting theorists as one of philosophical humility. Deconstruction as a philosophy of the limit invites philosophers to step back from the will to overcome or impose/uncover foundations. Instead, the task of philosophy is to affirm the "necessity of ambiguity, incompleteness, repetition, negotiation and contingency."[12] As such, a language and method that accepts philosophical limitations is required. To facilitate this, philosophers working in bioethics must acknowledge the potential violence of philosophical contributions. The first form of violence, the violence of "concepts,"[13] calls to attention how the categorizing and imposing of boundaries potentially permits a double violence. That individuals can be considered to have or lack capacity allows for individuals to be considered through that lens alone. Following from this, the distinguishing of individuals according to the presence of capacity may justify violence being performed on individuals. In ruling that an individual lacks capacity, practices including force-feeding of patients or forced caesarean sections are justified. The second form of violence may occur in "philosophical dialogue"[14] and highlights the potential treatment of other people's work in philosophy. When philosophers fail to acknowledge the views of another, they risk confusing their difference of opinions with the idea that the other's position is irrelevant or wrong. The third form of violence, the "silent violence of humanism,"[15] refers to treatment of others that is frequently justified or is not often condemned. Wood is referring here to the treatment and use of animals by the human species, as part of which animals are subjected to violence. This third violence draws attention to the focus of ethical thinking and more importantly to what is permitted generally in everyday life.

The call to step back allows practitioners and theorists to reflect on the potential consequences of their actions. The use of diagnostic tools to identify and distinguish patients from others risks viewing patients through those perspectives only. The identification by ethicists of what is of ethical importance in a particular context risks performing violence. Alternatively, the failure to impose limits on ethical responsibility in a context implies a limitless responsibility. The step back advocated for by Wood acknowledges this impossible demand placed on philosophy, and that philosophy is in a position of infinite responsibility. As philosophical bioethicists offer theories to map the ethical landscape of medicine and science, they support the privileging of particular interpretations, which facilitates violence in the form of differentiation.

Attending to Power

In "The Subject and Power"[16] Michael Foucault argues that power influences an individual's experience of the world. "Power" here refers to the ability to bring to bear on a particular practice a meaning or interpretation. Power can only be observed or identified in situations in which the uptake of a particular meaning might have been rejected but is maintained because it has been afforded a truth status. Therefore, compulsion, violence, and necessity do not equate with power.[17] Power relations, as the effects of a particular "knowledge" coming to bear on a practice, invite individuals to understand things in a specific way. The relationship between philosophy and the disciplines of medicine and science can be observed as an exercise of power. Philosophy, notably ethics, provides healthcare practices as well as future practices with frameworks and interpretations. The uptake by medical practitioners or politicians of these interpretations serves to influence how medical practices are evaluated. When an approach is adopted, however, it can become the lens through which practitioners or individuals evaluate action.

In considering power, Foucault also invites readers to consider the strategy of exercises of power. In offering justificatory schemas to healthcare and science, philosophy within bioethics can be challenged about its aim. Foucault identifies three types of strategy: the "means employed to achieve a particular end," the "manner in which a partner in a certain game acts," and "the procedures used in a situation of confrontation."[18] Philosophical bioethics may be asked to account for the consequences of its strategies as it engages with medical practice. Foucault's consideration of power and subjectivity when applied to bioethics asks questions as to the fundamental aim or purpose of philosophical bioethics but also emphasizes the role philosophical contributions can have in shaping institutional and individual practices. Healthcare practitioners who have been exposed to bioethical theory or approaches, who may then draw on such theory in practice, become complicit in the means by which individuals are evaluated by a specific philosophical gaze.

Relational Responsibility

In *Relational Responsibility*,[19] Sheila McNamee and Kenneth Gergen call for the adoption of an understanding of relationality. Because any theory offers meaning to those who accept it, the production of theory can be viewed as a relational

practice. Any theory can become a means by which individuals make sense of the world; however, the adoption of a theory can serve to permit certain actions while rejecting others. Philosophical approaches in bioethics can be viewed as invitations for healthcare to be understood in a particular way. In advocating for a relational approach, the idea of holding a person solely responsible for action is disrupted; instead the actions attributed to individuals are examined relationally. This call is not for a movement away from individual responsibility but to acknowledge that individual actions are informed and influenced by relationships.

