Contemporary Debates in Bioethics

Edited by Arthur L. Caplan and Robert Arp

“This outstanding volume brings the contemporary debates of bioethics to life. Thoughtful introductions to contextualize each topic combined with interactive debates result in an outstanding and unique resource.”

David Magnus, Director, Center for Biomedical Ethics, Stanford University

“I savor controversies and debates and this riveting new book has 15 great ones from the field of bioethics, debates that transcend academic disputes to engage the public, public intellectuals, and the Supreme Court on topics like assisted suicide, gene patenting, human cloning, and health reform.”

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Modern advances in medicine and biology are accompanied by an increasingly complex swirl of ethical dilemmas and debates. Contemporary Debates in Bioethics features a collection of divergent arguments contributed by today’s top bioethics scholars that focus on core bioethical concerns of the twenty-first century. After presenting highly accessible introductions to specific issues, chapters proceed to tackle each side of such topical concerns as international medical research, human cloning, markets in human organs, abortion, gene and embryo copyrighting, physician-assisted suicide, stem-cell research, primate research, biomedical enhancement, and more. Provocative and timely, Contemporary Debates in Bioethics introduces a variety of perspectives that allow readers at all levels to gain critical insights and a deeper understanding of some of the most controversial and important issues of our day.

Arthur L. Caplan is the Drs William F. and Virginia Connolly Mitty Professor and Head of the Division of Bioethics at New York University Langone Medical Center in New York City. He is the author or editor of 30 books and more than 550 papers in refereed journals. His most recent books are Smart Mice Not So Smart People (2006) and the Penn Guide to Bioethics (2009).

Robert Arp is co-editor of Contemporary Debates in Philosophy of Biology (2009), author of Scenario Visualization: An Evolutionary Account of Creative Problem Solving (2008), and co-editor of Information and Living Systems: Philosophical and Scientific Perspectives (2011).
Contemporary Debates in Bioethics
Contemporary Debates in Philosophy

In teaching and research, philosophy makes progress through argumentation and debate. Contemporary Debates in Philosophy provides a forum for students and their teachers to follow and participate in the debates that animate philosophy today in the western world. Each volume presents pairs of opposing viewpoints on contested themes and topics in the central subfields of philosophy. Each volume is edited and introduced by an expert in the field, and also includes an index, bibliography, and suggestions for further reading. The opposing essays, commissioned especially for the volumes in the series, are thorough but accessible presentations of opposing points of view.

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Contemporary Debates in Bioethics

Edited by

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Notes on Contributors

**Nicholas Agar**, Ph.D., is Reader in Philosophy at Victoria University of Wellington, New Zealand. He is interested in ethical issues arising out of human enhancement. His most recent book on this topic is *Humanity's End: Why We Should Reject Radical Enhancement* (2010).

**Richard J. Arneson**, Ph.D., holds the Valtz Family Chair in Philosophy in the Department of Philosophy at the University of California, San Diego. His recent current research is on distributive justice. Some of this work explores how one might best incorporate a reasonable account of personal responsibility into a broadly egalitarian theory of justice. He also considers how consequentialist morality (one ought always to do an act the consequences of which are no worse than those of any alternative available act) might be developed in a version that is appealing and appropriately responsive to its critics. This latter project involves exploring the structure of moderate deontology to identify the best rival of consequentialism.

**Robert Arp**, Ph.D., is author of *Scenario Visualization: An Evolutionary Account of Creative Problem Solving* (2008), co-editor with George Terzis of *Information and Living Systems: Philosophical and Scientific Perspectives* (2011), co-editor with Francisco Ayala of *Contemporary Debates in Philosophy of Biology* (Wiley-Blackwell, 2009), and co-editor with Alex Rosenberg of *Philosophy of Biology: An Anthology* (Wiley-Blackwell, 2009), and he has interests in bioethics as well. He works as a data analyst and modeler (see www.robertarp.webs.com).

**Tom L. Beauchamp**, Ph.D., is Professor of Philosophy and Senior Research Scholar, Kennedy Institute of Ethics, Georgetown University. His research interests are in the ethics of human-subjects research, the ethics of animal-subjects research and human uses of animals, the place of universal principles and rights in biomedical ethics, methods of bioethics, Hume and the history of modern philosophy, and business ethics.

**James L. Bernat**, M.D., is the Louis and Ruth Frank Professor of Neuroscience, and Professor of Neurology and Medicine at the Geisel School of Medicine at Dartmouth. He is a neurologist at Dartmouth-Hitchcock Medical Center where he directs the program in clinical ethics. bernat@dartmouth.edu.

**Edwin Black** is the award-winning, *New York Times*-bestselling and international investigative author of 80 award-winning editions in 14 languages in 65 countries, as well as scores of newspaper and magazine articles in the leading publications of the United States, Europe, and Israel. With more than a million books in print, his work focuses on genocide and hate, corporate criminality and corruption, governmental misconduct, academic fraud, philanthropic abuse, oil addiction, alternative energy, and historical investigation. For his award-winning eugenic work, *War Against the Weak: Eugenics and America’s Campaign to Create a Master Race*, he has received the Justice for All Award, the International Human Rights Award, and numerous other citations.

