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FROM THE EDITORS

Time brings transitions; and this issue of the newsletter marks time in several ways.

In a departure from our usual practice, we include two memorials in this issue, which is devoted to papers delivered during the last year revisiting the work of two pioneers in our area of interest, Mary Anne Warren and Bernie Gert.

Mary Anne's life was celebrated at the Pacific Division meeting in 2012, and this issue includes three papers and a poster from that session. Michael Boylan explores her treatment of animal rights, Wanda Teays discusses her views on personhood, moral agency, and moral status, and Michael Tooley writes on Warren and abortion. The poster on page 14 was assembled by her lifelong friend Wanda Teays.

Bernie Gert was the subject of three memorial sessions in the last few months: at the Central Division meeting in February, and at the annual meetings of our sister organizations—the American Society for Bioethics and Humanities (ASBH) last October, and the Association for Practical and Professional Ethics (APPE) in March. This issue includes several papers delivered at those occasions. Tom Beauchamp, Loretta Kopelman, and Rosamond Rhodes spoke in a memorial session at ASBH. At the Central Division meeting Michael Ferry discussed Gert's views on paternalism, Michael Nair-Collins spoke on brain death, and Rosamond Rhodes discussed Gert's view of common morality. And James Bernat, Robert Ladenson, and Ronald Green took part in the memorial session at APPE.

In another farewell, Rosamond Rhodes is leaving the chairmanship of the Committee on Philosophy and Medicine, to be succeeded in that role by Nir Eyal. Before assuming the chair of the committee she edited this newsletter for many years, and this proximity to the field has laid the foundation for some rich reflections in her final column.

Papers from other divisional meetings will be published in future issues. The 2012 Eastern Division program featured six speakers who spoke about justice and defining the requirements for a basic minimum of health care. Each speaker tackled the problem of specifying what the content of a just scheme of health care should include in a decent society. The committee also arranged a session on health care for prisoners at the 2013 Pacific Division meeting.

We are running low on book reviews! Why don't you write up your reactions to that book you are reading right now, and send them in?

The Editors

FROM THE CHAIR

My term as the first woman chair of the APA Committee on Philosophy and Medicine is coming to a close. I can report that during this academic year the committee has again sponsored superb sessions at all three divisional meetings.

This is my last official newsletter column. I take this as an opportunity to reflect back on bioethics, to muse about what is happening in the field today, and to imagine what might lie just over the horizon.

In the beginning

Historians in the field have identified the 1960s and 1970s with the birth of bioethics, noting that this period was marked by dramatic advances in biomedical technology that raised moral questions for society and anguished responses from the public.¹ Among the biomedical advances associated with the beginning of bioethics are the development of the birth-control pill in 1960, the development of the positive pressure mechanical ventilator to provide artificial respiration in the late 1960s and early 1970s, the development of the first cadaveric kidney transplant in 1962, the development of hemodialysis from 1960 to 1970, the establishment of the "God Committee" at Seattle's Swedish Hospital to allocate use of dialysis machines in 1962, and the birth of Louise Brown, the first test-tube baby, on July 25, 1978. During this era, US courts rendered landmark decisions on a number of medical issues such as contraception, abortion, the right to refuse medical treatment, and the right to discontinue life-preserving treatment.²

Life during this period bore the scars and memories of World War II and the aspirations expressed in the United Nations' *Universal Declaration of Human Rights*. It carried over the employment-based health insurance model created in response to World War II labor shortages. It bore witness to the horrors, doubts, and aftermath of the Vietnam War. It was the time of the civil rights movement, the women's rights movement, the gay rights movement, the disability rights movement, protests and riots in the streets. And in philosophy, John Rawls published his important book on political philosophy, *A Theory of Justice*, in 1971. With its emphasis on respect for autonomy, Rawls's work not only revived interest in Immanuel Kant's ethical theory, it also introduced an array of concepts that have informed discussions of ethics since then, such as "primary social goods," "veil of ignorance," "original position," "fair equality of opportunity," and the "difference principle."

Bioethics sprang up in this period of civic unrest, advocacy, uncertainty, and people clamoring for equality and liberty. Before the name "bioethics" was widely recognized, theologians, physicians, lawyers, and philosophers began to grapple with

the difficult decisions that medicine had to confront. At the same time, public outrage accompanied revelations related to the Tuskegee Syphilis Study (1932–1972), the Willowbrook hepatitis studies, and Henry K. Beecher’s 1966 exposé of clinical research practices in the *New England Journal of Medicine*. In response, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research was given the task of developing standards for the conduct of human subject research. On September 30, 1978, it ultimately issued the *Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*.³

The writings of this period were among the first pronouncements of the bioethics community. Some of these early bioethics articles provided needed clarification of important concepts that remain relevant. Judith Jarvis Thomson’s 1971 paper, “A Defense of Abortion,” and James Rachel’s 1975 paper, “Active and Passive Euthanasia,” are obvious examples. These seminal works are still papers that must be read and understood by anyone working in the field. Other papers mapped out the range of positions on important issues, not only abortion and euthanasia, but also on personhood and patients’ rights to information and confidentiality. These contributions to the bioethics literature continue to hold a place in ongoing contemporary debates, both of subtle issues that continue to benefit from new insights and refinements, and stark issues that represent deep and possibly irresolvable divides over foundational principles. As first steps into new territory, they were thoughtful and important contributions. Yet it’s easy to appreciate that some early efforts went astray at some points, and that there is room for improvement on some of those early positions.

The past half century of bioethics

Two concepts have dominated the last half century of bioethics. In clinical matters, bioethicists have focused on autonomy, a focus that springs from the 1960s’ and 1970s’ preoccupation with rights and liberty. In research ethics, bioethicists have focused on the protection of human subjects, a perspective that was largely influenced by atrocities perpetrated by Nazi researchers on concentration camp inmates during World War II and revelations of ethical problems in studies conducted with undervalued subject groups. Oddly, bioethicists have largely failed to notice the marked contrast between these two perspectives.

The Kantian conception of autonomy represents a demanding standard for the self-regulation of one’s actions. Autonomy, the ability for self-governance, gives beings moral worth and allows others to hold people responsible for their actions. From this perspective, we are required to regard adults as having a distinctive self-legislating ability and to respect their choices by allowing them to live by their own lights. With this in mind, bioethicists have demanded that patients with decisional capacity be allowed to make decisions about their own treatment and be given honest information about diagnosis, prognosis, risks, benefits, and likelihood from their doctors. Employing this concept, bioethicists have upheld the liberty of patients to make decisions about their own reproduction and decisions about where, when, and how to die. And, for example, in the bioethics literature’s treatment of genetics issues, bioethicists have attended to the individual’s rights to be informed about their genetic carrier status and to make informed reproductive decisions, and have argued for the importance of informing family members of genetic findings and the importance of not denying a child the right to an open future. Invoking respect for autonomy has driven a good many of the contributions that bioethics has made in its brief history and infused discussions in the bioethics literature.

Problems can and do arise, however, when the focus on liberty and respect for the autonomy of individuals overshadows other important moral concerns. In the bioethics literature and bioethics policies, individual concerns are often highlighted while the social good and social justice are often ignored or deemphasized. Many bioethicists focus on the importance of accommodating the personal values and culture of individual patients and their families but never acknowledge or address the costs that such accommodations may involve for other patients and for society. Yet, personal choices that take up one of a limited number of ICU beds and personal decisions about using antibiotics to treat viral illnesses or refusing vaccination can be at odds with the social good and violate principles of social justice.

Another set of problems arises when people employ the term “autonomy” with a far weaker meaning while still expecting it to imply the strong moral conclusions that accompany the Kantian concept. Some bioethicists see every expression of a wish or a want as a mark of autonomy and ascribe it inviolable moral value. Some European and US bioethicists have termed this expansive perspective “autonomy run amok” and dismissed the US bioethics community by attributing this fault to all of us. Some speak carelessly or incoherently of giving or taking away a patient’s autonomy. But autonomy cannot be bestowed or removed, and when it is absent it cannot be respected.

In the past half century, bioethics has made tremendous contributions to the ethical conduct of human subject research by creating clear ethical standards for studies, instituting valuable review mechanisms, and implementing effective oversight to ensure that the standards are upheld. In contrast to the autonomy focus of clinical ethics, however, the research ethics perspective has focused on protection. It assumes that in human-subject research people cannot adequately determine what should count as good for them. Thus, bioethicists who devote their attention to human-subject research maintain that protection is required to ensure that potential subjects avoid participation in research that does not serve their interests, whether they want that protection or not. Human subjects are vigorously protected from risks, undue inducement, the therapeutic misconception, and signing onto any research project that they don’t fully understand. Bioethicists who work on research ethics are resolute advocates for informed consent, and therefore presume that they are respecting autonomy. In contrast to bioethicists in the clinical arena who employ a maximally liberal use of the term “autonomy,” bioethicists in the research ethics domain often refuse to count anything short of perfect understanding as “autonomy.” They fail to notice that it is disrespectful of autonomy to presume that people cannot adequately assess their risks, to prevent people from being paid as much as they might otherwise receive for their efforts, to refuse to allow people to avert their eyes from stark reality, and to demand that people know and understand more than they choose to know and understand. Thus, standard research protections actually involve treating adults like children and impose unwarranted paternalistic constraints on them.

Very much like the situation that we find in clinical ethics, bioethicists who work on the ethical conduct of research also tend to concern themselves with the interests of individual research subjects and lose sight of the effects of their policies on the population outside of the study. Directing their attention to their limited scope of concern for protecting individual human subjects, bioethicists have, for example, argued against placebo studies and other study design efficiencies, and for requiring burdensome, time consuming, and costly consenting and re-consenting of subjects for uses of their samples, as well as for anonymizing data and thereby sacrificing much of its value. They

have also championed protections of privacy that far exceed what would be required to meet ordinary people's reasonable concerns. In advocating for such protectionist policies bioethicists do not give weight to the burdens experienced by those stake holders who are not study participants, such as people with chronic illness who are eager for improved treatment and people in a community who are vulnerable to infectious disease and have to bear risks while waiting for study findings. Although these bioethicists proclaim a commitment to justice, they fail to notice the ways in which their policies deny social justice. The point here is that attending to both reasonable protection of research participants and promoting the social good would, in many cases, lead to different study designs than what would be chosen when the sole or predominant focus is on protection.

During this period, some issues in bioethics have become more or less settled matters: the rights of patients, the importance of truth telling and informed consent, the value of advance directives, the use of health care proxies and surrogates in making decisions for patients who do not have decisional capacity, the acceptability of the brain-death standard for declaring death. Some issues that appeared to be settled, however, such as the rules for the ethical conduct of human-subject research, are now being reassessed by the Department of Health and Human Services (HHS), which recently posted an advance notice of proposed rulemaking, "Human Subjects Research Protections: Enhancing Protections for Research Subjects and Reducing Burden, Delay, and Ambiguity for Investigators."

Looking forward

In the foreseeable future bioethics will be challenged to respond to an array of biomedical developments that will raise ethical issues. Some challenges will be related to scientific advances, some will reflect social changes, and some will reflect the demands on bioethics itself. A number of these developments will direct bioethics to shift its narrow focus from the individual to encompass also the broader environment and society. Looking into the future is a perilous activity because so much is actually uncertain and unknowable. So, here is my venture into the realm of speculation, my best guesses about what lies ahead.

New and rapidly developing technology has opened new areas of science to research. Genetics, genomics, and investigations of the human microbiome are changing how we view ourselves in relation to others and in relation to the environment. These new domains for exploration that employ biobanked samples promise dramatic new insights into disease resistance and susceptibility, possibilities for new and better means of disease prevention, and the development of personalized medicine. Ironically, these advances and their promise of a better life for individuals require us to revise our thinking about whether research participation is entirely optional or a morally required activity for members of a just society.⁴ These areas of study are markedly different from clinical research in that they typically involve doing nothing more dangerous or burdensome to a subject than taking a blood sample, a stool sample, or a cheek swab. Whereas these biobank studies entail no more than minimal risk, they do require the participation of large numbers of subjects. Without broad participation, studies cannot provide accurate and complete knowledge about similarities and variations in the human genome and microbiome, and scientists will be unable to fully appreciate their significance.

The difference between clinical trials that typically involve invasive measures and risks, and biobank and other studies that are relatively benign, implies that these activities should

be addressed with different sets of regulations. The distinction also suggests that society should encourage participation in low-risk research by explaining the need for participation, making participation easy and rewarding, and publicizing what is learned and how it can help people.

Genome and microbiome studies will make clear how similar we are to one another. Microbiome studies will also reveal how much our lives and our health depend upon the bacteria, viruses, and fungi that live on us and in us. Scientists are learning about how we transfer our microbiomes to one another and how our genes interact with our personal microbiome. They are learning about how antibiotic use may be increasing health problems such as obesity and ulcer disease by killing off microbes and transforming our microbiomes. They are also learning about how bacteria (i.e., probiotics) can be used to promote health and how viruses (i.e., bacteriophages or phages) can be used to combat disease and prevent infection. Some of this work will reveal the need for looking at our interrelatedness and interdependency in a new light and appreciating how much we are a part of our environment rather than independent entities. This too will require bioethicists to reconsider their emphasis on individualism. At the same time, new kinds of therapies spawned by this new science, such as poop transplantation, probiotics, and phage therapies, will reveal a need for rethinking some FDA categories. These new kinds of treatments don't fit into existing regulatory categories, so to protect the public with the assurance of their safety and efficacy, new regulatory categories will have to be created.

The shift from genetic testing for specific genetic traits to whole genome sequencing will bring another set of challenges in its wake. The questions that are now being asked about which information revealed by whole genome sequencing should be disclosed to patients will have to be sorted out before the technology becomes incorporated into medical practice. Once it does get sorted out, arguments from previous decades over genetic testing of children for adult-onset conditions and newborn screening will be moot because parents will be presented with their child's whole genome sequence shortly after birth. I expect that the benefits of such an approach are likely to be significant while the fears of "the unbearable certainty of knowing" will be revealed as errors that reflect human bias.

Tissue engineering is another developing field that is likely to challenge bioethics. To the degree that the technology proves to be successful, it will change our thinking about ethical issues in transplantation. When the possibility of using engineered tissue for organ replacement becomes a reality, the technology will increase the supply of transplantable material. Questions about who should receive a cadaveric organ and who should receive freshly grown, and perhaps recipient matched, tissue will emerge. If the tissue supplemented organ supply is adequate to meet recipient needs, the use of living organ donors will have to be reexamined and justified. Tissue engineering may also inject new life into the old bioethics debates about enhancement and life extensions.

The aging of our population combined with the changes that will accompany the implementation of the Affordable Care Act and the creation of Affordable Care Organizations also can be expected to bring significant changes in bioethics thinking. The pressure from increased demand for services, coupled with the social changes that make access to health care more broadly available, may create a more hospitable environment for serious discussion of rationing care. To the extent that we move closer to a system in which people can feel that "we are all in this together," conversations may expand to include the word "solidarity" and, as a community, we may accept

the need to make hard choices and take responsibility for the consequences of our action as well as our inaction. Bioethicists will have an important role in explaining the issues, the options, and the reasons that support them to the public.

Developments in two different areas can be expected to lead to some radical changes in long-standing policies. On the one hand, increasing life expectancy means increasing age-associated health problems such as dementia, disability, and pain. Similarly, improved treatment of chronic acquired conditions such as AIDS, chronic genetic conditions such as diabetes, and chronic treatment-related conditions such as transplantation, mean that people will be dealing with the increasingly burdensome consequences of their treatment. These demographic and technology-related developments will not only put a strain on health resources, they can also be expected to increase demand for euthanasia and for the development of palliation with drugs that have heretofore been drastically restricted. The demand for removing barriers to euthanasia coupled with the experience in states that have already legalized aid in dying demonstrate the legalized practice to be safe. This should encourage the expansion of right-to-die legislation. At the same time, research on tightly controlled drugs to alleviate symptoms related to chronic conditions may lead to liberalization of drug control, not only for cannabis, but for heroin, and ecstasy, and LSD.

Given the challenges facing bioethics in the future, and the growing acceptance of bioethics as a critical element in clinical medicine, the need for professionalization of the field will increase. Other health professionals as well as patients, their families, and the public are coming to rely upon us. Our acceptance of their reliance creates robust responsibilities for setting standards of competency and upholding those standards. It is reasonable for those who rely upon us to expect someone who accepts the title “bioethicist” to know a good deal about moral and political philosophy; after all, ethics is part of the title. A bioethicist also should have command of the basic concepts of bioethics, be knowledgeable about key issues in bioethics, and have the communication and interpersonal skills for successful interaction in the medical arena. Furthermore, the training that is adequate for some bioethics roles is not adequate for other bioethics roles. Without proactive creation of standards and the implementation of an accreditation procedure, the future of bioethics is likely to be ceded either to the ivory towers of universities or to any health professional with a passing interest in the subject who chooses to take on the title “bioethicist.” The time has come for philosophers to muster the courage to move away from an egalitarian acceptance of everyone who wants to don the title “bioethicist” and to take a stand for a rigorous and robust standard for identifying professional competence.