McNamee and Gergen suggest four forms of relations that allow for the appreciation of the implication of other people in an individual's action. The first form, "internal others,"[20] signals that an individual's actions or views at a given time are products of relationships with others and the meanings that emerge in these relationships. In acting or speaking within a context, an individual adopts one of many positions available to him or her from the multiple contexts in his or her life. In doing so, however, other positions are silenced. When patients make a decision about their healthcare, they may be influenced by professional, family, economic, and religious contexts. The acknowledgment that these have been constituted relationally troubles the attribution of personal blame or approval. The second form, "conjoint relations,"[21] offers an understanding of individuals within their context. An individual action is part of a relationship, in which any act is part of a larger project or relationship. Any decision that an individual makes about his or her healthcare is not an isolated decision but is related to several relations within his or her life. The third form, "relations among groups,"[22] signals the use of traditionally individualist language in discussing collective units. According to this line of thinking, the action of a nurse can be viewed as the accepted professional behavior of a nurse rather than as an isolated individual decision. This type of reasoning serves to underscore the environment in which action takes place but can be criticized for replacing individual blame with group blame. The fourth concept, that of "systemic process,"[23] invites us to see that nothing occurs outside of a system. All actions are connected to other actions, and individuals who act within a system are complicit with it. As acknowledged in the public inquiry of the Mid Staffordshire NHS Foundation Trust,[24] the failures of a hospital can be attributed to systemic failures rather than the actions of discrete individuals.

If we accept the challenges of McNamee and Gergen, philosophical bioethics must attend to the relational contexts in which any decision is made, recognize that any action is one within a series of actions, and understand that individuals act as representatives of the groups they are part of and that wider systemic views need to be taken on board. This adds to the complexity of healthcare decisions and suggests that the multiple contexts surrounding any decision need to be acknowledged.

The Three Challenges: Overview

The three challenges invite philosophers working within bioethics and healthcare practitioners, who work in a context informed by philosophical ideas, to question the practical use of philosophical ideas and to enquire as to the specific role of philosophy in bioethics. Both Wood and Foucault ask us to consider the impact of philosophical ideas in practice, the potential for violence, and the possible

justification that philosophy can afford action. However, Foucault and McNamee and Gergen invite a secondary question about the role of philosophy in bioethics and in relation to healthcare more generally.

Emerging Postmodern Approaches in Bioethics

In *Relational Autonomy* and *Naturalized Bioethics*, numerous authors advance deconstructive readings to challenge the importance afforded to the ethical and legal notion of autonomy. In critiquing this notion, both anthologies reveal the presuppositions and biases that underpin the notion that an individual is "fundamentally individualistic and rationalistic."[25] In demonstrating that certain perspectives or ways of viewing a patient are prioritized over others, both anthologies invite readers to acknowledge that ethical approaches affect how the world is understood.

Jackie Leech Scully[26] observes, in bioethical thinking, two strategies used to allow for certain perspectives to be excluded. A "move of commonality"[27] suggests that people have so much in common that it permits one to speak for everyone. A "move of marginality"[28] seeks to identify a perspective as so insignificant or rare that it need not be afforded importance in ethical discussions. These strategies permit individuals to speak on behalf of others, assuming that any differences are minor. The task confronting bioethics is that it must continually address the assumptions that underpin theorizing and must develop ways of understanding everyone's perspective. Hilde Lindemann[29] draws attention to the risk in healthcare settings of focusing on one aspect of a patient, namely his or her decisionmaking ability. In doing so, key aspects of his or her identity, be it relationships with others or certain projects, are afforded less significance. Naomi Scheman[30] argues that the focus of medicine and research on the individual fails to acknowledge the role of communities, which in practice are the contexts in which identity is continually developed. In examining a study of women's contraceptive choices, Natalie Stoljar[31] argues that theories of autonomy fail to acknowledge the role of oppression and the effect it can have on decisionmaking. Paul Benson[32] argues that, on examining characteristics typically attributed to individuals, such characteristics are revealed to be relational concepts. In stating that someone has autonomy or moral responsibility, what is being claimed is that an individual demonstrates particular behaviors, which are associated or equated with autonomy or responsibility by other people.