**Catherine M. Brooks**, J.D., is a professor of law at Creighton University in Omaha, Nebraska,
specializing in children’s and family law. She is the co-founder of the Creighton Center for the Study of Children’s Issues and co-editor of the *Nebraska Juvenile Court Procedures Manual*. She has numerous publications in peer-reviewed journals and law reviews. Professor Brooks provides consultations to family law practitioners, child advocacy groups, and other social-service organizations, particularly in matters involving child custody disputes and child protection. She earned her law degree from the University of Virginia and her bachelor's and master's degrees from Thomas More College of Fordham University and the Graduate School of Arts and Sciences of Fordham University. Her current work focuses on the use of mediation and negotiation in resolving disputes within families and between families and state protection agencies.

Arthur L. Caplan, Ph.D., is the Drs William F and Virginia Connolly Mitty Professor and founding head of the Division of Bioethics at New York University Langone Medical Center in New York City. Prior to coming to NYU, he was the Sidney D. Caplan Professor of Bioethics at the University of Pennsylvania Perelman School of Medicine in Philadelphia where he created the Center for Bioethics and the Department of Medical Ethics. He is the author or editor of 30 books and over 550 papers in refereed journals. His most recent books are *Smart Mice Not So Smart People* (2006) and the *Penn Guide to Bioethics* (2009).

Mark J. Cherry, Ph.D., is the Dr Patricia A. Hayes Professor in Applied Ethics and Professor of Philosophy at St. Edward’s University. He earned his undergraduate degree in philosophy from the University of Houston and his doctorate degree in philosophy from Rice University in Houston, Texas. His research compasses ethics and bioethics, together with social and political philosophy. He is author of *Kidney for Sale by Owner: Human Organs, Transplantation and the Market* (2005) as well as editor of *The Journal of Medicine and Philosophy*, associate senior editor of *Christian Bioethics*, Editor-in-Chief of *HealthCare Ethics Committee Forum*, co-editor of the book series *The Annals of Bioethics*, and editor of the book series *Philosophical Studies in Contemporary Culture*.

Winston Chiong, M.D., Ph.D., is a clinical fellow in the University of California, San Francisco Department of Neurology, and is a postdoctoral research fellow in the Helen Wills Neuroscience Institute at the University of California, Berkeley. His current research encompasses neuroscientific and conceptual methods to investigate changes in decision-making, moral agency, and personhood in the context of neurological illness.

Carl Cohen, Ph.D., is Professor of Philosophy at the University of Michigan, and co-author (with Tom Regan) of *The Animal Rights Debate* (2001). He was for years a member of the Animal Care and Use Committee of the Pfizer Corporation, and has served for decades on the Institutional Review Board of the University of Michigan Medical Center in Ann Arbor.

Kevin S. Decker, Ph.D., is Associate Professor of Philosophy and Associate Dean of the College of Arts and Letters at Eastern Washington University near Spokane, Washington. His areas of research interest include American pragmatism, social and political theory, and applied ethics. He is the co-editor of three books on philosophy and popular culture.

Katrien Devolder, Ph.D., is Senior Research Fellow at Bioethics Institute Ghent at Ghent University. Her research interests include medical ethics (in particular, the ethics of cloning), stem-cell research, genetic selection, chemical castration, and medical complicity in others’ wrongdoing.

Jason T. Eberl, Ph.D., is Associate Professor and Graduate Director of Philosophy in the Indiana University School of Liberal Arts at Indiana University-Purdue University, Indianapolis. He is also an affiliate faculty member of the IU Center for Bioethics and the IUPUI Medical Humanities & Health Studies program. He has published articles and reviews in *American Journal of Bioethics*, *Bioethics, Journal of Medicine and Philosophy*, *National Catholic Bioethics Quarterly*, and *Linacre Quarterly*. His book *Thomistic Principles and Bioethics* was published in 2006.

John Geyman, M.D., is Professor Emeritus of Family Medicine at the University of Washington School of Medicine, where he chaired the Department of Family Medicine from 1976 to 1990. He has also

**Jean Kazez**, Ph.D., is Adjunct Assistant Professor of Philosophy at Southern Methodist University. She is the author of *Animalkind: What We Owe to Animals* (2010) and *The Weight of Things: Philosophy and the Good Life* (2007), both published by Wiley-Blackwell.

**David Koepsell**, Ph.D., earned his law degree and Ph.D. in philosophy from the University at Buffalo. He teaches ethics in the Philosophy Section, Faculty of Values and Technology, Delft University of Technology, The Netherlands. He has published widely on the philosophy of intellectual property, applied ethics, ontology, and civil rights (see http://davidkoepsell.com).

**John Lachs**, Ph.D., is Centennial Professor of Philosophy at Vanderbilt University. His latest book, *Stoic Pragmatism* (Indiana University Press), has just appeared.

**Patrick Lee**, Ph.D., holds the John N. and Jamie D. McAleer Chair of Bioethics, and is the Director of the Institute of Bioethics, at Franciscan University of Steubenville. He has published widely on bioethics, including written articles and books on bioethics, including *Body-Self Dualism in Contemporary Ethics and Politics* (with Robert P. George, 2007), *Abortion and Unborn Human Life* (2010).

**Stephen E. Levick**, M.D., is a clinical assistant professor of psychiatry at the University of Pennsylvania School of Medicine, where he supervises psychotherapy, and has his own private practice nearby. His book, *Clone Being: Exploring the Psychological and Social Dimensions* (2004), was described by cloning pioneer, Ian Wilmut, as “the first framework for detailed analysis of the ethical, psychological, and social consequences of human reproductive cloning.” He employs arguments generated from that framework as both siege engines and battlements in his debate with Dr Devolder on the issue in this volume.