Acknowledgement

This article draws on my commentary, “Bioethics: Looking Forward and Looking Back” (Rosamond Rhodes, *The American Journal of Bioethics* 13, no. 1 (2013): 13–16. An electronic version of that article is available online at <http://www.tandfonline.com/doi/abs/10.1080/15265161.2013.747318?journalCode=ujb20>.

Notes

1. Jonsen, *Birth of Bioethics*; Baker and McCullough, *History of Medical Ethics*.
2. *Griswold v. Connecticut*, 381 US 479 (1965); *Roe v. Wade*, 410 US 113 (1973); US Supreme Court *O'Connor v. Donaldson*, 422 US 563 (1975); *In re Quinlan*, 70 NJ 10, 355 A.2d 647 (1976)
3. http://videocast.nih.gov/pdf/ohrp_belmont_report.pdf.
4. Rhodes, “In Defense of the Duty to Participate in Biomedical Research.”

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TRIBUTE TO MARY ANNE WARREN

Mary Anne Warren and “Duties to Animals”

Michael Boylan
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This essay will appear in Environmental Ethics, 2nd ed., edited by Michael Boylan (Malden, MA: Wiley-Blackwell, forthcoming in August 2013), 308–12. This material is reproduced with permission of John Wiley & Sons, Inc.

Introduction

This essay will examine and defend Mary Anne Warren’s weak animal rights position, particularly in the context of Tom Regan’s strong animal rights position.¹ In doing so I will rely both on a published paper of Dr. Warren’s² and some discussions I had with her about a book that she was preparing on this subject for my series at Prentice-Hall: *Basic Ethics in Action*.

To begin, I would like to go over her reconstruction of Regan’s strong animal rights argument. I have set it out as follows:

- (1) Normal mammals are not only sentient but have other intellectual capacities as well (such as emotion, memory, belief, desire, the ability to use general concepts, intentional action, a sense of the future, and self-awareness)—A[ssertion]
- (2) All creatures that have the capacities mentioned in #1 are “subjects-of-a-life”—A
- (3) Normal mammals are subjects-of-a-life—1, 2
- (4) All subjects-of-a-life are not only alive in a biological sense but also possess psychological identity—A
- (5) Those creatures that have psychological identity can, over time, be benefitted or harmed—F[act]
- (6) All mammals can, over time, be benefitted and harmed—3–5
- (7) Utilitarian moral theory treats individuals as “mere receptacles” for morally significant value—A
- (8) [Utilitarianism does not allow for value independent of what others may place upon them]—F
- (9) In utilitarianism harm to one individual may be justified by the production of a greater net benefit to other individuals—7,8
- (10) Subjects-of-a-life—contra utilitarianism—have an inherent value independent of what others may place upon them—A

- (11) Utilitarianism is wrong when dealing with subjects-of-a-life—7–10
- (12) Perfectionism allows for differential value to be placed upon people—F
- (13) Differential value would be a value that is acquired in degrees—F
- (14) We get inherent value all at once—A
- (15) Perfectionism is wrong with respect to acquiring inherent value—12–14
- (16) Subjects-of-a-life have inherent value—11, 15
- (17) The *respect principle* (that forbids us to treat beings that have inherent value as mere receptacles on the path to the general good) is correct—A
- (18) The *harm principle* says we have a direct *prima facie* duty not to harm beings who have inherent value—A
- (19) Rights claims are made by individuals against other individuals not only to refrain from inflicting harm upon beings with inherent value but also to come to their aid when they are threatened by other moral agents—A
- (20) All rights claims entail *prima facie* duties incumbent upon all to respect and not to harm others that can be benefitted or harmed and have inherent value—17–19

- (21) All mammals properly possess rights to forbearance of harm and protection from harms caused by others—6, 16, 20

Warren's key concern with this argument begins with the understanding of "inherent value." The idea of *inherent* has a long tradition in philosophy. In ancient Greek philosophy it is depicted as *kath'auto*—in Latin, *per se*. It means "through itself." If something is inherently valuable, it derives its value through itself—or through an immediate examination of the definition of the term itself. Warren asserts that Regan's idea of inherent value is not adequately supported. Instead, it is a mysterious intuited posit that is set forth without argument. If this is correct, then Regan is guilty of the fallacy of asserting the conclusion (meaning that he has not offered inferential support for his point of contention).

Regan himself describes his conjecture about inherent value as a "postulate." This is not therefore a conclusion for which there is an argument, but an external value that is set in place in order to derive his conclusion.

A second concern of Warren's is whether there is a connection between inherent value (however justified) and moral rights. For example, some things—such as trees, ponds, and mountains—might have inherent value (under some sort of valuation), but does this entail a moral right? Warren is skeptical.

In short, Warren thinks that the intellectual concept of inherent value so applied is fraught with difficulty and so should not be the bulwark for a theory of animal rights.

The sharp line divide

The inherent value => moral rights paradigm creates a sharp divide according to Warren. This divide separates as follows: (A) those that have inherent value and therefore moral rights; versus (B) those that do not have inherent value and therefore do not possess moral rights. Warren calls this all or nothing position "dualism." She thinks that this sharp divide is necessary to Regan's argument and that it is wrong—thus providing a pivotal reason for rejecting the strong animal rights position. The reason for this is that *inherent value* is not naturally supported. We don't observe any observable properties that could confer inherent value being conferred all at once. What we do observe

is developmental traits that come to be as the organism moves towards maturity.

Because inherent value is a "posit," it has instead the status of a non-natural truth (on the scale of G. E. Moore's "good"). This would only be correct, of course, if Regan thought that what he was asserting was *true*. If his posit was an anti-realist, non-natural posit, then the proof would be constructed through some conventional political action and ascertained via some sort of public opinion poll of what people in various regions of the globe thought about what inherent value meant and how it should be applied. Warren's take on Regan here is that he is asserting non-natural realism, and I agree.

Back to Warren. She believes that *subject-hood* comes in stages. She queries on the sentient capabilities of various species of animals from mammals (Regan's primary explanandum) through fish, amphibians, and reptiles to invertebrates and protozoan fauna. She searches for some natural basis for attributing a moral right because of some particular characteristic.

In the process Warren rejects traditional *scala naturae* arguments about being "better." Instead, she wants to assert that what is missing from the strong animal rights position (as set out by Regan) is "the ability to listen to reason" in order to settle conflicts and cooperate in shared projects.³ This capacity amounts to something like the ability to execute human language, or something that is equal or more complicated.

Warren argues that the ability to set out claims for one's position that is rationally based and can respond to critical rational responses is critical to the difference between animals and humans in their interactions on earth. The fact that animals cannot engage in such a dialogue with their own species (as far as we can know) or with *homo sapiens* means that they do not possess the essential characteristics that would confer moral rights. This means that animal rights (such as they may exist) are asymmetrical to human rights.

This is a position that I agree with (though, as I will point out later, my version is somewhat different in its exposition).

How should we regard animals?

Warren rightly argues that since animals cannot confer with us in problem solving they do not possess what is morally relevant about reason: the ability to enter into cooperative dialogue for the sake of peace and conflict resolution. This, then, leads to the question of just how we should regard animals. If they have some variety of rights, how far do these rights extend?

Warren begins this discussion by wondering whether the word "right" is appropriate for animals. Since rights language is so inextricably tied to reason and reasoning, and since this stronger sense of reason is absent in animals, perhaps we should give up that term when dealing with animals? Rights-language with humans requires autonomous, sentient subjects-of-a-life. But on Warren's account of gradualism (as opposed to dualism), might it be the case that some sort of proportional response would be correct? What might this look like?

One feature that it would possess is a duty upon people not to be cruel to animals. Regan doesn't like this approach because the emphasis is upon the subject doing the harm and not upon the animal itself.

Cruelty, according to Warren, is the causing of harm and then either enjoying it or being indifferent to it.⁴ The question is whether putting the burden of a non-correlative duty is strong enough to stop cruelty to animals. If the reason rests upon the possible perpetrator only, does this render such actions optional?

Warren takes these questions to heart and fashions an *environmental moral rights language* that applies to certain animals (according to their capability to engage in some of the aspects of what grounds moral theory for Warren: rational dialogue for the purposes of cooperation and for peace and conflict resolution). Obviously, primates possess these capabilities to a higher degree than do fish and amphibians. It is an open question whether invertebrates (the greatest number of species in the world) possess *any* such capacity. Certainly micro-fauna (if they are considered to be animals) must be ruled out entirely.

Uncontroversial attributions may be made to mammals and perhaps to all vertebrates. Unlike the strong animal rights position, these do not come in an “all or none” package, but in the progression presentation depending upon various cognitive capabilities.

Thus, the weak animal rights position asserts:

- (1) Animals have rights to pursue their natural mode of life.
- (2) Animals have rights not to be subjected to pain, suffering, or frustration without a compelling reason.
- (3) No sentient being shall be killed without a good reason.

Obviously, by fashioning all animal rights as *prima facie* rights, Warren is in line with most positions on human rights as well.⁵ But what counts as a “good reason”? Is diet sufficient? What about scientific research? From my own discussions with Mary Anne I think she would answer, “yes” and then “no” (diet counts, but she is very skeptical about scientific research). However, the treatment of animals that are bred for slaughter in order to be part of our diet can be more or less humane. The organic movement, for example, emphasizes free range animal husbandry and living conditions that satisfy Warren’s criteria.

Where I differ from Warren

As I have said above, I am largely in agreement with Warren’s weak animal rights position. However, there are two points that I would like to point out in which we differ.

First, there is the grounding of moral rights in general. Warren’s position is to take a rational dialogue model as primary. While I think the sort of argumentative reason she describes are important, I put everything into the context of one’s striving towards what he or she takes to be *the good*. In order to achieve this fundamental aim an individual must be able to undergo purposive action. All goods necessary to allow purposive action are thus claimable as rights in a nested hierarchy according to their embeddedness in the foundations of the possibility of action. For me, it all begins with an autonomously formed vision of the good and then moves to the ability to get oneself there.

My account is compatible with Warren’s, but they are different and when pressed with searching questions, I could see possible divergence in some instances.

Second, Warren is wary of attributing *value* to issues of environmental ethics. Her reasons for this have been outlined above. I am less leery. My reason for this is that I take it for granted that duties to animals and to nature do not operate on the model of human moral rights. This is because animals, trees, mountains, and oceans do not have the sort of autonomous conception of the good that I hold to be fundamental. (At least, there is no way to detect whether there is one—and under one epistemological model of parsimony, if x cannot be shown to be the case, then one may properly doubt whether x is the case.) Thus, even if my dog has some sophisticated conception of the good that is never communicated in any discernible way to anyone or any other animal, then it is not unreasonable to doubt whether my dog has that level of understanding and thus does not have the sophisticated conception of the good necessary

for moral rights. All this is similar to Warren. However, I believe that the more we learn about nature and its inhabitants and their environments, that we will acquire a valuing of that objective space such that we will seek to protect it.⁶

I do not see this second difference as creating any insurmountable roadblocks. Rather, I am taking on a more expansive point because I am interested in creating a context of protection for both animals (of all sorts—even microscopic) and for insentient plants and landscapes.

In the end I think that Mary Anne Warren’s position is intriguing and is one that I support. I sometimes long for the book that she would have been able to finish to more fully express her weak animal rights position.

Notes

1. This essay was first presented at the APA Pacific Division Meeting in 2012. Tom Regan, *The Case for Animal Rights* (Berkeley, CA: University of California Press, 1988).
2. Mary Anne Warren, “A Critique of Regan’s Animal Rights Theory,” *Between Species* 2.4 (1987) reprinted in *Environmental Ethics*, ed. Michael Boylan (Upper Saddle River, NJ: Prentice-Hall, 2001). All page citations are to the reprinted text.
3. *Ibid.*, 336.
4. *Ibid.*, 338.
5. This is controversial. I am at this writing working on a text on human rights that seeks to address objections by Charles Beitz on this matter.
6. See my “Worldview and the Value-Duty Link to Environmental Ethics,” in *Environmental Ethics*, ed. Michael Boylan (Upper Saddle River, NJ: Prentice-Hall, 2001): 180–96.

Mary Anne Warren’s Legacy—Three Aspects: Personhood, Moral Agency, and Moral Status

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Introduction

Who doesn’t know Mary Anne Warren’s criteria for personhood?¹ By now most of us can list them in our sleep: consciousness and the capacity to feel pain, reasoning ability, ability to communicate, self-motivated activity, and self-awareness. In time, she came to find the concept of personhood lacking as a way to assess moral status and abandoned it in favor of the moral status of birth. It is, nevertheless, a valuable tool for examining personhood and for confronting the presumed necessity of genetic humanity.

Mary Anne’s work on personhood is as controversial now as it was in the 1970s when she wrote her first article on the subject and was the target of threats and intimidation in the years that followed.² The mere fact that voters in states such as Virginia and Mississippi have seen propositions to define personhood in terms of conception—the most fundamental stage of human development—indicates that it is still unresolved. In addition, the issue is not merely conceptual or abstract—how “personhood” is defined has all-too-real practical consequences. In line with Mary Anne’s own discussion, the concepts of “personhood,” “moral status,” and “moral agency” are all intertwined.

Personhood

As we know from the abortion debate, the concept of personhood sets the foundation for moral and legal status before and after birth. Though many speak of fetuses as humans *and*

persons, Mary Anne is not alone in questioning the use of these concepts. For example, in its ruling that there is no *use* of the term “person” in the US Constitution other than postnatally, the Supreme Court in *Roe v. Wade* (1973) concluded that the term “person” as used in the fourteenth amendment does not include the unborn. The court’s survey of religious, medical, and legal history gave no clear indication that fetuses and persons had equal moral status. Rather, fetuses have generally lacked the protections afforded persons (understood postnatally).

This is in accord with Mary Anne’s view that fetuses do not have sufficiently developed abilities to be considered persons or members of the moral community. This leads to the question of the permissibility of infanticide given there is little difference between newborns and late-term fetuses. This was likely a factor in Mary Anne moving her attention away from personhood to the moral status of birth. She came to believe that the focus should be on moral status, not personhood.

But what *is* it about this earlier article? Wherever you stand on the abortion issue, it is very useful to have a sense of what personhood entails. The concept is clearly hard to pin down and Mary Anne’s attempt—whether the focus is fetuses, extraterrestrials, or transgenic species—is incredibly interesting and philosophically worthwhile to examine.

That we have trouble *agreeing* upon a set of criteria, a definition, or classification system doesn’t negate the urge to nail down the concept. And if you don’t like Mary Anne’s list—and many do not—what *should* be the criteria? The task is not as easy as we might think, unless we just equate persons with humans and stop there. Mary Anne did not recommend this route.

In her estimation, being human is neither a sufficient nor a necessary condition for personhood. On one hand, the personhood territory shrinks—eliminating eggs, sperm, and embryos, as well as those with limited cognitive function. On the other hand, it expands in rather interesting ways. Since persons need not be human, what counts as a “person” can take different forms. She explains:

Just as a being need not belong to one’s own sex, race, or tribe in order to be a person, neither need it be biologically human, or of terrestrial origin. It need not even be a living organism. Personhood is a psychological concept, not a biological one. It is a being’s mental and behavioural capacities that make it a person, not the shape of its body, the microstructure of its chromosomes, or any other strictly physiological characteristic.³

She notes that the terms “human being” and “person” are often used interchangeably, “since in the real world all of the persons with whom most human beings are acquainted are members of the human species. Nevertheless,” she adds, “the terms have different meanings.”⁴ The term “person” has a broader use than “human.” She points out that children’s books, stories about gods and goddesses, angels and ghosts, and creatures from outer space commonly treat such entities as “persons.”

Mary Anne was an avid fan of science fiction novels and films. Her criteria would most certainly apply to many of these works. There are a number of benefits to having a checklist to put to use. Eliminating the physiological component of personhood allows for the following to qualify as persons: Replicants (*Blade Runner*), cyborgs (*Terminator 2* but not *T1*), androids (*Aliens* but not *Alien*), pre-cogs (*Minority Report*), vampires and werewolves (*Dracula*, *Kronos*, *Twilight* series, *True Blood*, etc.), as well as highly-advanced robots and human/robot hybrids (*Robocop*, *AI*, *Wall-E*, *2001*, etc.). The harnessed human/skitter hybrids (*Falling Skies*) are possible persons,

though this is not a clear call given their occasional lack of self-control and loss of volition.