I argue that a similarity can be observed between these five approaches and deconstruction. Deconstruction, in its most basic form, attends to accounts that offer "absolute descriptions." These descriptions, referred to as "closures," can be subjected to a secondary reading. In performing a secondary reading, the assumptions or that which has been omitted from a description is identified. These readings, however, disrupt and dislocate that attempted original finite definition. Scully, Lindemann, Scheman, Stoljar, and Benson offer to the proposed description of an individual as autonomous secondary readings revealing that which is omitted or assumed. These approaches allow for an acknowledgment of a secondary meaning for closure, namely, the impossibility of imposing an absolute description. It is only in accepting that absolute descriptions are impossible that the possibility of acting ethically is offered. These five authors respond to Wood and Foucault's respective calls for an awareness of the consequences of philosophizing.

Beyond Deconstruction

In acknowledging the critique of autonomy offered in both anthologies, two possible approaches emerge. The first, the practical strand, seeks to return to healthcare practice. Therein healthcare can attempt to reconcile that which has been omitted or sidetracked in a focus on the decisionmaking individual. Practicing patient-centered care demonstrates this attempt to care for the individual patient, rather than focusing on a discrete aspect of the individual. The second response, as theoretical, attends to the questions asked of philosophy by Foucault and McNamee and Gergen. The development of a theoretical approach seeks to address the role philosophy plays in its engagement with healthcare.

Todd Chambers[33] and Eva Feder Kittay[34] engage with the theoretical approach. Chambers holds that bioethics as a "sociopolitical endeavor" can be subjected to narrative examination. Read as a form of storytelling, bioethics attempts to provide a lens through which medicine and science can be encountered and understood. When bioethical narratives are subjected to a series of questions, the attempted universality implicit in the narrative is understood as a construct. The turn to narrative allows for philosophy to refute any imposition of a bioethical maxim or truth. Feder Kittay, addressing the role of individual philosophers, holds that we need to be aware of the limits of our knowledge. She warns philosophers of the dangers of idealization, particularly in relation to persons. This movement toward idealization, toward conformity, toward an imposed commonality, demonstrates poor practice. The challenge for philosophers in bioethics is to avoid succumbing to a reductive philosophy; to this end, Feder Kittay suggests four commitments philosophers can uphold:

1) "Epistemic responsibility: know the subject that you are using to make a philosophical point."
2) "Epistemic modesty: know what you don't know."
3) "Humility: resist the arrogant imposition of your own values."
4) "Accountability: attend to the consequences of your philosophizing."[35]

The approaches of Chambers and Feder Kittay can be considered as engaging with the strategic questions about the role of philosophy as identified in the discussion of Foucault and Gergen and McNamee. In calling for limits to be adhered to and for an awareness of the contextual nature of philosophical approaches in bioethics, Chambers and Feder Kittay offer interpretations of what philosophical bioethics should be. For Chambers, the development of narrative analysis skills allows for philosophers to address their engagements with healthcare, the strategies underpinning their engagements, and the broader strategies in which philosophers work. Feder Kittay, in seeking to foster awareness of limits and to encourage philosophers to work within these limits, attempts to define what the role of philosophical contributions should be.

However, the respective calls of both these theorists for philosophers to utilize certain approaches and to act with humility fail to provide an account of the overall role or purpose of philosophical bioethics. For the philosopher engaging in bioethics, knowing how to act and what methods or approaches to employ is important, but clarification is required as to the object of philosophical bioethical enquiry.

A Postmodern Philosophical Bioethics

I propose an understanding of postmodern philosophical bioethics as an approach that is resistant to and draws attention to the attempted imposition of absolute definitions or universality on healthcare. In outlining this approach, which responds to the three postmodern challenges discussed, I draw on Simon Critchley's understanding of ethics and deconstruction.[36] A postmodern philosophical approach allows for the strategic role of philosophy to be acknowledged and offers a practical role for philosophy in addressing healthcare but acknowledges a difficulty in identifying the object of philosophical bioethics.