**Jane Maienschein**, Ph.D., is Regents’ Professor, President’s Professor, and Parents Association Professor at Arizona State University, where she serves as Director of the Center for Biology and Society. She is also Adjunct Scientist and Director of the History and Philosophy of Science Program at the Marine Biological Laboratory in Woods Hole, Massachusetts. An MBL-ASU/HPS collaboration includes the Embryo Project (embryo.mbl.edu), HPS Repository, and Digital HPS Consortium. She is (co)editor of a dozen books and author of three, including *Whose View of Life? Embryos, Cloning, and Stem Cells* with Harvard University Press.

**Bertha Alvarez Manninen**, Ph.D., is an associate professor of philosophy at Arizona State University’s West campus. Her primary area of research is bioethics with an emphasis on the moral status of embryos and fetuses. Other interests include philosophy of religion, ancient philosophy, social and political philosophy, and philosophy and film.

**Don Marquis**, Ph.D., is Professor of Philosophy at The University of Kansas. His essay “Why Abortion is Immoral” was published in *The Journal of Philosophy* in 1989 and has been reprinted over 90 times.

**Daryl Pullman**, Ph.D., is a professor of medical ethics in the Faculty of Medicine, at Memorial University in Newfoundland and Labrador, Canada. He has published widely on issues in clinical and research ethics.

**Laura Purdy**, Ph.D., is Professor Emerita of Philosophy at Wells College. Her research has focused primarily on issues in reproduction and family.

Liberalism (Wiley-Blackwell, 2012), and more than 120 articles in philosophy and criminal justice journals and anthologies.

**Lawrence M. Sung**, J.D., Ph.D., is a Partner with the law firm of Baker & Hostetler LLP in the Washington, DC office, specializing in biotechnology, pharmaceutical, and medical device patent litigation, counseling, and technology transfer. Dr Sung is also a professor and the Director of the Intellectual Property Law Program at the University of Maryland School of Law in Baltimore, MD. He may be contacted at lsung@bakerlaw.com or lsung@law.umaryland.edu.

**Christopher Tollefsen**, Ph.D., is Professor of Philosophy at the University of South Carolina; he has twice been a visiting fellow in the James Madison Program at Princeton University. He has published over 60 articles, book chapters, and reviews on bioethics and natural law ethics, and is the author, co-author, or editor of five recent books, including Biomedical Research and Beyond: Expanding the Ethics of Inquiry (2012) and, with Robert P. George, Embryo: A Defense of Human Life (2011). He has recently completed a book manuscript, provisionally titled Truth, Lies, and the Natural Law: Why Lying for a Good Cause is Always Wrong. Tollefsen sits on the editorial board of a number of journals and is the editor of the Springer book series, Catholic Studies in Bioethics.

**Jamie Carlin Watson**, Ph.D., is Assistant Professor of Philosophy at Young Harris College (Young Harris, GA). With Robert Arp, he is the author of Critical Thinking: An Introduction to Reasoning Well (2011), Philosophy DeMYSTiFied (2011), and What’s Good on TV: Understanding Ethics Through Television (Wiley-Blackwell, 2011). He is currently working with Peter Fosl and Galen Foresman on The Critical Thinker’s Toolkit (Wiley-Blackwell).

**Glen Whitman**, Ph.D., is a professor of economics at California State University, Northridge and an adjunct scholar with the Cato Institute. He received his Ph.D. in economics from New York University in 2000. His research in applied game theory, economic analysis of law, and economic methodology has appeared in the Journal of Legal Studies, UCLA Law Review, Journal of Economic Behavior and Organization, and other scholarly journals. His current research interests include healthcare and paternalistic legislation.

**William J. Winslade**, J.D., Ph.D., Ph.D., is James Wade Rockwell Professor of Philosophy of Medicine, Professor of Preventive Medicine and Community Health, and Professor of Psychiatry and Behavioral Sciences, and is a member of the Institute for the Medical Humanities at the University of Texas Medical Branch, Galveston, Texas. He is also Distinguished Visiting Professor of Law at the University of Houston Health Law and Policy Institute. Philosophic, legal, and psychoanalytic ideas are applied in his work to the study of human values in science, medicine, technology, and law. His book Confronting Traumatic Brain Injury: Devastation, Hope and Healing was published in 1998. He has co-authored three other books: Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine, Sixth Edition (2006), written for health professionals; The Insanity Plea: The Uses and Abuses of The Insanity Defense (1983), written for a general audience; and Choosing Life and Death (1986), written for patients and their families as well as health professionals about medical–moral–legal–technological topics such as kidney dialysis, organ transplantation, treatment or non-treatment of damaged newborns, termination of life support, genetic screening and counseling, and healthcare costs and policies. In addition, he has written numerous scholarly articles and essays for general readers on topics such as privacy and confidentiality, human rights, death and dying, and legal and ethical aspects of mental-health practice. He is currently working on a book with Stacey Tovino, J.D., Ph.D., tentatively titled The Birth Life and Death of the Brain: Legal and Ethical Perspectives.
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General Introduction

Who Is This Book for?

This book features chapters written by contemporary scholars doing work in the central topics of the branch of applied ethics known as bioethics. The chapters are presented in a debate style with yes and no responses—often qualified—to core contemporary quandaries in the field. The book is intended to provoke discussion and debate for students in ethics, bioethics, and medical ethics classrooms in high school, college, and professional school.