There are limits, however. For example, the undead, zombies, and “Walking Dead” have little going for them, as they desire nothing beyond mere subsistence as cannibals. They move in herds but seem unable to communicate, lack self-awareness and self respect, have no self-motivated activity, and show little reasoning ability. In contrast, replicants satisfy all the criteria and are able to express complex emotions and states of mind like grief and *despair*. And, as seen with Roy Batty’s soliloquy in *Blade Runner*, replicants could be articulate, even poetic.

The cyborgs of the *Terminator* series show no poetic proclivities and mostly just follow pre-ordained programs and, thus, show little or no independent thought. However, in the sequel *T2*, the more advanced model cyborg is higher on the consciousness scale, as is cyborg Cameron of *the Sarah Connor Chronicles*. The earlier models/stages were much more in line with Kyle Reese’s characterization that the cyborg can’t be bargained with, can’t be reasoned with, and feels no pity, or remorse, or fear. And the fact it will not stop until Sarah Connor is dead speaks to its being programmed to act without any sense of self-awareness or doubt. Similarly, if we look at the android Ash in *Alien*, there isn’t a moral bone in its endoskeleton.

All these cyborgs, avatars, and the like remind us that the boundary between human and non-human is not as distinct as we might imagine. And, as replicants Roy Batty and Rachel (*Blade Runner*) and androids Bishop and David (*Aliens* and *Prometheus*) demonstrate, we ought not make too many assumptions about the exclusivity of humans when it comes to personhood or moral status. This we will turn to next.

Moral status

Personhood is not just about human gametes, embryos, and fetuses, as we saw in Part One. It’s also about moral communities and who or what qualifies for moral status. A great deal follows from this.

Recent work on animal rights presents moral status as a major concern. Mary Anne herself moved from the abortion debate and its focus on the relative status of mother, infant, and fetus to animal rights in the last decade of her life. In particular, the great apes—chimpanzees and other primates—as well as dolphins and other cetaceans, are seen as worthy of much higher moral status than typically granted.

Mary Anne’s early work on personhood has been instrumental in this area (animal rights) as well. We see this with Timothy I. White’s work on personhood and moral status with respect to dolphins. They are self-aware, non-human persons, he argues. “We’re saying the science has shown that individuality—consciousness, self-awareness—is no longer a unique human property.” That poses all kinds of challenges, he observes.⁵

White offers a variation of Mary Anne’s set of criteria—with a few differences.⁶ In his view,

- (1) A person is alive
- (2) A person is aware
- (3) A person feels positive and negative sensations
- (4) A person has emotions
- (5) A person has a sense of self
- (6) A person controls its own behavior
- (7) A person recognizes other persons
- (8) A person has a variety of cognitive abilities

There is considerable overlap between White’s and Mary Anne’s sets of criteria *except* for White’s traits “a person is alive” and

“a person has emotions.”⁷ Mary Anne argued that non-living things could be a person so long as some of the major criteria were satisfied. She did not specifically require persons to have emotions, though her sense of consciousness may subsume emotions.

White argues that some adaptation of the list—more leeway—should be made for different species and raises some concerns: How much should the list of necessary conditions take into account different species? Could there be differences between aquatic persons and land-based persons? And what is the best way to approach non-human intelligence? Dolphins cannot live on land, humans tend not to live underwater, and so on.

Mary Anne would likely recommend that we go back to the criteria and apply them to the entity in question. Yes, there are environmental contrasts, but the key issue is what the entity itself is capable of. If we can't figure out whether or how they communicate, then it's hard to conclude that they do. The differences may pose obstacles, as White notes, but he does not consider them insurmountable. In his view, “dolphins evidence all of the necessary traits to enough of a degree that they should be regarded as persons.”⁸ His conclusion is that “it does seem that dolphins should be recognized as members of the community of equals.”⁹

This “community of equals” is the moral community Mary Anne gave so much thought to. In developing her ideas on the subject, she advised us to pay close heed to moral agency and relationships. First, we should *not* think of moral agency as having but one defining characteristic. The search for one criterion of moral agency is misguided, she contends. Secondly, feminist ethicists think those who we care about and who are responsive to our caring gestures must be reckoned with.

For that reason, Mary Anne highlighted the importance of relational properties in moral reasoning and in setting out a moral theory. These are properties involving more than one person or entity—like being a brother, a naturalized citizen, or a best friend, all of which would not be possible if the entity in question were the only thing in existence.¹⁰ Relational properties are fundamental for caring-for and being cared for by others.

In seeing relationships as relevant to moral status and moral reasoning Mary Anne takes ethics off its pedestal and into the context of our lives. This makes it less abstract and theoretical and more concrete and practical. It's not that principles don't matter; it's just that other concerns may count more when plotting a moral course of action. Mary Anne rejected the stance by Kant and others (Singer, Regan, etc.) who see moral agency resting on one key trait.

Whether the property is rationality (Kant), sentience (Peter Singer), being subject-of-a-life (Tom Regan), or any other *single* trait, we shouldn't think the playing field can be so limited. A more expansive view of moral status is required, Mary Anne argued. She recommended seven moral principles—the following three are particularly relevant to personhood and moral agency:

- (1) Moral agents have full and equal basic moral rights, including the right to life and liberty¹¹
- (2) Within the limits of their own capacities, humans capable of sentience but not of moral agency have the same moral rights as do moral agents¹²
- (3) To the extent that is feasible and morally permissible, moral agents should respect one another's attribution of moral status¹³

Besides deconstructing notions of moral agency, feminist ethicists hold social considerations in moral reasoning. They give more credence to relationships than to rules and principles.

Mary Anne used this to move the focus of moral agency away from the lone-trait approach so common in the history of ethics. Mary Anne expanded the scope of those deserving equal moral status beyond the set of moral agents. Her second principle allows that sentient humans who are not capable of moral agency should not be consigned to an inferior moral status. The third principle calls us to approach the issue with a more open mind so we can determine if certain entities should be accorded a stronger or weaker moral status. This last principle would get a nod from animal rights activists such as Tim White and Peter Singer. These principles (especially #2) provide the ethical foundation for leveling the playing field. Another consequence of the three principles (especially #1) is that all those non-human persons mentioned earlier have full and equal moral status.

Moral status

Our overview wouldn't be complete without looking at Mary Anne's work on reproductive technology and how much freedom should be permitted. Two stand out—her article “IVF and Women's Interests: An Analysis of Feminist Concerns” and her book *Gendercide*. Both shed light on the morally complex issues around the use of IVF and new reproductive technologies (NRTs). And both raise vital questions, one of which is the moral acceptability of sex selection. Her work in this area has had significant impact on feminist ethicists.¹⁴

As Mary Anne discusses in her 1988 article on IVF and NRTs, ordinarily the spotlight is on the fertilized ovum and pre-embryo. Little attention has been given to the women utilizing such procedures and who have been used as experimental subjects and faced dangers in reproductive research. Furthermore, Mary Anne examined the societal underpinnings behind couples using IVF and the fact that little has been done to counteract the causes of infertility in the first place. She pointed out that many women using IVF and NRTs face heartbreak, given the low success rate.

Obtaining informed consent in such contexts is problematic, as some women will tolerate greater risks and uncertainties if they see motherhood as central to their lives.¹⁵ Without voluntary and informed consent firmly in place, there are troubling questions around women participating in experimental IVF programs. Mary Anne rightfully sounded the alarm, suggesting that we ought not trust that women's interests are being safeguarded.

That does not mean women should be prohibited from using IVF or NRTs. In her view, women—as much as men—should have the right of self-determination, particularly when no one else is harmed. It would be an injustice to women to deny IVF for paternalistic reasons, she asserts.¹⁶ That's one position expressed across all her work in philosophy—moral agents should be given considerable freedom to exercise their rights over what is done to their own bodies.

Nevertheless, not all the problems are easily resolved. One of the more disturbing issues Mary Anne highlighted is the intentional destruction of female embryos and fetuses. Her book on sex selection gave it a name—*Gendercide*. When it was published in 1985 the issue was global in scope and the concerns most timely. Unfortunately, they still are. On March 4, 2010, the lead article of *The Economist* was on gendercide. It acknowledged Mary Anne's earlier work of more than twenty-five years ago:

Gendercide—to borrow the title of a 1985 book by Mary Anne Warren—is often seen as an unintended consequence of China's one-child policy, or as a product of poverty or ignorance. But that cannot be the whole story. The surplus of bachelors—called

in China *guanggun*, or “bare branches”—seems to have accelerated between 1990 and 2005, in ways not obviously linked to the one-child policy, which was introduced in 1979. And, as is becoming clear, the war against baby girls is not confined to China.

Parts of India have sex ratios as skewed as anything in its northern neighbour. Other East Asian countries—South Korea, Singapore and Taiwan—have peculiarly high numbers of male births. So, since the collapse of the Soviet Union, have former communist countries in the Caucasus and the western Balkans. Even subsets of America’s population are following suit, though not the population as a whole.¹⁷

Thanks to the “war against baby girls,” as *The Economist* states, gendercide is an entrenched practice. Given the access to a diverse assortment of procedures to determine gender and eliminate unwanted fetuses, it may take more “bare branches” before things turn around. Mary Anne’s work calls us to address the mentality that allowed discrimination to take such a deadly turn.

Final remarks

Mary Anne’s philosophical writings, teaching, and research, as well as her piercing comments and questions when attending sessions at the American Philosophical Association meetings and other conferences, have been a major contribution to the field. Her work on personhood, moral status, and moral agency has had an impact on the greater society as well.

Social and political events around reproductive freedom, reproductive technologies, and feminism—not to mention animal rights—make it clear that the weight of Mary Anne’s work is still being felt. Her attempt to define “personhood,” her argument for the significance of birth when assessing moral status, and her expanded views of moral agency continue to reverberate inside philosophy and out in the world.

I wish I could relay to Mary Anne this much: *Things aren’t the same without you. But they are better because of you.* Few leave behind a legacy of such depth and quality, as has Mary Anne Warren. How lucky we are.

Notes

1. In honor of our friendship going back more than thirty years I will refer to Mary Anne Warren as “Mary Anne.”
2. She endured this with courage and grace.
3. Warren, *Moral Status*, 93–94.
4. *Ibid.*, 94.
5. White, “Dolphins Deserve the Same Rights,” 2012.
6. Herzing and White, “Dolphins and the Question of Personhood,” 65.
7. White’s criterion (2) is similar to her two criteria of consciousness and self-awareness. His criterion (3) links to Mary Anne’s criteria of consciousness and the capacity to feel pain. Criterion (4) is not on Mary Anne’s list explicitly, as she didn’t mention emotions per se. Criterion (5) matches with her criterion of self-awareness; (6) lines up with Mary Anne’s self-motivated activity; (7) seems in line with her ability to communicate criterion; and (8)’s cognitive abilities lines up with the ability to reason and the trait of consciousness.
8. Herzing and White, “Dolphins and the Question of Personhood,” 66.
9. *Ibid.*, 80.
10. Warren, *Moral Status*, 122.
11. *Ibid.*, 156.
12. *Ibid.*, 164.
13. *Ibid.*, 170.

14. See, for example, Mary Briody Mahowald’s *Bioethics and Women* (2006); Rosemary Tong’s *Feminist Approaches to Bioethics* (1997); and Helen Bequaert Holmes and Laura M. Purdy’s *Feminist Perspectives in Medical Ethics* (1992).
15. Warren, *Moral Status*, 39.
16. *Ibid.*, 40.
17. “Gendercide,” <http://www.Economist.Com/Node/15636231>.

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Mary Anne Warren on Abortion

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1. Mary Anne Warren’s views on abortion in “On the Moral and Legal Status of Abortion”

In the area of abortion, Mary Anne Warren is best known for her essay “On the Moral and Legal Status of Abortion,” which is the most widely reprinted defense of a liberal approach to abortion, and deservedly so. In that essay, it is clear that the concept of a person is central, for in the opening paragraph of her essay Mary Anne says, “For it is possible to show that, on the basis of intuitions which we may expect even the opponents of abortion to share, a fetus is not a person, hence not the sort of entity to which it is proper to ascribe full moral rights.”¹

Mary Anne’s discussion is then divided into two parts. In the first part she asks “whether or not it is possible to establish that abortion is morally permissible even on the assumption that a fetus is an entity with a full-fledged right to life”—as Judith Jarvis Thomson argued in her famous essay “A Defense of Abortion.” Mary Anne’s answer is that it is not—“at least not with the conclusiveness which is essential to our hopes of convincing those who are skeptical about the morality of abortion . . .”²

Given this negative conclusion, Mary Anne then goes on, in the second part of her essay, to tackle the question of the moral status of human embryos and fetuses. Here is the summary that she offers of that part:

I will propose an answer to this question, namely, that a fetus cannot be considered a member of the moral community, the set of beings with full and equal moral rights, for the simple reason that it is not a person, and that it is personhood, and not genetic humanity, i.e., humanity as defined by Noonan, which is the basis for membership in this community. I will argue that a fetus, whatever its stage of development, satisfies none of the basic criteria of personhood, and is not even enough *like* a person to be accorded even some of the same rights on the basis of this resemblance. Nor, as we will see, is a fetus's *potential* personhood a threat to the morality of abortion, since, whatever the rights of potential people may be, they are invariably overridden in any conflict with the moral rights of actual people.³

1.1 Mary Anne Warren on Judith Jarvis Thomson's defense of abortion

How does Mary Anne argue against a Thomson-style defense of the view that abortion is morally permissible? The answer is that she grants that the argument seems strong in the case where pregnancy is due to rape, but argues that the extension of the argument to cases where the woman has voluntarily exposed herself to the chance of becoming pregnant is problematic, and in support of the latter claim, Mary Anne advances what has now become known as the "responsibility objection."

What is the responsibility objection? At the heart of the responsibility objection is the idea that if one makes it the case that someone is in a situation in which they cannot survive without one's assistance, and where they would not have been in such a situation of needing assistance were it not for one's action, then, if one knew that these things would be the case, and one nevertheless voluntarily performed some action that involved the risk of creating such a situation, then if one nevertheless performs the action, and it does have the result in question, one has a moral obligation to provide the individual in question with the assistance that he or she needs in order to survive.

A crucial response to the responsibility objection was advanced by Harry Silverstein in his 1987 article "On a Woman's 'Responsibility' for the Fetus," where Silverstein introduces the distinction between (1) causing it to be the case that someone exists at a certain time who will necessarily be in need of something at that time if they are to continue to exist, and (2) causing it to be the case, given someone whose existence at a certain time does not depend upon one's action, that that person will be in need of something at that time if they are to continue to exist. Silverstein argues that the second of these things gives rise to a moral responsibility to provide assistance, but that the first does not. A woman who voluntarily engages in intercourse, however, does at most the first of these things, and so she incurs no responsibility of providing assistance by acting as a life support system for the fetus.

The distinction in question was not, however, a novel one, since Mary Anne in her article explicitly addresses the question of whether that distinction is morally relevant. Here is what she says,

My own intuition, however, is that *x* has no more right to bring into existence, either deliberately or as a foreseeable result of actions he could have avoided, a being with full moral rights (*y*), and then refuse to do what he knew beforehand would be required to keep that being alive, than he has to enter into an agreement with an existing person, whereby he may be called upon to save that person's life, and then refuse to do so when so called upon. Thus *x*'s responsibility for *y*'s

existence does not seem to lessen his obligation to keep *y* alive, if he is also responsible for *y*'s being in a situation in which only he can save him.⁴

Mary Anne's discussion, in anticipating a Silverstein-style response, is, then, a strikingly circumspect one. Moreover, although Mary Anne did not show that the distinction in question is not morally significant, subsequent discussion has, it seems to me, strongly confirmed the correctness of her intuition, and, thereby, her view that the responsibility objection is the crucial objection to the type of attempt to defend the moral permissibility of abortion first advanced by Thomson, and then defended at much greater length, and very resourcefully, by my colleague David Boonin in his book *A Defense of Abortion*.

As regards the question of whether the distinction that Warren mentions, and to which Silverstein later appeals, is morally significant, an especially important, albeit very brief discussion is found in a 1993 article by Richard Langer, entitled "Silverstein and the 'Responsibility Objection'." There Langer argues that, if the responsibility objection to Thomson's argument is not sound, then it will also be true that a parent who abandons older children in a situation where there is no one else who can care for the children, knowing that the result will be that the children will die, has done nothing morally wrong.⁵

1.2 Mary Anne Warren on the moral status of human fetuses

The issue that Mary Anne addresses in the second part of her essay is as follows:

How are we to define the moral community, the set of beings with full and equal moral rights, such that we can decide whether a human fetus is a member of this community or not? What sort of entity, exactly, has the inalienable rights to life, liberty, and the pursuit of happiness?⁶

Mary Anne approaches this question as follows. First of all, she points out that the term "human" gets used in two different ways. Sometimes it is used to refer to individuals with a certain *genetic* makeup, and at other times it is used instead to attribute a certain *moral* status to an individual, and Mary Anne suggests that some typical anti-abortion arguments suffer from the fallacy of equivocation, using the term in the genetic sense when it is claimed, for example, that fetuses are humans, but then using the term in the moral sense when it is claimed that humans have a right to life.