When philosophers turn their focus to practices in healthcare, they encounter a practice already established within an ethical framework. This practice can be understood as a product of a tradition, which has justified its use by appeal to some ethical view. The philosopher, in engaging with the issue, is also a product of a tradition, as the methods he or she employs to make an argument have been considered acceptable. The philosopher is also constrained by the context in which he or she is seeking to contribute. Depending on the context, the philosopher might be funded and supported by institutions that support specific philosophical approaches over others, may be working in conjunction with practitioners or legal theorists, or may be seeking to challenge how a particular issue is understood by either the public or practitioners. In each case, the philosophical contribution occurs within a context; what is offered, although attributed to the philosopher, is influenced by the context in which he or she is working, the philosophical approach used, and the healthcare practice addressed. These variables help in understanding why the questions posed by Foucault and McNamee and Gergen are challenging.

The practical application of a postmodern bioethics can be considered in regard to what it offers practitioners and what issues it addresses. In addressing healthcare practitioners directly, I propose that a postmodern bioethics would not seek to give normative advice for practice, or to offer alternative absolute descriptions to replace others. Instead, what philosophy can offer is a space to recognize that absolute descriptions of persons may be required in healthcare but that this imposes on practitioners a particular way of encountering people. A postmodern philosophical approach could provide a space in which attempted descriptions can be scrutinized, highlighting that which has been excluded or bracketed in practice. In drawing out the dislocations in practice, that is, the privileging of a view of the autonomous self in medicine at the expense of relational practices, alternative strategies may be outlined. The role of such a philosophical approach is not to provide a definition or account of the individual in healthcare but to disrupt notions of certainty or truth in healthcare. In continually questioning the presuppositions of healthcare, the potential violence that any approach may permit is sought out.

Besides asking what a postmodern bioethics would offer to practitioners, the question may be asked as to what issues in medicine it should address. Here, a postmodern bioethics faces difficulties. In examining one issue at the expense of another—for example, in challenging the notion of autonomy and not the distinction between somatic and mental health—philosophers could be accused of prioritizing one issue over others. I suggest that this possible reproach is an

inevitable criticism of any postmodern approach; however, it merely highlights the fact that contemporary healthcare is influenced by absolute descriptions. That philosophers attend to one description at the expense of another acknowledges the thrust of Wood's argument. In differentiating issues, and in responding to or treating things separately, we run the risk of doing violence to them. The object for philosophical inquiry in bioethics, as suggested previously, can questionably be attributed to philosophy alone. The context in which philosophers are working in bioethics influences how and why issues are examined. Although a philosophical examination of any aspect of healthcare is possible, in practice, influence is exerted on the direction of philosophical inquiry.

Conclusion

The adoption of a postmodern bioethics, identified previously as a possible approach in which the limits of knowledge have been acknowledged, calls for a particular relationship to be developed between healthcare and philosophy. The movement toward this philosophical perspective, I suggest, can be noted in the two anthologies *Relational Autonomy* and *Naturalized Bioethics*. However, philosophers might not have the ultimate say as to whether this approach is considered a rival of traditional moral theories. As philosophers in bioethics find themselves implicated in relationships with healthcare, science, law, and also institutions that provide funding, limits can be identified on the relative freedom of philosophy.

The challenges of postmodernism to bioethics are threefold. First, as philosophers engaging in ethics, we must step back and acknowledge the provisionality of all our contributions. The act of framing an action as ethical or unethical is, in itself, imposing a limit, which may involve violence. Second, Foucault's thinking invites us to consider the role philosophy plays in practices of power. In attending to or offering interpretations of action, philosophers run the risk of colluding with particular practices. If philosophy offers interpretation only to some existing practices, it is privileging interventions that are already operating but in doing so may be perpetuating dominant discourses that have privileged the interest of some over others. Third, Gergen and McNamee, in introducing the challenge of relational responsibility, draw attention to the web of relationships in which the philosopher in bioethics operates.

A postmodern approach to bioethics characterized by a resistance to the imposition of closures responds to the three challenges of postmodernism. In foregoing any attempt to guide practice but providing a space to acknowledge the impossibility of closure, the philosopher is wary of the violence that attempted closures can justify. Arising from this postmodern approach is a critical awareness that underpinning modern medicine are closures that have served to exclude and disqualify. The philosopher engaged with various actors in the medical field must acknowledge the system in which he or she is acting, the relationships that are constituted in that system, and the expectations within that system.

Notes

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