What Is Bioethics?

The English word “bioethics” comes from two Greek words: bios (βίος) meaning “life” and ethikos (ἠθικός) meaning “displaying moral character.” In 1927, Fritz Jahr used the term in an article, “Bio-Ethik: Eine Umschau über die ethischen Beziehungen des Menschen zu Tier und Pflanze,” which can be translated as “Bio-Ethics: A Review of the Ethical Relationships of Humans to Animals and Plants” (Jahr, 1927; Sass, 2007; Goldim, 2009). In that article, Jahr wanted to extend a “bioethical imperative” to all forms of life, arguing that we ought to treat other humans and living things with respect as ends in and of themselves (Kant, 1785/1998). In 1971, Van Rensselaer Potter also used the term in his book, Bioethics: Bridge to the Future (Potter, 1971). He subsequently wrote Global Bioethics: Building on the Leopold Legacy, and in 1995 co-authored the article, “Global Bioethics: Converting Sustainable Development to Global Survival” (Potter, 1971, 1988; Potter & Potter, 1995). For both Jahr and Potter, what they referred to as “bioethics” would be considered today to be the related branch of applied ethics known as environmental ethics. This area of ethics explores our relationship to the natural world, our duties to preserve and protect nature, and whether morality extends beyond humans to animals, other living things, and the entire biosphere itself (Attfield, 2003; Keller, 2010).

Bioethics, while keenly aware of the ways in which health is shaped by climate and the environment, is focused today mainly on humans and the issues that emerge in conducting biomedical and clinical research, healthcare, and the policies that ought to govern medicine, nursing, allied health, and the related biomedical sciences (Caplan, 1992b, 1994, 1997, 1998, 2009; Jonsen et al., 2011). So, while the name “bioethics” derives from scholars seeking to create environmental ethics, the history of bioethics is actually rooted in medical ethics, a branch of applied ethics concerned with the practice of medicine and healthcare (Ramsey, 1970; Katz, 1984; Veatch, 1989, 2011; Pellegrino, 2008; Kuhse & Singer, 2009; Pence, 2010). Given the close connection between bioethics and medical ethics, some refer to the discipline as biomedical...
ethics (Beauchamp & Childress, 1979/2009; also Glannon, 2004; Mappes & DeGrazia, 2005).

The Canon of Bioethics

Bioethics has a subject matter and specific questions that it has developed near the end of the twentieth century, and the topics that comprise this subject matter include:

- abortion;
- contraception;
- cloning;
- genetic engineering and enhancement;
- patenting genes and organisms;
- markets for human organs and tissues;
- physician-assisted suicide;
- stem-cell research and therapies;
- defining death;
- in vitro fertilization and reproductive technologies;
- animal experimentation;
- clinical trials;
- patients’ rights and informed consent;
- codes of ethics for healthcare professionals;
- psychosurgery and engineering the human brain;
- healthcare access and reform;
- allocation and rationing of scarce medical resources.

Most of these topics are debated by the contributors to this book. Each core topic is described further in the introductions to each section, including relevant reading material. The reader should consult various other resources in bioethics to get a sense of the scope and breadth of view on the core topics such as:

Edited books and encyclopedias:

- Encyclopedia of Bioethics, edited by Warren Reich (Macmillan, 1995);
- Medical Ethics: Applying Theories and Principles to the Patient Encounter, edited by Matt Weinberg and Arthur L. Caplan (Humanity Books, 2000);
- Encyclopedia of Bioethics, edited by Stephen Post (Macmillan, 2003);
- Bioethics: An Anthology, edited by Helga Kuhse and Peter Singer (Wiley–Blackwell, 2006);
- The Oxford Companion to Bioethics, edited by Bonnie Steinbock (Oxford University Press, 2007);
- The Blackwell Guide to Medical Ethics, edited by Leslie Francis, Anita Silvers, and Rosamond Rhodes (Blackwell, 2007);
- The Penn Center Guide to Bioethics, edited by Vardit Ravitsky, Autumn Fiester, and Arthur L. Caplan (Springer, 2009);
- Case Studies in Bioethics, edited by Robert Veatch, Amy Haddad, and Dan English (Oxford University Press, 2009);
- The Ethics of Research Biobanking, edited by Jan Helge Solbakk, Soren Holm, and Bjorn Hofmann (Springer, 2009);
- Trust and Integrity in Biomedical Research: The Case of Financial Conflicts of Interest, edited by Thomas Murray and Josephine Johnston (Johns Hopkins, 2010);
- Progress in Bioethics: Science, Policy, and Politics, edited by Jonathan Moreno and Sam Berger (MIT Press, 2010);
- The Oxford Textbook of Clinical Research Ethics, edited by Ezekiel Emanuel, Christine Grady, Robert Crouch, Reidar Lie, Franklin Miller, and David Wendler (Oxford University Press, 2011);
- A Companion to Bioethics, edited by Helga Kuhse and Peter Singer (Wiley–Blackwell, 2011);
- Global Justice and Bioethics, edited by Joseph Millum and Ezekiel Emanuel (Oxford University Press, 2012);
- Also see the books in the Basic Bioethics series, edited by Glenn McGee and Art Caplan (MIT Press, 1999 to present).