Mary Anne next turns to the question of how the moral community is to be defined, and her answer is this: "The suggestion is simply that the moral community consists of all and only *people*, rather than all and only human beings . . ."⁷

But what makes something a person? Mary Anne suggests that a good way of tackling this is to consider the possibility of extraterrestrial beings who are persons, but not, of course, human persons, so that one will be less tempted to incorporate references to properties that humans may share, but that, intuitively, are not morally significant. She then goes on say that when this is done, the following is a natural conclusion:

I suggest that the traits which are most central to the concept of personhood, or humanity in the moral sense, are, very roughly; the following:

1. consciousness (of objects and events external and/or internal to the being), and in particular the capacity to feel pain;

2. reasoning (the *developed* capacity to solve new and relatively complex problems);
3. self-motivated activity (activity which is relatively independent of either genetic or direct external control);
4. the capacity to communicate, by whatever means, messages of an indefinite variety of types, that is, not just with an indefinite number of possible contents, but on indefinitely many possible topics;
5. the presence of self-concepts, and self-awareness, either individual or racial, or both.⁸

Given this account of what a person is, Mary Anne then goes on to conclude, “a fetus is a human being which is not yet a person, and which therefore cannot coherently be said to have full moral rights.”⁹

Mary Anne then goes on to consider the following two questions. First, can it be the case that while a fetus is not a person, it is, in late stages, *sufficiently like* a person that it thereby has at least *some* rights? Secondly, “To what extent, if any, does the fact that a fetus has the *potential* for becoming a person endow it with some of the same rights?”¹⁰

Her answer to the first of these questions is as follows:

Thus, in the *relevant* respects, a fetus, even a fully developed one, is considerably less personlike than is the average mature mammal, indeed the average fish. And I think that a rational person must conclude that if the right to life of a fetus is to be based upon its resemblance to a person, then it cannot be said to have any more right to life than, let us say, a newborn guppy (which also seems to be capable of feeling pain), and that a right of that magnitude could never override a woman’s right to obtain an abortion, at any stage of her pregnancy.¹¹

An important point to note here is that Mary Anne does *not* assert, as some defenders of a personhood approach to abortion do, that *only* persons can have a right to life. Her contentions are rather that, first, any right to life that a fetus has by virtue of its resemblance to a person is *extremely weak*, and, secondly, that it is certainly not strong enough to override “a woman’s right to obtain an abortion, at any stage of her pregnancy.”¹² Thus, Mary Anne goes on to say, referring to a passage in Judith Jarvis Thomson’s article, “Whether or not it would be *indecent* (whatever that means) for a woman in her seventh month to obtain an abortion just to avoid having to postpone a trip to Europe, it would not, in itself, be *immoral*, and therefore it ought to be permitted.”¹³

Next, Mary Anne goes on to address the important—and, indeed, crucial—question of whether a fetus’s being a *potential person* might not endow it with a right to life. Here she begins by suggesting that those who think that it does may be confusing a deontological proposition concerning a *right* to life with a proposition concerning the *axiological value* of potential persons: “It may be that our feeling that it is better, other things being equal, not to destroy a potential person is better explained by the fact that potential people are still (felt to be) an invaluable resource, not to be lightly squandered.”¹⁴

Here, however, just as in the case of the appeal to the idea that late-term fetuses are person-like, Mary Anne goes on to consider how things would stand if one were to think that being a potential person does give that entity *some* moral status, and she says,

But even if a potential person does have some *prima facie* right to life, such a right could not possibly outweigh the right of a woman to obtain an abortion, since the rights of any actual person invariably outweigh those of any potential person, whenever the two conflict.¹⁵

Mary Anne recognized that those who think that being a potential person gives something a right to life may not agree with her claim that any such right is too weak to outweigh a women’s right to an abortion, and at this point she introduces a justly famous argument:

Suppose that our space explorer falls into the hands of an alien culture, whose scientists decide to create a few hundred thousand or more human beings, by breaking his body into its component cells, and using these to create fully developed human beings, with, of course, his genetic code. We may imagine that each of these newly created men will have all of the original man’s abilities, skills, knowledge, and so on, and also have an individual self-concept, in short that each of them will be a *bona fide* (though hardly unique) person. Imagine that the whole project will take only seconds, and that its chances of success are extremely high, and that our explorer knows all of this, and also knows that these people will be treated fairly. I maintain that in such a situation he would have every right to escape if he could, and thus to deprive all of these potential people of their potential lives; for his right to life outweighs all of theirs together, in spite of the fact that they are all genetically human, all innocent, and all have a very high probability of becoming people very soon, if only he refrains from acting.¹⁶

Mary Anne’s conclusion as regards the relevance of potential personhood to abortion is then, “it seems reasonable to conclude that the rights of a woman will outweigh by a similar margin whatever right to life a fetus may have by virtue of its potential personhood.”¹⁷

This argument has sometimes been challenged on the grounds that in the cloning case one has only what might be referred to as a *passive* potentiality for personhood, whereas in the case of the fetus one has what might be referred to as an *active* potentiality for personhood. But as I have argued in detail elsewhere, it can be shown that such a challenge is open to a decisive objection.¹⁸ The objection involves considering the case of a temporarily comatose but otherwise normal adult human being. Anti-abortionists are fond of appealing to this sort of case, as they like to argue that such a human does not presently have a *capacity* for rational thought or for self-consciousness, and yet surely has a right to life. What such philosophers overlook, as I have pointed out elsewhere on several occasions, is that in the case of a human who is not irreversibly comatose, it does not matter whether the individual will, on his or her own, recover consciousness, or whether, on the contrary, some medical intervention is needed for the individual to recover consciousness. In short, it does not matter in such a case whether the person has an active potentiality for recovering consciousness, or merely a passive one. So if what I have elsewhere referred to as *general* potentialities gave something a right to life, it would not matter whether those general potentialities were active or passive.

Mary Anne’s conclusion to her essay as a whole is then as follows:

Thus, neither a fetus’s resemblance to a person, nor its potential for becoming a person provides any

basis whatever for the claim that it has any significant right to life. Consequently, a woman's right to protect her health, happiness, freedom, and even her life, by terminating an unwanted pregnancy, will always override whatever right to life it may be appropriate to ascribe to a fetus, even a fully developed one. And thus, in the absence of any overwhelming social need for every possible child, the laws which restrict the right to obtain an abortion, or limit the period of pregnancy during which an abortion may be performed, are a wholly unjustified violation of a woman's most basic moral and constitutional rights.¹⁹

1.3 Summing up: the many virtues of Mary Anne Warren's essay

Mary Anne's essay is, in my opinion, absolutely first rate. Its principal virtues are, I think, as follows.

(1) Mary Anne discovered, in the responsibility objection to Judith Jarvis Thomson's argument, the crucial objection to Thomson's attempt to defend abortion without addressing the moral status of the fetus—an objection to which my colleague David Boonin's later discussion is also exposed. That objection can, as I mentioned earlier, be developed further, and when that is done, it seems clear that, as regards defenses of the general, moral permissibility of abortion, a personhood approach is, in the end, the only alternative.

(2) In distinguishing between humans, in the biological sense, and persons, understood in a psychological and species-free sense, Mary Anne focused on the idea that is crucial for formulating principles dealing with the right to life—or, as I would prefer to say, the right to continued existence.

(Anti-abortion groups, of course, are now engaged in a concerted effort to steal the term "person," with their so-called "personhood" amendments. As a result, some of us have taken to speaking explicitly of "neo-Lockean" persons.)

(3) Mary Anne showed that one could address such questions as the relevance of potential personhood, and the relevance of a thing's resembling a person, to the question of something's moral status, without having to defend the thesis that only persons have a right to life, since one can argue that if either of these properties gives an entity *some* right to life, that right is *far too weak* to make abortion morally wrong, let alone to justify its legal prohibition.

(4) Finally, Mary Anne's cloning argument in the case of the question of the moral relevance of potentialities is both an argument whose initial force is easily grasped, and also an argument that is perfectly able to handle any objection that rests upon the claim that active potentialities are morally significant, whereas passive potentialities are not.

2. Mary Anne Warren's later discussions of abortion

Mary Anne returned to the topic of abortion on many occasions. First of all, she added a postscript to her article in 1975, and then a revised postscript in 1982, dealing with the objection that a personhood defense of abortion also leads to the conclusion that infanticide is morally permissible.

In both the original and the expanded version of this postscript, Mary Anne argues that although infanticide is not the killing of an entity with a right to life, there are, in general, strong consequentialist reasons against infanticide in the case of normal infants: first, because many people want to adopt children; and secondly, simply because many people would strongly prefer to see the lives of infants preserved.

In 1977, Mary Anne published an article entitled "Do Potential People Have Moral Rights?" In this article she was

replying to R. M. Hare's article "Abortion and the Golden Rule," in which Hare argued that a natural extension of the Golden Rule that one should do unto others as one would want them to do unto you is that one should do unto others as one is glad *was* done unto you. But you are, hopefully, glad that your mother did not have an abortion. Therefore, you should refrain from having an abortion.

In response, Mary Anne argues, first, that Hare's argument for the claim that the bearing of one's actions upon merely possible persons is morally relevant rests upon a confusion, and then, secondly, Warren outlines a moral theory supporting the contention that there cannot be any sound alternative argument for the claim that merely possible persons are morally relevant.

In 1989, Mary Anne returned, once again, to the infanticide objection in an article entitled "The Moral Significance of Birth," published in *Hypatia*. This was a much more extended discussion, of about twenty pages in length.

This was followed in 1991 by a survey article entitled "Abortion," which was published in a Blackwell volume, *A Companion to Ethics*, edited by Peter Singer.

Next, in 1997, Mary Anne published a book with Oxford University Press entitled *Moral Status: Obligations to Persons and Other Living Things*. A chapter of that book is devoted to the topic of abortion.

The final publication that I want to mention is an article published in 2000, entitled "The Moral Difference between Infanticide and Abortion: A Response to Robert Card." Here, Mary Anne was replying to an article by Robert Card, entitled "Infanticide and the Liberal View," in which Card argued that the considerations that Warren offers in the expanded postscript for holding that infanticide is morally wrong can also be used to show that late-term abortions are equally wrong. Card then took it as obvious that the view that infanticide is not morally wrong is "morally repulsive," and so he concluded that Warren was faced with a very serious dilemma.²⁰

2.1 Mary Anne Warren's book, *Moral Status*

Here I shall confine my remarks to the last two publications that I have mentioned. First of all, then, in the book *Moral Status*, Mary Anne defended what she referred to as a "multi-criterial approach to moral status."²¹ Such an approach has two significant aspects. The first is that Mary Anne held that there are at least three *intrinsic* properties that contribute to a thing's moral status, namely, being a living thing, being sentient, and being a person. The second is that Mary Anne also defended the view that a thing's moral status is not a matter of its *intrinsic* properties alone: its *relations* to other entities can also contribute to a thing's moral status. Thus, Mary Anne says, "Chapter 6 proposes a new account of moral status, which gives weight both to such intrinsic properties as life, sentience, and personhood, and to social, emotional, and biosystemic relationships."²²

The idea that a thing's relationships to other things affect its moral status represents a significant divergence from traditional accounts of moral status, and one that seems to me problematic. Its importance in the present context is that, if this view can be defended, it provides one with a further way of attempting to drive a wedge between a personhood defense of abortion and acceptance of infanticide.

Another important aspect of Mary Anne's discussion in the book *Moral Status* involves the following two principles that she advances:

The Agent's Rights Principle: *Moral agents have full and equal basic moral rights, including the rights to life and liberty.*

The Human Rights Principle: *Within the limits of their own capacities and of principle 3, human beings who are capable of sentience but not of moral agency have the same moral rights as do moral agents.*²³

The question that immediately comes to mind, of course, is how this affects the issue of the moral permissibility of third-trimester abortions. Mary Anne addresses this question in Chapter 9, “Abortion and Human Rights,” but her answer is also clearly set out in the final publication that I want to discuss.

2.2 Mary Anne Warren’s article, “The Moral Difference between Infanticide and Abortion: A Response to Robert Card”

This article, published in the year 2000, is one that I recommend very highly, since it both makes clear some things that are rather in the background of Mary Anne’s 1973 article “On the Moral and Legal Status of Abortion,” and it also incorporates some changes that reflect developments in her views concerning moral status since that article.

First of all, Mary Anne addresses a question raised by Robert Card concerning whether her view is a liberal one or a moderate one. Her answer is as follows:

Professor Card wonders whether my view on abortion is liberal or moderate. I would describe it as liberal with respect to both the legal status of abortion and the moral status of early abortion, but moderate with respect to the moral status of late abortion. In other words, I argue that abortion should be legal, safe, and accessible at all stages of pregnancy, but that late abortion calls for more in the way of moral justification than early abortion. I also argue that infanticide is rarely justified in the contemporary world, because there are usually alternatives that would give the child a chance to live a good life, without violating anyone else’s basic moral rights.²⁴

Secondly, why does Mary Anne say that her view with regard to the moral status of late abortions is a moderate one? Her answer is as follows:

Although I did not emphasize the point in the 1973 article, I have since then argued that the primary reason that late-term foetuses have a moral status different from that of younger foetuses is that they may already be sentient.²⁵

If an organism is sentient, and can experience pleasure and pain, then there are certainly ways of treating it that are *prima facie* wrong. But the crucial question is why the presence of sentience *on its own* should make the *painless killing* of such an organism morally problematic in any way. Here, Mary Anne’s answer is that sentient organisms “benefit not only from pleasure and the avoidance of pain, but also from continued sentient life, the precondition for future experiences.”²⁶

Here, I am inclined to think that Mary Anne is going astray in the same way that it seems to me that Don Marquis goes astray in his future-like-ours defense of the immorality of abortion.²⁷ When one has a being that is sentient, but that does not have experiences at different times that are *psychologically connected* either by backward-looking psychological states such as memories, or by forward-looking psychological states such as desires, intentions, and expectations, then one does not have any *continuing self*, any *continuing subject* of mental states. What one has, instead, is simply a succession of *momentary* subjects of mental states, and any such purely momentary subject is neither benefited nor harmed by states of affairs that exist at other times, including whether it

is or is not followed by other purely momentary subjects of experiences.

Mary Anne’s view that sentience on its own gives an organism moral status obviously has implications with regard to abortion. With regard to this matter she says, “Thus, contrary to the impression that may have been inadvertently created in the 1973 article, I regard both sentient foetuses and infants as having significant moral status based upon the capacity for sentience.”²⁸

Next, Mary Anne turns to the question of why it is that infanticide is more difficult to justify than late abortion. Here, a point arises that, if memory serves—which it doesn’t always do!—was not present in any of her early discussions of this issue. She says,

I have always suspected that the mental capacities of infants are greater than they are often thought to be. While they presumably cannot think in words, I find it impossible to believe that they do not think at all, or that they have no form of self-awareness.²⁹

Mary Anne’s basic line of thought on this matter, however, is contained in the following passage:

Professor Card argues that the concern that most people have for the well-being of infants cannot support a moral distinction between abortion and infanticide, since many people also care for foetuses, and want to protect them. But the cases are fundamentally different in that the prohibition of infanticide need not violate anyone’s basic moral rights. Birth is morally significant because, once the infant is physically separate from the mother, its life can be protected through the attribution of legal personhood without simultaneously endangering her life and, in effect, her legal personhood. That being the case, we are free to take account of what Professor Card calls utilitarian considerations. Both the sentience of infants and the value that other human beings place on their lives are good reasons for protecting them, so long as the basic rights of persons are not thereby jeopardized.³⁰

There is much here that deserves careful discussion. As I have just indicated, I do not think that sentience *on its own* makes the killing of an organism morally wrong, and as regards the value that other human beings place on the lives of humans that are not persons, my view is that in certain contexts that may be a significant *consequentialist* consideration, but I share Robert Card’s view that is it not anything more than that. In particular, it seems to me that an entity’s moral status rests entirely upon its *intrinsic* properties, and so I am not inclined to agree with the view, which Mary Anne defends in her book *Moral Status*, to the effect that *relations* to other things can also contribute to an entity’s moral status.

The upshot is that my own views here are closer to those that Mary Anne defended in her 1973 paper “On the Moral and Legal Status of Abortion.” But I do think that the somewhat different views that she advanced and defended in her later writings are certainly deserving of careful consideration. Mary Anne was a very clever, very thoughtful, and very good philosopher, and also a very fine human being. Her early death was a great loss for all of us who are concerned with problems in the areas of philosophy about which she thought so deeply.

Notes

1. Warren, “On the Moral and Legal Status of Abortion,” 43.
2. *Ibid.*, 47.
3. *Ibid.*, 47–48.
4. *Ibid.*, 51.

5. Boonin, *Defense of Abortion*, 104–15.
6. Warren, “On the Moral and Legal Status of Abortion,” 52.
7. *Ibid.*, 54.
8. *Ibid.*, 55.
9. *Ibid.*, 56. It appears at one point that Mary Anne may be claiming that a fetus does not satisfy any of the above five conditions, since she says, “All we need to claim, to demonstrate that a fetus is not a person, is that any being which satisfies none of (1)–(5) is certainly not a person.”
10. *Ibid.*, 57.
11. *Ibid.*, 58.
12. *Ibid.*
13. *Ibid.*, 59.
14. *Ibid.*
15. *Ibid.*
16. *Ibid.*, 59–60.
17. *Ibid.*, 60.
18. Tooley, “Abortion,” 37–40.
19. Warren, “On the Moral and Legal Status of Abortion,” 60–61.
20. Card, “Infanticide and the Liberal View,” 341.
21. Warren, *Moral Status*, 148.
22. *Ibid.*, 19.
23. *Ibid.*, 156 and 164.
24. Warren, “Moral Difference between Infanticide and Abortion,” 352.
25. *Ibid.*, 350.
26. *Ibid.*, 353.
27. Marquis, “Why Abortion is Immoral.”
28. Warren, “Moral Difference between Infanticide and Abortion,” 354.
29. *Ibid.*, 355.
30. *Ibid.*, 357–58.

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- . “‘Postscript on Infanticide, February 26, 1982’ to ‘On the Moral and Legal Status of Abortion’,” in *The Problem of Abortion*, 2nd ed., 116–19. Belmont, CA: Wadsworth Publishing, 1982.
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- . *Moral Status: Obligations to Persons and Other Living Things*. Oxford: Oxford University Press, 1997.
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Mary Anne Warren

Things aren't the same without you.
They'll never be.
But they are better because of you.

TRIBUTE TO BERNARD GERT

Bernard Gert's Contributions to Theory in Bioethics

Tom L. Beauchamp
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This little piece is intended as a tribute to the long and highly productive career of Bernard Gert. I begin with a slice of his history, and mine.

Bernie and his cherished friend Dan Clouser wrote a stinging criticism in 1990 of my book *Principles of Biomedical Ethics*, coauthored with Jim Childress. The Gert-Clouser article was well received in bioethics, especially among the more philosophically inclined. It did more than chip away at what Childress and I had been writing about theory and method over the previous decade; it blasted away at our work. In this article they coined the label “principlism,” which has since stuck in talk about theory and method. Their work was astute, original, and penetrating, and it has been enduring. Gert and Clouser continued to criticize us right through the occasion of a retirement symposium held in Gert’s honor at Dartmouth.

As Gert, together with Clouser and a few other scholars, continued to dismantle my views (as well as other “inferior” moral theories), Gert’s reputation in bioethics as a writer in what might be called theory and method flourished. At almost the same time came the introduction and rise in popularity of the casuistry of Albert Jonsen and Stephen Toulmin. This was a grand period for feasting on principlism as an account of theory and method in bioethics.

In 1996 Bernie, Al, and I were participants at two university symposia. It was apparent by the way those symposia were structured that Bernie had managed to convince many in bioethics that there were three and only three competitors in the area of theory of method: Casuistry, Principlism, and Gertian Theory. Not everyone was wild about this idea. Norman Daniels published an article at the time in which he lamented that theory and method discussions in bioethics had divided up the landscape of theory in this way.¹ Nonetheless, Bernie’s vision of the landscape stuck.

But how did the landscape become configured in this way, and why is it important for thinking about Bernie’s contributions to bioethics? The simple answer is that Bernie was more responsible than anyone else for presenting the way the competitor theories are to be understood, as well as what was at stake in the choice of theory. Dan Clouser once said to me as we rode on a bus to Will Gaylin’s retirement dinner that he was proud of the way bioethics had recently allowed for what he called second-level theory—theory that distances itself from the practical normative problems of bioethics—and had begun to think about the foundations of this form of practical thinking and the methods appropriate to it. We’ve finally gotten to the point, he said, that we have the luxury, the interest, and the talent to have a whole literature in bioethics devoted to second-level analysis. Clouser and I both knew that, more than anyone else, Bernie was the person who had taken us down this path.

Two seminal publications, more than any others, led bioethics down the path of controversy about theory and method. First, Jonsen and Toulmin burst onto the scene in 1988 with *The Abuse of Casuistry: A History of Moral Reasoning*, a book that received sustained attention in bioethics. The second was the previously mentioned 1990 article by Gert and

Clouser.² The criticism of principles from both quarters led to a burgeoning literature. I will not say anything about the large literature on theory that soon developed, except to note that Bernie created and nourished it more than anyone, and he had the most comprehensive vision of which issues needed to be addressed and how to go about it. I know that I have never thought that anyone has had criticisms of my work as penetrating as Gert’s.

Bernie vigorously and unmercifully pursued the thesis that both principlists and causuists lack a moral theory. He argued that Childress and I failed to provide a theory of justification or any general moral theory. Rather, according to him, we produced a patchwork of different theories, while Jonsen and Toulmin were without theory altogether. I think there is much to be said for what they claim; Jim and I do not have an integrated systematic theory, and Jonsen and Toulmin are antitheoretical when it comes to practical ethics. Over the years Bernie pushed ever harder for a close, integrated bonding between a moral theory and practical ethics. No one has pressed the case so elegantly, and I seriously doubt that anyone ever will. Certainly no one now on the horizon in bioethics has the philosophical background and specific commitment to press the case as well as Bernie did. We often say in “tributes” to seminal individuals that their contribution was unique. I know of no better example in all of bioethics of a unique academic contribution than Bernie’s. He was an unrivaled advocate of a universalist common-morality theory with an emphasis on *theory*. His contribution has left an enduring mark on bioethics that many in the field may not even recognize as his.

Bernie and I have both, since 1995, been engaged, in our separate ways, in a defense of common morality theory. He and I (together with our partners, Clouser and Childress) have invested heavily in the theory. There is something of a storm of protest against our views, some directed chiefly at Bernie and some at me—and most of it at both of us. These protests make careful inspection of Bernie’s views all the more important. I am convinced that he is closer to the right set of views than are most of his critics, and I expect common morality theory to continue to be carefully dissected in upcoming years. I also expect his book on the subject, together with his other major work in theory, to continue to be the deepest work on the subject.

I have developed an account of the common morality as the source of considered judgments in something of a Rawlsian framework of justification—a theory that Bernie rejected. Never mind our differences here; we both have argued that no more central moral content exists as a starting point for biomedical ethics than the kinds of norms found in the common morality—my views being expressed as clusters of principles and Bernie’s presented in terms of basic moral rules and moral ideals. I have not been so bold as to claim to be able to capture the full, or even the primary, content of the common morality. Here again there is a contrast between what mortals like me attempt to capture and the intrepid and ambitious side of Bernie’s moral theorizing. He claims to capture the basic structure and comprehensive scope of the common morality. On the one hand, he presents an astonishingly bold universalistic theory, and on the other hand, there is probably much more to the common morality than even an immortal like Bernie has been able to capture. If I’m right, a great deal remains to be written on the subject. We will all remember that Bernie got us started in this area much earlier than anyone.

Finally, I want to say something about Bernie’s beautiful friendship and collaboration with Dan Clouser, who was one of the loveliest persons I’ve ever known and one of the major contributors to the development of bioethics throughout its history, right from the beginning of the field. Clouser needs to be

given credit for gently pushing Bernie, year after year, onto the more practical turf of bioethics. One of the beautiful things about their relationship was that Dan had an enormous admiration of, and an excellent understanding of, Bernie's complicated moral theory. As Dan coaxed Bernie ever deeper into bioethics, they emerged as a unit cemented around Bernie's notably philosophical ethics. I say "notably philosophical" meaning that Bernie was a no-compromise person when it came to the use of theory in practical ethics. Theory was the entry point and was ever present in everything Bernie wrote, something Dan Clouser accepted and indeed relished. This in itself I mean as a significant tribute to Bernie. For a person of deep substance like Dan Clouser to have learned so much from Bernie's ethical theory and to have been so successful in using it is a substantial mark of respect and esteem.

Clouser and I agreed that, of all of us who have come into bioethics through philosophy, Bernie was the one who most consistently kept ethical theory at the forefront of everything he did. For this contribution we will all remember him as a pioneer of the field.

Notes

1. Norman Daniels, "Wide Reflective Equilibrium in Practice," in *Philosophical Perspectives on Bioethics*, ed. L. W. Sumner and J. Boyle (Toronto: University of Toronto Press, 1996), 96–114.
2. K. D. Clouser and B. Gert, "A Critique of Principlism," *Journal of Medicine and Philosophy* 15, no. 2 (1990): 219–36.

A Tribute to Bernard Gert

Loretta Kopelman

East Carolina University

Writing this tribute to the life and philosophical works of my good friend Bernard Gert reminded me that we first met at a bioethics conference where we soon began discussing the concept of rationality in the work of David Hume. I was more sympathetic to Hume than Bernie who, as we all know, preferred the views of Thomas Hobbes. After a gap of about a year, I saw him walking along the beach outside of another conference. As he approached he picked up our discussion about Hume exactly where we had left off months ago. Since then we had many more conversations on other topics and I learned a great deal from every discussion we had.

I began reading his work soon after I met him, in part because his comments were so exceptional and in part because he contributed to a volume of *The Journal of Medicine and Philosophy* that I was editing with our mutual friend K. Danner Clouser. In this issue Clouser and Gert wrote a paper criticizing "principlism," a name they made up for the popular four-principle approach to analysis and problem solving in bioethics offered by Tom Beauchamp and James Childress.¹ The name "principlism" stuck. Clouser and Gert criticized Beauchamp and Childress for failing to ground their theory and for not offering a method for resolving disagreement when conflicts arose in using the four principles.

Most philosophers are aware of Bernie's extraordinary contributions in ethical theory and Hobbes scholarship, but his work in bioethics was also lasting and superb. For example, he argued that policy permitting competent and informed patients to refuse medications, interventions, nutrition, or hydration offered a more effective and less contentious means for patients to end a burdensome life than physician-assisted suicide. Under these circumstances, such refusals should

not be viewed as suicides.² Bernie not only developed key arguments and responded to objections but also worked to have the policy implemented. Many states now have policies honoring these rights.

His interest in integrating theory and practice was also apparent in his willingness to serve on institution-based ethics committees. It was shown as well in another important contribution that he made concerning the clarification of the concepts of rationality and irrationality. He argued that the latter concept is more basic. This insight is both theoretically and practically important and has had lasting influence in philosophy as well as in psychiatry.³

Bernie's outstanding work shows how to seamlessly link moral theory with practice, which is especially important to philosophers working in bioethics because of the nature of the discipline. Bioethics is different from most new fields, which split off from parent disciplines to limit the subject matter and promote greater expertise in the narrower field. Brain surgery split off from general surgery for these reasons. In contrast, bioethics is best understood as a *second-order discipline*, or so I have argued.⁴ People doing bioethics seek to expand rather than narrow its subject matter and seek expertise from many fields to address competently the complex and interdisciplinary problems comprising bioethics. Good solutions to bioethical problems, such as how much information is needed to obtain informed consent, profit from many professional and disciplinary perspectives. In a second-order discipline like bioethics it is necessary to rely in part upon people's primary professions or fields to set their own educational or other standards of competency for their members. Because many different professions or fields offer important perspectives on the problems characteristic of bioethics, it is sometimes challenging to maintain one's identity as a philosopher.

One of Bernie's lasting contributions to bioethics was the example he provided of how to be philosophically rigorous in bioethics, and how to tie together theory and practice. He was a good friend, and the best person I knew with whom to discuss philosophy.

Notes

1. Clouser and Gert, "Critique of Principlism"; Beauchamp and Childress, *Principles of Biomedical Ethics*.
2. Gert et al., *Bioethics*, 320–29.
3. Gert et al., *Bioethics*.
4. Kopelman, "Bioethics as a Second-order Discipline."

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The Ethics of Medicine: UnCommon Morality*

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I am deeply indebted to Bernard Gert for his friendship and support. I am grateful for all that he taught me about Hobbes and common morality. He was an impressive Hobbes scholar with

an excellent grasp of the conceptual components of Hobbes's theory, particularly the critical understanding of Hobbes's conception of reason, and had a clear vision of how the many pieces fit together. His work on common morality goes far in translating Hobbesian insights into contemporary ethics and making the contractarian constructivist approach accessible and compelling.

I also very much admire a good deal of his two volumes on bioethics, and his ongoing support for the work of the APA Committee on Philosophy and Medicine, on which he served and at one point chaired. His insights into decisional capacity are more subtle, nuanced, and informative than any other account in the field.

That said, I wish to take issue with Gert's fundamental move in bioethics.

Bernie and his co-authors, Dan Clouser and Charles Culver, were the first to coin the term "common morality," and they played an important role in popularizing the view. So, it is now commonplace to view bioethics, or as I prefer to call it, medical ethics, as the application of common morality to questions of ethics that arise in medicine. That well-entrenched view is reflected in the vast literature of the past thirty-odd years. Starting with that assumption, authors discuss autonomy in Kantian terms, allocation of scarce resources in utilitarian terms, access to health care in terms of rights theory, and professionalism in terms of virtue theory. This dominant view was articulated by a co-author of *Bioethics*, K. Danner Clouser, in his 1978 *Encyclopedia of Bioethics* article on "Bioethics." There he explained that "bioethics is not a new set of principles or maneuvers, but the same old ethics being applied to a particular realm of concerns." The strategy is further elaborated by Gert, Clouser, and Culver in *Bioethics: A Return to Fundamentals* and again in *Bioethics: A Systematic Approach*, where they identify ten moral rules as the crux of common morality. The claim that common morality is the ethics of medicine is also the approach most prominently expounded by Tom Beauchamp and James Childress in the six editions of their *Principles of Medical Ethics*. In those volumes Beauchamp and Childress identify the four principles of respect for autonomy, beneficence, nonmaleficence, and justice as the common features of prominent moral theories, and they show how to apply these principles to the practice of medicine.

In this paper I challenge that assumption and make the case for the distinctiveness of medical ethics. In other words, I argue that the principles of medical ethics are different from, sometimes diametrically opposed to, common morality, and even when they appear to be similar, their justifications are different. I also argue that Gert and colleagues took a wrong turn when they espoused their commitment to the common morality view of medical ethics. In fact, as I see it, common morality is not consistent with a good deal of the content of their own *Bioethics*, and following the path of common morality led them into an awkward and untenable position on euthanasia.

My view of medical ethics is not entirely original in that others have taken positions along these lines. I shall count as allies in this cause Hippocrates, Thomas Percival, John Gregory, and more contemporary authors David Thomasma, Edmund Pellegrino, and Lawrence McCullough. I also wish to point out that in arguing for the distinctiveness of medical ethics, I am arguing for a position that reflects a point made by John Rawls in *Political Liberalism*. There Rawls notes that "the distinct purposes and roles of the parts of the social structure . . . explains there being different principles for distinct kinds of subjects."¹ In that light, perhaps every profession has its own set of moral rules and requires a distinctive character from its members. Perhaps there are areas of the social world in addition to the professions

that also have distinctive sets of moral rules. Exploring those questions, however, goes beyond the limited scope of this paper. Here, I shall only challenge Gert's view that medical ethics is just common morality applied to the complex issues that arise as dilemmas in clinical medicine, largely as a response to remarkable technological advances in the field.

To make my case, I first present an argument for holding that medical ethics is different from the common morality of everyday life.

The distinctiveness of the ethics of medicine

The reigning view articulated by Gert, Clouser, and Culver expresses a universal claim that all medical ethics is just common morality. It entails that there is nothing distinctive about the moral principles of medicine or the moral virtues of a physician. A single counter-example would refute such a universal claim, but because the belief that the ethics of medicine is just ordinary morality has come to be so generally accepted, I offer several examples.

Non-judgmental regard. By common morality, we are free to associate with whomever we choose. In fact, we were taught, and we teach our children, to be careful in the friends we choose. We are supposed to attentively distinguish between people based on their character and reputation. We are supposed to avoid the unsavory and those who might have a bad influence on us, and to seek out those who are likely to be good role models and steer us toward good character and noble accomplishment. Carefully choosing our associates violates no moral rules. But in medicine, doctors are supposed to be non-judgmental and to minister to every patient's medical needs without discrimination.