Journals:

- Bioethics;
- The Hastings Center Report;
- Journal of Medical Ethics;
- Journal of Medicine and Philosophy;
- American Journal of Bioethics;
- Kennedy Institute of Ethics Journal;
- Theoretical Medicine and Bioethics;
- Cambridge Quarterly of Healthcare Ethics;
- Journal of Clinical Ethics.

Bioethics centers maintain websites with useful information, including:

- Columbia University Center for Bioethics: http://www.bioethicscolumbia.org/
- The Hastings Center: http://www.thehastingscenter.org/
Motivations for Topics in Bioethics

The core topics of bioethics oftentimes emerged as a result of the moral outcry elicited by some highly publicized practice, event, or series of events in biomedicine or clinical research that actually (or potentially) harmed people, animals, or even the biosphere. In this respect, the topics in bioethics are no different than any ethical topic that has emerged in the course of human history (Cavalier et al., 1989; MacIntyre, 1998).

For example, the Nazi experimentation on humans that took place between 1939 and 1945, where people were subjected to various hazardous and horrific experiments often designed to assist in the advancement of military medicine and the physician-directed racial euthanasia campaigns of the Nazis, raised many questions about the ethics of those involved (Caplan, 1992a; Conot, 1993; Annas & Grodin, 1995; Lifton, 2000; Spitz, 2005). During and after the Nuremberg trials (1946–1949), where numerous Nazis were tried for a variety of atrocious crimes, the Nuremberg Code was devised and codified in response to the systematic abuse of human subjects in research. The Code, which was in reality the decision in one of the trials of German doctors, includes basic biomedical principles related to human experimentation (clinical research) such as absence of coercion in recruiting subjects, the necessity of informed consent, non-maleficence toward participants in experiments, and the correct formulation of a scientific protocol (Weindling, 2004; Schmidt & Frewer, 2007; NIH, 2011a).

It would seem that anyone who lived during the middle of the twentieth century and was made aware of the Nazi human experimentation would sympathize with the Jewish slogan that refers to the atrocities of the Holocaust and murder fueled by racism and anti-Semitism: Never Again! However, the US and the world were shocked to hear in 1972 that, for 40 years, an experiment monitoring the effects of syphilis upon poor, rural, and illiterate African-American men—who, having been lied to by researchers, thought they were being treated for the disease but in fact were not—had been conducted by the US Public Health Service and Centers for Disease Control and Prevention. The Tuskegee Syphilis Experiment—so named because Tuskegee Institute was a willing participant—began as an observational study in 1932 with 600 African-American men, 399 with syphilis and 201 without the disease. In 1972, when the study became known through whistle-blowing in the media, 74 of the 600 men were still alive. Concerning the original 399 men with syphilis, 28 died of syphilis, and 100 died of syphilis-related complications, while 40 of their wives were infected with syphilis, and 19 of their children were born with syphilis (Jones, 1992; Reverby, 2009). What makes this experiment all the more insidious is the fact that, by 1945, penicillin was being mass-produced in the US to treat diseases like syphilis, and the infected men in the experiment easily could have been treated after 1945; and many lives would have been saved as well as much pain and suffering avoided (Katz & Warren, 2011).
National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1974–1978), and in 1979 the Commission issued a landmark document for biomedicine or clinical research called, “The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research.” It was named “The Belmont Report” for the Smithsonian Institution’s Belmont Conference Center (Elkridge, MD) where the Commission met in February of 1976 when first drafting the report (Childress et al., 2005; NIH, 2011b). The Belmont Report affirmed all of the basic bioethical principles found in the Nuremberg Code, as well as articulated other principles, including the principle of justice whereby “equals ought to be treated equally.” The report called for peer review of all studies to insure that the risk/benefit ratio involved made moral sense and that the informed consent of subjects was adequate. Unfortunately, there are numerous cases of unethical human experimentation documented in the US and other countries throughout the twentieth century, and these cases form the basis for a central topic in bioethics (Moreno, 2000; Dresser, 2001; Goliszek, 2003; Guerrini, 2003; the papers in Hawkins & Emanuel, 2008).

Historical technological innovation has also driven the emergence of bioethics. Although Willem Kolff is credited with inventing the first kidney-dialysis machine (he also helped invent the artificial heart and heart-lung machine, as well as invented an artificial eye and ear, and the intra-aortic balloon pump), it was Belding Scribner who improved upon Kolff’s machine and opened the first center devoted to dialysis, the Seattle Artificial Kidney Center, in 1962 (Pietzman, 2007; Brown, 2009). Since there were a limited number of machines in the center and many more patients who needed dialysis in order to live, ethical questions related to who should receive dialysis emerged immediately (Jonsen, 2000, pp. 104–106; also Katz & Capron, 1982; Emanuel, 1991; Elger et al., 2008).

Harvard medical researchers, Philip Drinker and Louis Agassiz Shaw, invented the “iron lung” in 1927 to assist or restart breathing in individuals; but even with John Emerson’s improvements on the mechanism in 1931, iron lungs were big, bulky, and expensive to operate. Simple, hand-operated, bag valve mask ventilators began to be used by doctors and others in 1953; but they suffered from the obvious problem of having to be constantly squeezed by someone (Gorman, 1979; Laurie, 2002; Ambu, 2011). In 1971, Siemens introduced the medical world to a small, fairly quiet electronic ventilator—the SERVO 900—and various models soon became a staple in ERs, then in ambulances, too (Maquet Critical Care, 2001, 2005). The electronic ventilator now could be used to assist someone in their breathing, potentially indefinitely, and this occurred regularly for people in comas. The extended use of a ventilator (usually in combination with a feeding tube) has been the source of much debate, and cases of people in persistent vegetative states requiring ventilators and feeding tubes—such as the widely publicized cases of Karen Ann Quinlan, who lived with a feeding tube in a persistent vegetative state from 1975 to 1985, and Terri Schiavo, who lived with a feeding tube in a persistent vegetative state from 1990 to 2005—cause people to think about the extent to which these biomedical technologies are ethically appropriate or not (Armstrong & Colen, 1988; Buchanan & Brock, 1990; Caplan et al., 2006).