Caring. According to common morality, we are free to care most about those who are closest to us. We bestow gifts on those who are nearest and dearest. We invite those whose company we enjoy to our homes. We are expected to give our love only to a select special few. In medicine, however, doctors have a positive duty to care about the well-being of every patient and to bestow their caring attention on each. In fact, doctors are required to avoid the intrusion of special personal attachments to favorite patients and to allocate the scarce resources at their disposal, such as intensive care beds, transplant organs, their time, their energy, and their comforting smiles, with professional devotion to each patient.²

Intimates. In ordinary relationships we expect those nearest and dearest to act on behalf of their loved ones who cannot make decisions for themselves. Parents select the names for their children, they choose whether or not to inculcate religious beliefs, they decide on where to raise them, what to feed them, and the schools they should attend. Family members typically make decisions on behalf of elderly relatives who have lost their decisional capacity. We count on spouses, offspring, and siblings to choose where demented family members should reside, to make decisions about their health care, and to manage their finances. In medicine, however, doctors do not have those liberties. Professional standards require them to refer family members to the care of other clinicians precisely because their strong feelings can interfere with clinical judgment.

Confidentiality. In the course of ordinary social interactions, we freely share our experiences. Common morality allows us to tell others about what we learn in the course of our daily lives and what we discover about others. We convey information about who can and who cannot be trusted to repay a loan, which restaurants serve good food, which teachers grade fairly, who is speaking with whom, whose relationships are on the rocks, which doctor was hours late for an appointment, and which dentist has a gentle touch.

This sharing of information is useful and entertaining, and it is very much a part of the fabric of our lives. We are free to impart what we learn, and exceptions actually require explicit requests for keeping divulged information in confidence (e.g., making explicit promises, signing non-disclosure agreements) or some special understanding arising from the details of an intimate relationship. Yet in medicine, at least since the time of Hippocrates, confidentiality is presumed as a professional duty, although some exceptions can be justified.

Non-sexual regard. Most people today consider sexual activity among consenting adults to be ethically acceptable. Unless force, deception, or indecent exposure is involved, sexual interactions between adults are morally unproblematic. In medicine, however, disclosure and consent do not legitimize a physician's sexual involvement with a patient. We expect that a patient's invitation for a tryst will be declined and that one would not be issued to a patient by a doctor even when all of the parties are adults and no force or deception is involved. And we even use different terms to describe what transpires: the "ogling" of common morality is "inspection" in medicine, "fondling" and "groping" are "examination" and "palpation." Again, since the time of Hippocrates, physicians have acknowledged and accepted the constraint on taking sexual advantage of their intimacy with patients as part of the ethics of medicine.

Probing. In ordinary social situations, it is considered rude to ask probing and personal questions. I have heard that in Texas you never ask a man how much money or how much land he has. But in reality, the boundaries on polite conversation are far more constraining. We do not usually inquire about the details of other people's sex lives, their constipation, their drug use, or even their diet. Many people don't speak about death or disease or emotions. Yet, taking a complete and detailed patient history includes asking about a patient's diet, bowel habits, sexual practices, drug use, previous illnesses, and fears. Conversations that are out of bounds for others are part of a doctor's professional responsibility.

Possible replies

Because we have exchanged views on this point before, I know that Bernie would respond to these examples by showing how the moral requirements in these cases could be accounted for by common morality. For example, I would expect him to point out that the "moral ideals" of preventing death, pain, disability, loss of pleasure, and loss of freedom would explain the morality of all of my examples.³ Yet, in the sense that a specific response is required from doctors, I see these as specific moral duties. From my point of view, the transformation from an ideal of beneficence to a strict duty, or, in Kantian terms, from an imperfect to a perfect duty, is a very significant difference.

I also expect that Bernie would reply that his rule #6, "Keep your promise," and his rule #10, "Do your duty," explain the cases that I have identified. That kind of account might explain how a moral ideal can become a more stringent moral requirement when someone makes a promise to uphold the ideal or takes on a role that involves a stronger kind of commitment to the ideal, but I do not see how rules #6 or #10 could radically change the content of moral responsibility. Another example will make this point more explicit.

Rules #4 and #5 of Gert's version of common morality prohibit the deprivation of freedom or pleasure. These rules seem to express the view that we should allow others to act as they choose and advance their own conception of the good. Doctors, like others, observe this rule when they are not in their clinical setting. When they see others smoking cigarettes, they walk by with respectful disregard even though they worry about cancer.

They hold their tongues when they observe others sporting multiple tattoos or numerous items of body piercing jewelry, even though they are concerned about hepatitis. Doctors even remain silent as overweight others indulge in decadent deserts, all the while thinking about the dangers of obesity and high cholesterol diets. Nevertheless, in a visit to the doctor's office, it is hard to imagine that a good doctor would fail to admonish a patient about the risks of cancer, hepatitis, or obesity.

In other words, physicians are not allowed to presume that their patients are acting autonomously. Instead, they are responsible for the vigilant assessment of patients' decisional capacity, and they are sometimes required to take steps to oppose patients' stated preferences. In fact, Gert and colleagues provide numerous examples to illustrate this point. For example, they describe an elderly depressed woman who has lost a great deal of weight. She understands and appreciates her life threatening situation, but has an irrational fear that keeps her from consenting to the electroconvulsive treatment that she knows is likely to cure her of depression.⁴

Both editions of *Bioethics* devote significant attention to the analysis of competence and medical paternalism. The careful and insightful attention to these interrelated concepts demonstrates that the assessment of competence is a critical medical responsibility. Philosophically, it is important to notice, however, that acknowledging physicians' moral duty to assess the decisional capacity of patients is exactly opposed to the preeminent moral duty of common morality which requires us to go as far as possible in presuming that others have decisional capacity and respecting their choices and freedom in pursuit of pleasure. Although I fully agree that physicians have the duty that Gert's discussion suggests that they have, the duty to assess capacity is clearly at odds with common morality and cannot be derived from it.

Such considerations suggest that common morality is significantly different from the ethics of medicine in dramatic and important ways. Together these examples show that the ethics of medicine cannot be common morality applied to high-tech medicine, and they reveal that medical ethics requires a different framework to explain its special responsibilities.

Euthanasia

Holding fast to the common morality approach leaves Gert, and Clouser with the difficult problem of what to say about euthanasia or physician-assisted dying. They see physicians as committed to the rules of common morality with at least as much stringency as others are, or perhaps, with greater stringency since they have made a special promise or taken on a special duty. Then, because "do not kill" is a rule of common morality, and because "prolonging life is following a moral ideal," they are hard pressed to find a way for physicians to respond to the requests of "competent patients who rationally prefer to die."⁵

So, what to do? They opt for dancing a little side-step and taking a giant leap into the specious equivocation of double-effect reasoning. They write, "Not treating counts as killing only when there is a duty to treat; in the absence of such a duty, not treating does not count as killing."⁶ They go on to maintain that "if a competent patient rationally refuses treatment, abiding by that refusal is not killing."⁷ But they also hold that there is no moral distinction between refusing, withholding, and withdrawing treatment.⁸ In that light, they see the removal of life-preserving treatment, such as nutrition and hydration, ventilator support, or continuous dialysis, as abiding by a competent patient's wishes, and not as killing.

But if I, a mere philosopher with no duty to treat anyone, walked into a patient's room and disconnected the patient

from nutrition and hydration, ventilator support, or continuous dialysis and death resulted, I would be charged with murder because what I did was killing. And if a parent simply neglected to feed a very young child who died of starvation, the parent would be charged with murder because withholding food for a significant period was killing. It is hard to see how the very same act could be both killing and not killing. Such acts are killing because of the link between nutrition and life, because of the implicit responsibilities of the person who withdraws or withholds nutrition, and because of the dependency of the individual who ends up dead. The only way that Gert and colleagues avoid recognizing these incontrovertible facts is by hiding behind the old illusion of pretending that they are not doing what they are obviously doing and claiming that they are really only abiding by a competent patient's rational request. **Really**, they are doing both that **and** killing.

It is not hard to see, however, that an act which is forbidden for most people may be permitted when performed by people with special social powers and privileges. An army infantryman in battle may be justified in shooting people when others are not. A policeman may be justified in imprisoning people when others are not. And a physician may be justified in administering poisons (e.g., chemotherapy), cutting into another's body with knives, or removing a limb or a vital organ (i.e., performing surgery), and even killing (i.e., performing euthanasia) when others are not. These special powers and privileges are socially and morally allowed to such professionals because we need them to perform these extraordinary acts. There is no obvious reason to presume that the rules which govern the use of extraordinary professional powers and privileges are the same as common morality. In fact, when people in the military kill, and when police deprive people of freedom, they are likely to be performing their duty. Similarly, when physicians cause pain, disable, and kill, they are likely to be performing their duty.

Without recognizing that the moral rules of these professions are radically different from common morality we end up in the same mess as Gert and his colleagues. They call killing not killing, and focus on one intention while pointedly ignoring another. A simpler and more honest approach involves accepting that the ethics of the professions involve departures from common morality. In the specific case of passive or active euthanasia, medical ethics involves recognizing that the distinctive powers and privileges of physicians allow them to withhold and withdraw life-preserving treatment (which Gert et al. accept), to provide advice on how to hasten death by refusing nutrition and hydration (which Gert et al. also accept), as well as to actively administer fatal drugs (which Gert et al. refuse to accept).

Gert and colleagues see no moral difference between acts and omissions, and I agree. The conclusion that they should draw from this point is the one that James Rachels drew decades ago. When it is wrong for a doctor to kill, it will be wrong for a doctor to let a patient die. And, when it is morally required for a doctor to allow a patient to die, it may be morally better for a doctor to help a patient die by using whatever means best serve the patient's interests.

Why the view of professional responsibility

My point is that Gert's rules #6 and #10, "keep your promise" and "do your duty," do not provide an adequate explanatory framework for medical ethics. The reason turns on the old philosophic distinction between act and rule ethics, a point that I expect Gert to take very seriously.

Once the moral rules of the *Bioethics* approach are established, any violation of a moral rule requires justification

and then an assessment of whether or not the violation could be publicly allowed. Whereas clinicians always have a duty to evaluate and compare the risks and benefits of alternative treatment plans, the *Bioethics* approach would require an evaluation at a much more fundamental level. Before every medical action, it would require clinicians to assess the legitimacy of employing any medical intervention which risks death, pain, disability, loss of pleasure, or loss of freedom and then testing the decision by the publicity standard. Clearly, imposing treatments and tests that entail risks and inconveniences without any promise of medical benefit violates several moral rules. But standard of care medical interventions are not seen as violations of moral rules that have to be justified *per se*; they are seen as "indicated" treatments or tests. Furthermore, it is hard to see how the publicity standard would work within the profession because judgments as to the appropriateness of particular medical interventions turn on medical expertise that is not available to the public. In other words, although the ultimate ethical acceptability of an action in common morality will reflect whether or not it would be publicly allowed, in medicine, the ethical acceptability of an action reflects whether it is what a consensus of exemplary doctors would allow.

Although Gert and colleagues may be happy to have each medical decision made in their step-wise fashion, the problem with a case-by-case approach is that it opens medicine to tremendous variability and it deprives patients of the ability to rely upon clinicians to consistently uphold a set of standards for their practice, particularly where no violation of the moral rules is involved. The common morality approach would leave it open for clinicians to evaluate the merits of maintaining non-judgmental regard, a caring attitude, confidentiality, non-sexual regard, and the rest, on a case-by-case basis. It would require a justification for the assessment of decisional capacity.

Patients expect their doctors to uphold the standards of medical professionalism and display character traits and attitudes that go beyond the requirements of common morality. Without being able to expect that clinicians will be non-judgmental and caring, and will uphold confidentiality, maintain their professional competence, and the rest of their distinctive responsibilities, patients would have to be guarded and skeptical with respect to interactions with their doctors. Undermining the trust in what could be legitimately expected from a doctor would, in turn, undermine the good that could be achieved by medical professionals.

The alternative is to identify categories of actions and virtues that are relevant to the practice of medicine. This sort of consideration of **distinctive rules for the profession** would follow the outline of the two-step procedure advocated in *Bioethics*. Violations of the moral rules of common morality would first have to be evaluated in terms of their foreseeable consequences in order to determine whether or not general medical practice in violation of the rule would be justified. We would then have to consider whether or not, when publicized, the practice would be generally accepted as a rule for the profession. Similarly, we would have to consider whether attitudes or behaviors that were merely moral ideals should be more stringent for medical professionals and whether additional rules should be imposed to constrain the freedom of clinicians. If such limitations on the freedom of medical professionals can be justified, and if the more demanding requirements meet the publicity standard, the requirements would stand as duties of the profession. The sum total of special rules and requirements for action and character would comprise the ethics of the profession and provide the content for the duty that professionals can be legitimately presumed to take on when they join the profession. Without such an account, duty

would always have to be an individual undertaking and Gert would be unable to explain how rule #10, “Do your duty,” gets its content. In other words, he needs the more general account of professional duties to explain why professionals of any kind have the duties that they do.

Conclusion

Whereas Gert’s version of common morality is a superb account of the ethics of everyday life, I think his account of the ethics of medicine misses the mark by failing to recognize that something different is required for the professions. There is a lot more to medical ethics than applying common morality to the technology-created conundrums of modern clinical medicine.

Notes

1. Rawls, *Political Liberalism*, 262.
2. Rhodes, “Love Thy Patient.”
3. Gert et al., *Bioethics*, 43.
4. *Ibid.*, 222.
5. *Ibid.*, 322.
6. *Ibid.*
7. *Ibid.*, 323.
8. *Ibid.*, 310–22.

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* This paper weaves together arguments and themes from several previous works. (Rhodes 1995, 2001, 2006, 2007)

Professor Gert’s Views on Death: An Analysis and Critique

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Introduction

In this paper I analyze and critique Gert’s views on death, tracing the evolution of his ideas throughout his career. I argue that the definitions-criteria-tests framework that he and his colleagues introduced, along with their approach to death as a biological phenomenon to be understood in biological terms, are immensely important and largely correct. However, there is no scientific justification for claiming that brain-dead bodies are biologically dead bodies. Furthermore, continuing to use the language of “death” to describe such bodies as a matter of

public policy constitutes paternalism. I use Gert’s analysis of the justification of paternalism to argue that the paternalism inherent in the language of “death” is unjustified.

Few authors have had as profound an effect on the literature on death and brain death as Professor Bernard Gert and his colleagues. While it is certainly the case that Gert and colleagues have not settled the debate and much dispute remains, nonetheless the imprint of Gert’s work can be found throughout the brain-death literature. In this paper I will describe and analyze Gert’s views on death, arguing that although his work is insightful and important, he is ultimately unsuccessful in establishing either the scientific or moral validity of describing brain death as equivalent to death. Perhaps somewhat surprisingly, one of Gert’s other important bioethical contributions, on paternalism, will be helpful in making the moral case against his view on equating brain death with death as a matter of public policy.

The definitions-criteria-tests framework

Gert and colleagues’ most significant and enduring contribution to the brain death literature is surely their widely cited description of the three-part distinction for understanding death, known as the definitions-criteria-tests framework.¹ On this view, the first step is to formulate a definition of “death” that makes the ordinary meaning of the term explicit, which is considered primarily a philosophical task. Next, the physiological criteria, or necessary and sufficient physiological conditions for the instantiation of that definition must be determined (a combined medical/philosophical task), and finally, tests must be devised to discern when those physiological criteria have occurred (solely a medical endeavor).² This framework has structured much of the literature on brain death over the last thirty years. Although it is not universally accepted, it is nearly universally addressed. Whether accepted or challenged, it is never ignored.

Given this framework, Gert and colleagues have argued that a number of background assumptions hold. First, the formulation of the definition of the word “death” involves making explicit what the term has always meant in its ordinary use. That is, “death” is not (or not solely) a technical term; rather, it is an ordinary word that we all use reasonably correctly. The task of defining “death,” therefore, is to clarify and make explicit what the term has always meant. In its most straightforward and literal use, “death” refers to an event, not a process, that separates the process of living (or dying) from the process of disintegration and decay. Furthermore, although a commonsense term, “death” refers to a biological event, and thus its cognates (e.g., “dead”) cover biological organisms as such. The same word, “dead,” applies to a human family member and the family cat, as well as the mouse that the cat brought in. All and only biological organisms can literally die, according to Gert and colleagues.

This is important because a number of other influential views, often taken as challenges to Gert’s views on death, actually address orthogonal questions. Considerations involving personhood or personal identity, the ability to meaningfully interact with the environment, and the determinants of moral worth are important issues to consider when addressing questions about end of life care, resource allocation, and organ transplants. But, at least for Gert and colleagues, the first question to address is a descriptive biological question: Is the organism biologically dead?

Gert and colleagues initially defined “death” as the permanent cessation of functioning of the organism as a whole.³ They argued that permanent loss of functioning of the entire brain is the criterion for death, as it is “perfectly correlated with the permanent cessation of functioning of the organism as a

whole because the brain is necessary for functioning of the organism as a whole.”⁴ They endorsed an early set of tests, but subsequently accepted refined versions of the diagnostic tests, of which the essential elements are cerebral unresponsiveness (allowing for spinal reflexes), brainstem areflexia, and apnea, coupled with a known, irreversible cause of coma.⁵

Gert and colleagues make clear that they intend their claims regarding the criterion and tests for death to be empirically testable and validated assertions about biology, not conceptual points about personhood or moral status. As such, these claims are vulnerable to evidence. I therefore refer to their thesis that the absence of neurological function is a criterion for biological death as “the brain death hypothesis.”

Before considering the revisions to these ideas that Gert and colleagues later proposed, let us first take a look at what we ought to say in light of some empirical evidence regarding “brain dead” bodies, while granting all of Gert’s background assumptions and conceptual framework. I will first address the adequacy of the tests and then the adequacy of the criterion.

To avoid confusion with the unclear and loaded term “brain death,” I’ll introduce the term “state X.” By “state X” I mean the irreversible cessation of clinical functions of the brain, as judged by cerebral unresponsiveness, brainstem areflexia, and apnea, coupled with a known, irreversible cause of coma. Thus, any patient that satisfies the standard clinical diagnostic tests noted above is, by definition, in state X, though I intend this term to be neutral with respect to biological death as well as the irreversible cessation of *all* functions of the brain.

Empirical evidence has shown that bodies in state X can maintain organized cortical and subcortical electrical activity, including normal or near-normal sensory evoked potentials.⁶ They also can develop a febrile response to infection, thus exhibiting thermal regulation, and, with blankets, can regulate temperature in the absence of infection.⁷ Children in state X have grown and sexually matured, and pregnant women in state X have gestated fetuses.⁸ Approximately half of bodies in state X maintain free water homeostasis through hypothalamic osmoregulation.⁹ Each of these observations constitutes evidence that the combination of apnea, brainstem areflexia, and cerebral unresponsiveness is consistent with the preservation of some neurological function,¹⁰ and hence, the tests generate false positives (indeed, the positive predictive value of these tests is, at best, 50 percent, an extremely poor test by any standard¹¹).

Furthermore, the preservation of neuroendocrine function is significant. Gert and colleagues write, “the functioning of the organism as a whole means the spontaneous and innate activities carried out by the integration of all or most subsystems (for example, neuroendocrine control),”¹² and specifically mention the hypothalamus as a part of the brain that must be destroyed for their physiologic criterion to be satisfied:

Many other functions of the organism as a whole including neuroendocrine control, temperature control, [etc.] . . . reside in the more primitive regions (hypothalamus, brainstem) of the brain. Thus total and irreversible loss of functioning of the whole brain and not merely the neocortex is required as the criterion for the permanent loss of functioning of the organism as a whole.¹³

It follows that, on Gert’s view, preservation of neuroendocrine function is inconsistent with both the criterion for death (since some brain function is preserved), and the definition of “death” (since neuroendocrine control is a function of the organism as a whole).

In addition to the inadequacy of the tests, empirical evidence has also shown the inadequacy of the criterion. Gert and colleagues state that permanent loss of functioning of the entire brain is perfectly correlated with the permanent cessation of functioning of the organism as a whole. The notion of “functioning of the organism as a whole,” as a biological concept, is typically understood in terms of homeostasis and the resistance of entropy, and Gert and colleagues cite with approval Korein’s early attempts to define the brain as the critical system controlling the organism as a whole in terms of entropy.¹⁴ Bodies in state X clearly maintain homeostasis through the preservation of a variety of functions of the organism as a whole, including, in addition to neuroendocrine functions, gas exchange at the alveoli, cellular respiration, circulation, elimination, detoxification, and recycling of wastes, wound healing, nutrition, immune responses to infection, hemodynamic and endocrine responses to incision, gestation of fetuses, and growth and sexual maturation for children.¹⁵ Such bodies can be maintained for many weeks and in some cases for years.¹⁶

This was acknowledged in the recent President’s Council white paper:

Nonetheless, *something like health* is still present in the body of a patient [in state X]. This can be seen clearly in the ‘donor management’ procedures . . . [that] aim to maintain the body in a relatively stable state of homeostasis so that . . . the organs remain as healthy as possible. Thus, there is some degree of somatically integrated activity that persists in the bodies of patients [in state X].¹⁷

Furthermore, Gert and colleagues argue that permanent cessation of brain function is an adequate criterion for permanent cessation of the organism as a whole “because the brain is necessary for functioning of the organism as a whole.”¹⁸ Yet, as Shewmon has pointed out, patients who suffer spinal shock at the cervico-medullary junction are clearly alive, though in this case the body is completely divorced from communication with the brain.¹⁹ The spinal shock case shows that although the brain is normally an important modulator of organic integration and maintenance of homeostasis, with adequate medical and nursing support, integrated maintenance of homeostasis and thus biological life can continue in the absence of neurological modulation. Finally, many patients in state X are indeed more homeostatically stable than some other patients not in state X, when those other patients are clearly alive.²⁰ Therefore, the evidence has shown that patients in state X are able to maintain homeostasis and resist entropy—that is, to function as an integrated whole—for a considerable period of time, and hence are biologically living (irrespective of any questions about personhood or moral status).

Changing definitions

As is apparent, Gert and colleagues’ early views equating state X with death are empirically inadequate. The evidence has shown that both the tests and neurologic criterion generate false positives in which patients are declared dead despite the fact that they do not meet Gert and colleagues’ definition or criterion for death. In subsequent publications, they revised their view on the definition of “death,” but not on the criterion or tests. Here are the evolving definitions of “death” (I’ve italicized the changes from each predecessor definition):

- (1) We believe that the permanent cessation of the functioning of the organism as a whole is what has traditionally been meant by death.²¹
- (2) We believe that the permanent cessation of *all clinically observable* functioning of the organism as a

whole and the permanent absence of consciousness in the organism as a whole and in any part of that organism, is what has traditionally been meant by death.²²

- (3) We believe that the permanent cessation of all *observable natural* functioning of the organism as a whole, the permanent absence of consciousness in the organism as a whole, and in any part of that organism is what has traditionally been meant by death.²³

The proposed modifications are unsuccessful because they do not achieve empirical adequacy, and there are a number of philosophical reasons for their insufficiency as well, which I will detail presently. Ultimately, their original framework and definition of “death” remain conceptually adequate and ought to be retained; the evidence simply shows that patients in state X are biologically alive.

The first shift appends the phrase “clinically observable” to “functioning of the organism as a whole.” This is a common move, though it is problematic for several reasons. First, in all three definitions, Gert and colleagues endorse the very next line from their first book, *Philosophy in Medicine*:

This definition retains death as a biological occurrence which is not unique to human beings; the same definition applies to other higher animals. We believe that death is a biological phenomenon and should apply equally to related species. . . . This is supported by our ordinary use of the term *death*, and by law and tradition.²⁴

Thus, they recognize that death itself is a biological phenomenon, and is therefore amenable to explanation according to the conceptual and evidentiary frameworks of scientific biology. In light of this, it should be clear that clinical observability is irrelevant. It makes no difference to the biological reality of death whether a neurologist needs a penlight to look for pupillary reflexes, imaging technology to look for blood flow, or a blood test to look for neuroendocrine hormones. No biologist would say, for example, that DNA is irrelevant to understanding the heritability of genetic disease because DNA is not clinically observable. The move is *ad hoc*, and, worse, it conflates metaphysics (the nature of biological death) with epistemology (the epistemic means by which doctors know that biological death has or has not occurred). Biological death, as a biological phenomenon, is not relative to a neurologist’s penlight.

Additionally, it doesn’t save the hypothesis anyway, as almost all of the preserved functions are clinically observable. Hypothalamic osmoregulation is observable through normal urine output; gas exchange and cellular respiration are observable via skin color, as the patient would be cyanotic without these functions; circulation is observable by feeling for a pulse; thermal regulation can be observed by touching the patient’s skin; growth and sexual maturation are observable over a period of years, and so forth.

Clearly, the move to clinical observability is unsuccessful in saving the hypothesis, since a number of preserved functions are clinically observable. The next move from definition (2) to (3) changes the phrase “all clinically observable” to “all observable natural” functioning, but this sets up a dilemma. By “observable,” they must mean either “observable relative to some parameter” (e.g., current technology or current clinical practice, i.e., clinically observable), or not, in which case it can only mean “observable in principle.” The first horn conflates metaphysics with epistemology, as argued above, and is unacceptable. As I mentioned, the nature of biological death is not relative to a neurologist’s penlight, nor any other

epistemic means of accessing it. On the second horn, however, “in principle” observability asymptotes into all biological functioning, since in principle, technology can continue to improve until all possible biological functioning is observable. In this case, observability does no work and the definitional phrase collapses into “all functions of the organism as a whole.”

The “natural” criterion seems similarly unnecessary. As Tomlinson (1984) has argued, it is not the substrate that performs the function that matters, rather, it is the function itself. Gert and colleagues introduced this criterion so that if nanochips can be implanted into the brainstem of a patient in state X and regulate autonomic and other brainstem functions, they would still be declared dead. But I can’t see why it would matter whether a medical device enables the organism to function as a whole, so long as the organism continues to maintain homeostasis and resist entropy. Pacemakers, dialysis machines, insulin, and many other medical devices enable organisms to function as an integrated whole, and without them, the individuals who need them would be dead, but this does not imply that they are already dead. I don’t see what difference it would make for the medical device to be implanted in the brainstem rather than the heart or somewhere else.

Finally, the consciousness requirement was added in definition (2) and retained in definition (3) in order to account for the gruesome practice of cutting off animals’ heads and then showing that they still respond to stimuli; thus, the creature appears to still be conscious for a brief time after its beheading. In order to consider the conscious head to be alive, they added the requirement that consciousness may not be present in the organism as a whole nor in any part of the organism, though this seems an unnecessary move as well.

It seems equally plausible to state that the conscious head is a mutilated whole organism that continues to function as an integrated whole (and is thus covered under the original definition), than to say that it is a part of an organism. If the headless body were also maintained, it too would be a living yet mutilated organism, functioning as a whole. As to concerns about division of organisms, I don’t see any reason why one living organism cannot split into two distinct living organisms. If the head is still conscious, the person that once existed still exists and is instantiated by the head (which is now a distinct living organism), and the biologically living body is alive but no longer instantiates a person. In this circumstance, Gert and colleagues’ original definition of “death” continues to be satisfactory and explanatory for these cases, and mention of consciousness is not conceptually necessary.

So where does this leave us? Gert and colleagues’ basic framework and set of assumptions are useful and important. I don’t have space to defend them from objections here, but I do endorse the basic framework.²⁵ Their original definition of “death,” with death understood as a biological phenomenon, is entirely adequate and there was no reason to change it. It can be made slightly more precise by way of the concepts of homeostasis and entropy, and indeed this remains the best theory of biological death on offer, which draws on one of the most important and ubiquitous biological concepts, that of homeostasis. The various revisions that Gert and colleagues made throughout the years were not based on new theoretical or empirical advances regarding death itself; rather, they were unsuccessful attempts to save the brain death hypothesis from empirical refutation.

Indeed, it is interesting that, in contrast with what is known as “evidence-based medicine,” the empirical evidence did not change clinical practices; rather, clinical practices changed what counts as evidence. Once it was discovered that the clinical diagnostic tests are not sensitive to neuroendocrine

function, neuroendocrine function ceased to matter, despite the fact that it was previously held up as a paradigm of functioning of the organism as a whole.²⁶

In any case, the evidence simply shows us something that may not be welcome because of its potential ethical and public policy implications: individuals in state X are biologically alive. Gert and colleagues' claim that patients in state X are biologically dead is not scientifically justified. This is to say nothing of personhood or moral status, which are different issues. But given the evidence on the biological status of patients in state X, an additional moral concern now arises, if we continue to identify state X with death as a matter of public policy.

Paternalism and the language of "death"

In basic outline, the concern is this.²⁷ Using the word "death" to describe biologically living patients in state X is misleading to the general public, and this is so even if state X patients are not persons, not moral agents, not moral patients, or not considered members of the moral community. Patients in state X are biologically alive though irreversibly comatose; therefore, using the word "dead" to describe them is misleading. But does this constitute paternalism?

Consider any arbitrarily chosen adult, whom I shall name Smith. I'll argue that the misleading language of "death" interferes with Smith's autonomy, disregards Smith's preferences or values, and achieves a benefit for Smith in so doing; therefore, we ought to construe the language of "death" as paternalism.²⁸

Smith's autonomy, her ability to direct her life according to her reasons and her values, is limited because she lacks basic information about state X, believing it to be the death with which she is familiar. If she uses that misinformation to make health care decisions (e.g., by signing a donor card) then her ability to direct her life based on informed reason is diminished, since she may not have wished to be biologically killed in order to donate her organs. Furthermore, Smith's ability to participate in the political process is diminished, since her support (or lack of opposition) to the practices of transplant medicine, which involve biologically killing organ donors, is based on her mistaken belief that state X is death in the sense with which she is familiar.

Second, the misleading language reflects a disregard or indifference for her preferences and values. Assuming a clear understanding of state X, Smith might agree with Veatch that the individual in state X is not owed moral regard in the same sense that she was prior to her injury or illness.²⁹ She might agree with Miller and Truog that organ retrieval from those in state X is licit because those in state X are beyond harm.³⁰ But Smith might agree with Byrne and the many other authors who recognize that state X is not biological death, but who also support the dead donor rule and thus oppose organ retrieval from state X patients.³¹ Smith might have religious commitments that imply that biologically living humans have souls, or inherent dignity demanding they not be killed, irrespective of their capacity for psychological states or self-ventilation. Whatever her values, the use of misleading language that prevents Smith from informed deliberation and informed political participation shows an indifference to those values.

Finally, the misleading language is to Smith's own benefit, since it is a benefit to Smith to have the legal and political possibility of a transplant should she or a loved one ever need one (in the same way that wearing a seatbelt is to my benefit even if I never get into an accident), and quite plausibly, *the language of "death" is what makes transplant medicine politically and legally possible.* Without describing organ donors

as "dead," it is entirely plausible that removing organs from patients in state X would be not be politically or legally possible. Removing vital organs from a patient in state X is the direct and immediate cause of the biological death of that patient; hence, organ removal kills the donor. Since directly and intentionally killing a living human is nowhere legal in the United States (except for the death penalty) and is only practiced in a handful of nations, it only stands to reason that similar policies would be enacted with respect to organ removal, and in that case, the institution of transplant medicine would be severely curtailed, as the majority of transplanted organs come from patients in state X.³² It is important to note that this argument holds even if patients in state X are not persons or not considered to be members of the moral community, since it is the language of "death," not the language of "personhood," "moral agency," or "moral community," which makes transplant medicine politically and legally possible, while simultaneously misleading the general public (Smith included).

Similar arguments can be made that this satisfies Gert's views on paternalism as well:³³ (1) The medical and bioethics community calling patients in state X "dead" makes transplant medicine possible and thus benefits Smith; (2) the medical and bioethics community recognizes that using false or misleading language in general requires moral justification; (3) there is no reason to believe that the general public (including Smith) will or would consent to being misled; and (4) all agree that the general public believes it can make its own decisions on the matter.

As Gert and colleagues correctly argued, not all paternalism is unjustified; however, all paternalism requires justification. The first step of their justificatory procedure is to identify the morally relevant features. They list ten questions to be addressed in doing so, but for the sake of brevity I will only address two: What moral rules would be violated? What benefits would be created?³⁴ The moral rules to be violated include "do not deprive of freedom" (since the public lacks the freedom to meaningfully participate in the political process regarding whether to allow causing biological death for organ removal), "do not deceive" (since the language of "death" is misleading), and "do not kill" (since organ removal kills the donor). The benefit is that transplant medicine will continue, and hence people with organ failure who receive a successful transplant will live when they would otherwise die.

The second step is to ask:

Would the foreseeable consequences of that kind of violation being publicly allowed, that is, of everyone knowing that they are allowed to violate the moral rule in these circumstances, be better or worse than the foreseeable consequences of that kind of violation not being publicly allowed?³⁵

It seems to me that the breakdown of trust in the medical profession would be quite severe upon learning that medical professionals are allowed to kill unconscious patients for the purpose of organ removal, while misleading the general public and surrogate decision-makers by using the language of "death." And this holds regardless of whether such bodies are no longer persons, no longer moral agents, or no longer considered to be members of the moral community, since this is not the language used to describe patients in state X: The medical profession describes such bodies as "dead." This breakdown of trust in the medical profession would presumably have significant consequences, since public trust is a necessary condition for the practice and institution of medicine. Furthermore, there is a logical problem that shows that this paternalism *could* not be justified (assuming Gert's theory of the justification of

paternalism), since the consequences of the public knowing that the public is misled would necessarily result in the public no longer being misled and the moral rules prohibiting deprivation of freedom and deception would no longer be violated, thus removing the paternalism. Thus, it seems to me that the paternalism is not justified.