By the end of the twentieth century, women were giving birth to so-called “designer babies,” which is a negative term really, but refers to babies who have been born after having their embryos screened for genetic diseases through methods of pre-implantation...
genetic diagnosis (PGD). PGD requires in vitro fertilization (IVF) techniques to obtain the embryos for the screening, and IVF itself is its own bioethical topic surrounded by arguments and controversy (Cook-Deegan, 1996; Buchanan et al., 2000; Skloot, 2010). In 1990, Debbie Edwards gave birth to twin girls in Hammersmith Hospital in London after having been implanted with female embryos that had been screened by Drs Alan Handyside and Norman Winston utilizing methods of PGD. Given Edwards’ medical history, there would have been a 50% chance that a baby boy would have developed brain damage and die young, so she turned to Handyside, Winston, and PGD to ensure that she would give birth to a baby girl (Maugh, 1990; Handyside et al., 1992). One can imagine screening embryos so as to “design” the kind of child we want—affecting intelligence, height, eye color, looks, etc.—so it is easy to see how the moniker has been applied (see the papers in Savelescu & Bostrom, 2009; Harris, 2007).

PGD has also been used to screen embryos when a mother wants to give birth to a child who can act as a “savior sibling” by providing a cell transplant to a sibling who suffers from a disease like anemia or leukemia. In 2000, a young girl named Molly Nash received stem cells from the umbilical cord of her newborn brother (whose tissue type had been screened as an embryo), and the stem cells were successful in treating Nash’s Fanconi anemia (Wolf et al., 2003; Marcotty, 2010).

Still more fascinating, at the American Society for Reproductive Medicine’s 2007 annual meeting, it was announced that researchers used a virus to add a gene, a green fluorescent protein, to an embryo left over from assisted reproduction (Zaninovic et al., 2007; CellNEWS, 2008). Many take this to be the first documented case of genetic modification of a human embryo. The kind of genetic engineering of the traits in these examples fits squarely as a key topic in the realm of bioethics, as a question like, “Are doctors and scientists justified in playing god or altering the course of nature with respect to living things, especially human beings?” becomes front and center (see the papers in Magnus et al., 2002).

Dr Jack Kevorkian died on June 3, 2011 at the age of 83. His actions caused the controversial topic of physician-assisted suicide to be part and parcel of contemporary bioethics. He was a medical doctor with a specialty in pathology who claimed to have assisted over 130 people with their own suicides. He invented and used the Thanatron (named after the Greek god that personifies death, Thanatos), a device that allowed one to push a button that released deadly potassium chloride into one’s body intravenously, and the Mercitron, a device that employed a gas mask that could be filled with carbon monoxide to let people kill themselves (Kevorkian, 1988; Roscoe et al., 2000; Dowbiggin, 2003; Nicol & Wylie, 2005; Schoifet, 2011).

The Hippocratic Oath is something that every medical school student knows about. The oath specifically asks the new doctor to promise ἐπὶ δηλήσει δὲ καὶ ἀδικίᾳ ἔρξειν, “to refrain from doing harm” (AMA, 2001, 2004; Magner, 2005). So, when Kevorkian assisted in the suicide of Janet Adkins in 1990 with the Thanatron—his first assisted suicide—many utilized the ethical obligation to “refrain from doing harm” to condemn his actions (Kass, 1989; Hartmann and & Meyerson, 1998; Somerville, 2001).

Morally, it is one thing to assist in a suicide by providing the person who wishes to do so with instruction and a device that they may activate on their own. It is ethically different if someone administers a lethal injection seeking to kill a person. Kevorkian killed a severely disabled man, Thomas Youk, on September 17, 1998, and taped his behavior for later broadcast on national television. His involvement in homicide resulted in a second-degree murder conviction and over 8 years of prison time (Johnson, 1999). Still, many argue that Kevorkian’s lethal injection was a sympathetic action, along the lines of the Scottish doctor, John Gregory’s, claim—made in the beginning of the nineteenth century—that a doctor, like any other human being, needs to have a “sensibility of heart which makes us feel for the distresses of our fellow creatures, and which, of consequence, incites in us the most powerful manner to relieve them” (Gregory, 1817, p. 22).

The 1972 play and 1981 movie by the same name, Whose Life is It Anyway?, is a fictional story about a man who becomes paralyzed from the neck down after a car accident and wants to end his own life, and he offers several arguments in favor of his position, including the “I have a right to do with my body what I want to” argument (also see Berg et al., 2001; Annas,
This popular story was solidly planted in the American psyche when Dr Kevorkian assisted in Adkins’ suicide in 1990 and, not only did fiction become reality, but a bioethical “hot-button” topic became fodder for discussion, dialogue, and debate.

In this introduction, we could speak about the motivations for all of the topics in bioethics, but because of space limitations, we are unable to do so. Bioethics has a varied and complex history that would take several lifetimes to ingest completely, but a great place to start is with Albert Jonsen’s *The Birth of Bioethics* (Jonsen, 1998) and Vincent Barry’s *Bioethics in a Cultural Context: Philosophy, Religion, History, Politics* (Barry, 2012).

**The Classification of Bioethics**

Concerning its classification within the general discipline of Western philosophy, bioethics is usually envisioned as a branch of applied or practical ethics, along with environmental ethics, business ethics, legal ethics, engineering ethics, and cyberethics (there are others). Applied ethics, metaethics, and normative ethics are branches of ethics or moral philosophy, and ethics, political philosophy, metaphysics, epistemology, and logic are understood to be the classical branches of Western philosophy (Copleston, 1994; Jones, 1997; Solomon, 2005). *Metaethics* deals with issues such as the nature of moral knowledge, the proper grounds for justifying moral claims, the metaphysical/ontological status of moral norms and entities, and cultural and ethical relativism (Bok, 2002; Jacobs, 2002; Miller, 2003; for a discussion of relativism in relation to bioethics, see Macklin, 1999). *Normative ethics* deals primarily with the development, investigation, and critique of various ethical/moral theories such as religious-based deontology, ethical egoism, Kantian deontology, utilitarianism, natural rights theory, and virtue ethics (Kagan, 1997; Fieser, 1999; Pojman, 2005; Kamm, 2006; for application of normative ethical theories specifically to bioethics, see Pellegrino & Thomasma, 1981; Powers & Faden, 2006; Veatch, 2011). As the name suggests, *applied ethics* is primarily concerned with the application of ethical/moral theory to practice insofar as the actions and interactions of humans (as well as the interactions of humans with animals and the biosphere) in the realms of professions, institutions, and public policy generate ethical problems and dilemmas that are in need of solutions and resolutions (McGee, 1999; Cohen & Wellman, 2005; LaFollette, 2006).

Figure 0.1 represents a partial taxonomic classification of bioethics, and we are aware that there are many other philosophical disciplines and sub-disciplines not shown, as well as that it is possible to classify the discipline of Western philosophy by historical time periods or major movements. Also, note that the figure attempts to represent the idea that bioethics could also be called biomedical ethics, and that medical ethics could be considered a species of bio(medical)ethics.

**A Philosophical Discipline**

Although doctors, nurses, clinicians, lawyers, biologists, theologians, and other researchers make valuable contributions to it, bioethics is first and foremost a philosophical discipline concerned with “issues that emerge in conducting biomedical and clinical research, healthcare, and the policies that ought to govern medicine, nursing, allied health, and the related biomedical sciences,” as we noted in the definition of bioethics above. And we also saw that bioethics is a branch of applied ethics, which is a branch of ethics, itself a branch of Western philosophy; thus, if the classification is correct, the basic features, properties, and characteristics of Western philosophy should be present in bioethics. This means that the principles of correct reasoning and logic trumpeted and championed by the philosopher—including the formation of sound or cogent arguments, complete with objective evidence that any rational person could assent to—should not only act as the primary tool utilized in discussing the topics in bioethics, but also provide thinkers with a level playing field, so to speak, where ideas and arguments can be respectfully explained, analyzed, debated, evaluated, and critiqued. Anyone, regardless of ideology, world view, or perspective, is welcome to play on the field, provided they play by the rules of correct reasoning and logic. Beauchamp and Childress (1979/2009) affirm this philosophical approach in the first chapter of their famous work in bioethics, *Principles of Biomedical Ethics*, as does H. Tristram Engelhardt (1986/1996) in the first two chapters of his book, *The
Foundations of Bioethics. Of course, as Dan Brock (1993, pp. 414–416) notes in the final pages of his book, *Life and Death: Philosophical Essays in Biomedical Ethics*, philosophers have a bad reputation as being “unrealistic, head in the clouds, ivory tower academics;” however, as Brock also notes, philosophers have made important contributions to bioethics and the public policies generated from this important discipline.

**Dealing with Hot-Button Issues**

The topics discussed in bioethics are some of the most emotionally charged of all of the disciplines in applied ethics—abortion, suicide, stem-cell research, the allocation of scarce vital organs, and socialized medicine, for example, are “hot-button” issues for most Americans (see Steinbock, 1996; Caplan & Coelho, 1998; Meisel & Cerminara, 2004; Angell, 2005; Callahan & Wasunna, 2006; George & Tollefsen, 2008; Callahan, 2009). While it is important to be sensitive to these emotions, the bottom line is that reason motivated by a sincere desire to find common moral ground ought to drive bioethical reflection and discussion. One of the authors in this book, Jeffrey Reiman, puts the point a little differently in his chapter defending abortion: “People’s moral beliefs may be influenced by emotions, affections, and fears,
which may distort people’s judgment so that they believe what is not rationally grounded … We want an answer (to a moral question) that we have good reason to believe is true; and we must recognize that what people actually believe may be false.” The reader will see that the chapters of this book have been written by philosophers and other thinkers who engage in the debates adhering to the principles of correct reasoning and logic—or, at least they attempt to adhere to them, and are called out by an interlocutor when they violate a principle.

We hope that students and scholars of bioethics alike will benefit from the material in this book. Best in your reading, research, reflection, thinking, and bioethical decision-making.—Art Caplan and Robert Arp

References


Are There Universal Ethical Principles That Should Govern the Conduct of Medicine and Research Worldwide?

Introduction

If the question that forms the basis for the debate in this section were “Are there universal ethical principles that do in fact (rather than should) govern the conduct of medicine and research worldwide?” the answer would prima facie be no, and the matter likely settled by appealing to data and facts contrasting the current ethical justifications for the medical practices of one group, culture, or nation with another (or several groups, culture, or nations). For example, female genital mutilation (FGM)—defined by the World Health Organization (WHO) as “all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for nonmedical reasons”—is not practiced in the mainstream medical communities of the US and many other countries based primarily on ethical reasons pertaining to principles of autonomy, beneficence, and nonmaleficence. By contrast, the WHO estimates that, as of February 2010, between 100 and 140 million girls and women worldwide have had some form of FGM, and in many of the countries where FGM is practiced there are oftentimes religious, ethical reasons given as justification for the procedure (Boyle, 2002; Skaine, 2005; WHO, 2010). So, by virtue of the fact that FGM is practiced in certain societies around the world, it is apparent that principles of autonomy, beneficence, and nonmaleficence are not governing the conduct of medicine and research worldwide; conversely, by virtue of the fact that FGM is not practiced in societies such as the US, it is also apparent that certain religiously based ethical principles also are not governing the conduct of medicine and research worldwide. And there are many other conflicting or
contradictory medical and biomedical practices worldwide that can be pointed to as examples of the fact that there seem not to be universal ethical principles governing these practices (Young, 2006; Unschuld, 2009; Caplan, 2010).

A cultural anthropologist, sociologist, psychologist, or any other researcher can look at medical and biomedical practices worldwide and note descriptively that it is the case that there are not universal ethical principles governing these practices. Although, we must be cautious here since many thinkers who have argued for one version or another of soft universalism have attempted to show that there are in fact a handful of universal ethical principles in existence, but that these principles make themselves manifest in culturally grounded ways, giving the mere appearance of being relative (Foot, 1979/2002; Nussbaum, 1993; Walzer, 1994; Bok, 2002; Miller, 2002). In any event, the bioethicist (and any other thinker, for that matter), as philosopher, can look at medical and biomedical practices worldwide and question whether prescriptively there should be universal ethical principles governing these practices. Consider FGM again. The number of good arguments against FGM that appeal to (ostensibly) universalizable principles of autonomy, beneficence, and nonmaleficence would seem to suggest that practitioners of FGM either are unaware of these principles, knowingly disregarding them, or may be pressured into disregarding them due to cultural or religious factors (Nussbaum, 1999; Cohen, Howard, and Nussbaum, 1999; Gruenbaum, 2001). In other words, it can be argued that these ethical principles (and laws emerging from them) should be guiding medical practice worldwide such that FGM stops occurring altogether, no matter what the culture or social situation.

Immanuel Kant’s (1724–1804) deontological moral theory, with its emphasis upon autonomy, respect for persons, and blind justice, as well as John Stuart Mill’s (1806–1873) utilitarian moral theory, with its emphasis upon bringing about the most nonharmful (and hence, pleasurable) and beneficial consequences to a person (or sentient being) affected by an action, have acted as the basis for practical moral decision-making since the theories were formulated in the eighteenth and nineteenth centuries (Kant, 1785/1998; Mill, 1861/2001; Korsgaard, 1996; Baron, 1999; Hooker, 2000). And many of the standard philosophical arguments against FGM appeal to Kant and/or Mill, in one form or another (Nussbaum, 1999; Cohen et al., 1999; Wallis, 2005; Bikoo, 2007; Burkhardt and Nathaniel, 2008; cf. Lander, 1999). The principles emerging from these theories were affirmed in the Nuremberg Code (1946–1949), The Belmont Report (1979), and Tom Beauchamp and James Childress’ famous work, Principles of Biomedical Ethics (NIH, 2011a, 2011b; Beauchamp and Childress, 1979/2009), which has become a standard reference work for medical and other bioethical decisions. Given the wide rational appeal and application of these principles to multiple practical issues—bioethical or otherwise—along with their success in application in terms of conflict resolution and just policy making in numerous countries, it can be argued that they are the types of universal ethical principles that should govern the conduct of medicine and research worldwide.

In fact, in the first chapter of this section Daryl Pullman affirms what he calls the principle of respect for human dignity, which he argues is present most clearly in Kant’s moral philosophy and acts as the foundation for any moral decision. Thus, it is Pullman’s contention that not only is a respect for human dignity actually at work universally in moral decision-making (descriptively), but also that it should be at work universally in moral decision-making (prescriptively) (also see Walzer, 1994; Macklin, 1999; Bok, 2002). “Our concept of morality is predicated on the assumption of the intrinsic moral worth or dignity of humanity,” Pullman notes, and the “essence of morality is to guard, protect, and advance this fundamental value.” To bolster his position, Pullman appeals to a well-known strategy that has been used against proponents of ethical relativism who think that it is not possible for one group, society, or culture to criticize morally the actions of another group, society, or culture (see Harman, 1975/2000, 1984/2000, 1996), namely, without at least the principle of respect for human dignity, there is “no way to measure moral progress or regress, and no basis for judging the actions of other nations, social groups, or even individuals as either morally praiseworthy or blameworthy.”

“It might seem surprising to demand of ethical principles that they be universal, given that most moral decision-making will concern those fairly close