Conclusion

Gert and colleagues' body of work on death represents some of the most clear-thinking, straightforward, and insightful contributions to this literature, in characteristic Gert fashion. He and his colleagues were not able to establish a scientific justification for equating brain death with death. Further, continuing to use the language of "death" to describe patients in state X, as a matter of public policy, appears to constitute unjustified paternalism. However, their work forms a crucial foundation upon which others will continue to build in furthering our understanding of death, both as a biological phenomenon and as an event with tremendously important social, moral, and legal implications, requiring sensible, forthright, and scientifically informed public policy.

Notes

1. Bernat, Culver, and Gert, "Definition and Criterion of Death."
2. Although Bernat, Culver, and Gert, "On the Definition and Criterion of Death" (1981) is widely cited in association with the aforementioned framework, the ideas go back somewhat earlier, at least to Capron and Kass, "A Statutory Definition of the Standards for Determining Human Death" (1972). Capron and Kass introduce a four-part framework, including the *basic concept* of death, the *general physiological standards* for recognizing the instantiation of the concept of death, *operational criteria* for those general physiological standards, and finally *specific tests and procedures* to determine if the operational criteria have been realized. For example, one way of cashing out this framework might be to claim that the concept of death involves the irreversible cessation of the integrated functioning of the organism as a whole; the physiologic standard for this to occur is the irreversible cessation of all circulo-respiratory function; the operational criteria for this standard is the absence of blood flow and the absence of gas exchange at the alveoli and in cellular metabolism; and the tests for determining whether this has occurred involve feeling for a pulse, looking for blood flow in the retinal vessels, watching for the chest to rise, and feeling for the expiration of air from the mouth.
3. Bernat, Culver, and Gert, "Definition and Criterion of Death"; Culver and Gert, *Philosophy in Medicine*.
4. Bernat, Culver, and Gert, "Definition and Criterion of Death," 391.
5. Beecher, "Definition of Irreversible Coma"; Wijdicks et al., "Evidence-based Guideline Update."
6. Halevy and Brody, "Brain Death."
7. Shewmon, "Chronic 'Brain-death'"; Shewmon, "Brain and Somatic Integration."
8. Shewmon, "Brain and Somatic Integration"; Powner and Bernstein, "Extended Somatic Support."
9. Joffe, "Recent Defences."
10. Electrical activity measured with an electroencephalogram reflects the coordinated activities of thousands of cortical neurons, not just a "nest" of cells, which suggests some preserved function. Maintenance of evoked potentials is stronger evidence of preserved function, since surely one of the functions of the peripheral and central nervous systems is to transduce ambient energy into electrochemical signals and pass that sensory information along a dedicated sensory information channel; and this is what an evoked potential reflects. Growth, sexual maturation, and fetus gestation all require hormonal stimuli, and thus the secretion of hypothalamic releasing hormones which control anterior

pituitary hormones, providing the necessary hormonal signals in the general circulation. Hypothalamic osmoregulation is a paradigmatic example of both a brain function as well as a "function of the organism as a whole," as described further in the text, in the following section.

11. Positive predictive value is a standard measure of the utility of a diagnostic or screening test. Its value tells us, given a positive test result, how likely the individual who tested positive actually has the disease in question (that is, it is a ratio of true positives to the sum of false and true positives). Since half of patients in state X maintain hypothalamic osmoregulation (a brain function by all accounts) yet are declared to be brain dead (i.e., declared to lack all brain function), it follows that the ratio of true positives (those patients with lack of *all* brain function) to the sum of true and false positives (those patients with the lack of all brain function plus those patients with maintained hypothalamic function who are falsely labeled as lacking all brain function) is equal to 50 percent.
12. Bernat, Culver, and Gert, "Definition and Criterion of Death," 390.
13. *Ibid.*, 392.
14. Korein, "Problem of Brain Death"; cf. Korein and Machado, "Brain Death"; Bernat, Culver, and Gert, "Definition and Criterion of Death," 391.
15. Shewmon, "Brain and Somatic Integration"; Pennefather, Dark, and Bullock, "Haemodynamic Responses to Surgery"; Hill, Munglani, and Sapsford, "Haemodynamic Responses to Surgery"; Fitzgerald et al., "Endocrine Stress Reaction"; Powner and Bernstein, "Extended Somatic Support."
16. Yoshioka et al., "Prolonged Hemodynamic Maintenance"; Sugimoto et al., "Morphological and Functional Alterations"; Shewmon, "Chronic 'Brain-death'."
17. President's Council on Bioethics, "Controversies in the Determination of Death," 39; emphasis in the original.
18. Bernat, Culver, and Gert, "Definition and Criterion of Death," 391.
19. Shewmon, "Spinal Shock and 'Brain Death'."
20. Shewmon, "Constructing the Death Elephant," 259.
21. Culver and Gert, *Philosophy in Medicine*, 182.
22. Gert, Culver, and Clouser, *Bioethics: A Return to Fundamentals*, 261.
23. Gert, Culver, and Clouser, *Bioethics: A Systematic Approach*, 293.
24. Culver and Gert, *Philosophy in Medicine*, 182.
25. Nair-Collins, "Death, Brain Death, and the Limits of Science."
26. Parenthetically, it is worth noting that the laws which give statutory authority to declare an individual dead by neurological criteria are based on the Uniform Determination of Death Act, which states that an individual is dead when *all* functions of the *entire* brain have ceased. Physicians currently lack the statutory authority to declare an individual with a functioning hypothalamus to be dead since some brain function remains.
27. I only outline the arguments here; please see the paper from which this section is drawn (Nair-Collins, "Brain Death, Paternalism, and the Language of 'Death'") for a fuller presentation.
28. I am drawing from Dworkin's treatment of paternalism; see Dworkin, "Paternalism," 1999; and Dworkin, "Paternalism," 2010). I'll briefly argue that Gert's definition of paternalism is satisfied as well.
29. Veatch, "Dead Donor Rule"; Veatch, "Abandon the Dead Donor Rule."
30. Miller and Truog, *Death, Dying, and Organ Transplantation*.
31. Byrne et al., "Brain Death"; Byrne and Weaver, "'Brain Death' Is Not Death."
32. Organ removal in so-called "donation after cardiac death" introduces its own set of problems that I won't address here, but similar problems with forthright communication

and doubts about whether such bodies are truly biologically dead arise in that context as well.

33. Cf. Gert, Culver, and Clouser, *Bioethics: A Systematic Approach*, ch. 10.
34. *Ibid.*, 264–65.
35. *Ibid.*, 267.

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On Bernard Gert's View of the Nature of Paternalism

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Professor Gert's work on the topic of paternalism, work done largely in coordination with Charles M. Culver and K. Danner Clouser, is important for at least two reasons. First, Gert and his coauthors provide a clear list of the conditions necessary for an act to count as paternalistic. Our ordinary use of the term "paternalism" is rather amorphous, and Gert's discussion of paternalism pushes us towards a clearer understanding of both the nature and the extension of that term. Second, Gert defends a moral framework that can help in determining whether or not a given act of paternalism is justified. And this framework is one that, unlike certain consequentialist approaches, will allow that even well-conceived acts of paternalism (those, say, that really do promote the subject's long term well-being without causing harm to others) are often impermissible and *always* stand in need of justification. But this framework also allows, unlike some strict applications of Kantianism, that acts of paternalism may indeed be justified in many cases. Thus, the account better accommodates our common intuitions with regard to the moral permissibility of paternalism, and, as such, I suspect it better squares with our widely held preferences regarding the limits of paternalism in the practice of medicine.

In this paper, I will review and clarify Professor Gert's account of the nature and justification of paternalism. I will argue that the definition of "paternalism" that he defends is, in important ways, too narrow. Thus, I will argue that his account of the justification of paternalism may, in fact, be usefully applied to a broader range of acts than he himself suggests.

1. Defining paternalism

In *Bioethics: A Systematic Approach*, Gert, Culver and Clouser provide the following as a definition of paternalism:

A is acting paternalistically towards S if and only if:

- (1) A believes that his action benefits S;
- (2) A recognizes (or should recognize) that his action toward S is a kind of action that needs moral justification;
- (3) A does not believe that his action has S's past, present, or immediately forthcoming consent; and
- (4) A regards S as believing that he (S) can make his own decision on this matter.¹

Conditions (1) and (3) seem clearly necessary for an act to count as paternalistic. Paternalism, at the very least, involves promoting someone's good without her consent. As written, condition (1) may make the definition too broad in that one could believe that his act benefits S without caring whether it benefits S. If I steal drugs from a drug addict in an effort to protect him from his addiction, that is an act of paternalism. But if I steal those drugs so that I may enjoy them myself, it is not. And this is so regardless of whether I happen to believe that my action will ultimately benefit the victim of my theft (that is, that he is better off without the drugs). In context, however, it is clear that Gert and his co-authors mean to imply by condition (1) not just that A believes the act will benefit S but also that A intends by the act to benefit S. As they put it, "A's belief that S will benefit from her action must provide a sufficient motive for A's acting in this way."² Conditions (2) and (4), on the other hand, are less obvious, and it will be useful to take a closer look at each.

2. The justification requirement

Condition (2) in the above definition requires that for an act to count as an instance of paternalism it must be a "kind of action that needs moral justification." One initial question that we might ask about this condition is whether we should understand the concept of paternalism as, by definition, a normative concept. While everyone agrees that paternalistic acts regularly raise moral questions, it is less clear that this feature should be built into the very definition of the term; it is at least not obvious that paternalism is a thick moral concept. For instance, one might attempt to define paternalism simply as action that is intended to benefit another without that subject's consent (or perhaps even against her will). Roughly, this would be to exclude condition (2), the justification requirement, from the above definition. Nonetheless, I think Gert and Culver are quite right to include something like the justification requirement insofar as it allows them to better capture the ordinary use of the term paternalism. Our ordinary use of that term implies something beyond simply intending to promote someone's good against her wishes; it implies that one is doing so in a way that is, at least *prima facie*, wrong or *wrong-making*. Imagine I buy my dad a birthday present despite his clearly telling me that I shouldn't. This act could aptly be described as intended to benefit another without his consent, or even against his wishes, but it could hardly be described as paternalistic since it lacks the right sort of moral dimension; it is not the *kind* of going against one's wishes that, to use the language of condition (2), "needs moral justification."

And so I think Gert and his coauthors are right to include something like condition (2) in their definition. That said, I also believe that their interpretation of that condition is unnecessarily narrow. They use this part of their definition of paternalism to exclude acts that, it seems to me, *are* instances of paternalism and that do, in fact, require justification. They write:

It is important to distinguish between performing the kind of action that needs moral justification (i.e.,

violating a moral rule), and failing to act in a way that is morally encouraged, but whose omission does not require justification (i.e., not following a moral ideal). . . . It is not paternalistic behavior for a person to refuse to give money to a beggar because he believes the beggar will only buy whiskey with it, which will be harmful to him. Such behavior may reveal a paternalistic attitude, for example, a willingness to act paternalistically toward the beggar if the situation arose, but it is not itself a paternalistic act.³

Here, Gert equates an act's needing moral justification with that act's violating a moral rule, and he provides one example of an act—refusing the wishes of a beggar—that does not qualify as violating a moral rule (presuming one had no obligation to give the beggar what he wants) and so does not need moral justification.

Gert also considers the following examples drawn from work by Gerald Dworkin:⁴

- (1) Realizing that you are getting upset about the fact that I regularly defeat you at tennis, I refuse to play with you, and I do so for your own good and against your wishes.
- (2) Knowing that his wife is suicidal, a husband hides his own sleeping pills from her in order to prevent her from using his pills to harm herself.

As is the case in the beggar example, these examples both involve (insofar as they involve paternalism at all) what is sometimes called passive paternalism. That is, they do not involve an active intervention against the person's wishes, but rather they involve the refusal to carry out a person's choices or to adhere to a person's wishes. It is important that in the second case—the case involving the sleeping pills—the pills are the husband's pills. So he is not taking from his wife what is rightfully hers, but rather he is acting well within his right to put his own pills wherever he would like (even if his wife would like them to be available to her). Thus, Dworkin offers these as examples of paternalism that do not involve the violation of a moral rule, though they do, according to Dworkin, involve (in some sense) a violation of autonomy, and so they do, on Dworkin's view, require justification. Gert and his coauthors respond to these examples by denying that they are, in fact, examples of paternalism. They write, referring to Case (2) in particular:

Regardless of whether a person who hides his own pills to prevent his wife from using them to commit suicide is violating her autonomy or not, it is clear that his action does not violate a moral rule with regard to her. Would Dworkin claim that the husband who hides his own pills from his wife because he wants to use them all himself needs to justify his action? Unless he would, Dworkin does not regard the husband hiding his own pills as needing justification. We do not regard such an action as needing justification, and hence we do not regard it as paternalistic.⁵

They go on to note that, as in the beggar case, this example may involve evidence of a paternalistic attitude but not a paternalistic action.

Dworkin claims that these examples involve acts of paternalism because they involve "an attempt to substitute one person's judgment for another's" in order to "promote the latter's benefit."⁶ In reference to Case (1)—the tennis example—Gert replies that "Dworkin may rightly characterize his example . . . as an attempt to substitute one person's judgment for another's, but it does not violate a moral rule and so does not need moral justification."⁷ But this reply seems problematic

insofar as Dworkin's very point is that this case is paternalistic *even though it does not involve a rule violation*. That is, the case is meant, at least in part, as a challenge to Gert's interpretation of the justification condition. Thus, it simply begs the question against Dworkin to say that it cannot be paternalistic because it does not satisfy that condition. More generally, it seems that we should define a common term like paternalism with an eye towards capturing the ordinary extension of the term and that we should not, instead, define away cases to which we might ordinarily apply the term. But then we must ask whether Dworkin's examples are, indeed, examples of acts we would ordinarily describe as paternalistic, and I believe the answer is that they are.

In replying to the example of the husband who hides his pills from his wife in order to prevent her from harming herself, Gert, if you recall, claims that unless Dworkin "claims that the husband who hides his pills because he wants to use them all *himself* needs to justify his actions. . . Dworkin does not regard the husband hiding his own pills as needing justification."⁸ But this seems to elide two acts that are, morally speaking, rather different: (1) hiding his pills with the specific intention of thwarting his wife's suicidal aims (of denying her an option she might like to avail herself of), and (2) hiding his pills in order to preserve his supply. While in the latter case, the husband may still limit his wife's options, denying her an option is not the very point of the act, as it is in the former case. To borrow Dworkin's language, he intends in the former case to "substitute his judgment" for hers. I must say it is not entirely clear to me that hiding his pills from his wife to preserve his own supply is an act that does not need *any* moral justification. But regardless, it seems clear that hiding his pills where the point is to protect her from herself by substituting his judgment for hers *does* require moral justification, and is, in any case, paternalistic. The good at stake in this case may indeed easily justify the action, but that does not mean that the action is not of a sort that requires moral justification.

Gert claims that "only when one's refusal to acquiesce to a person's wishes involves violating a moral rule does that action count as paternalistic. Normally this refusal involves intervening, but when one has a duty to carry out those wishes, it can also involve not carrying out a person's wishes." And so Gert suggests that passive paternalism is restricted to those cases in which the agent has some obligation to carry out the subject's wishes, as a nurse may well have an obligation to respond to reasonable requests for pain medication. But as the cases above show, this defines the concept of paternalism in a way that is significantly too narrow. The examples above are cases of passive paternalism—they involve the refusal to provide something the subject wants (pills, or a tennis partner, or money in the case of the beggar)—where the agent does not seem to be under any duty to adhere to the subject's relevant wish.⁹ Whether the refusal is paternalistic will depend, in part, on *why* the wish is refused. Even if I have no general obligation to play tennis with you, it is paternalistic for me to refuse to play *specifically in order to* protect you from your own decision-making. Perhaps this is because there is a *prima facie* moral rule against attempting to substitute one's judgment for another's in ways that are intended to limit that person's options.¹⁰ Perhaps this should count as a sort of deprivation of freedom.

In that case, we could address the question of whether a given instance of this sort of paternalism is justified by means of the moral framework Gert provides. Whether an instance of paternalism is justified is settled, according to Gert, by the question of whether the harms *avoided or prevented* by publicly allowing the relevant kind of violation outweigh the harms *caused* by its being publicly allowed. That is, "would the

foreseeable consequences of . . . everyone knowing that they are allowed to violate the moral rule in these circumstances, be better or worse than the foreseeable consequences of that kind of violation not being publicly allowed?"¹¹ Insofar as this is the right way to think about the justification of paternalism in general, there is no reason it could not apply to the sorts of cases described in the examples above. And so it seems a mistake to limit the concept of paternalism, and especially passive paternalism, in the way that Gert does.

3. The competence requirement

The other condition in Gert's definition of paternalism that deserves a closer look is condition (4). This is the claim that for an act to count as an act of paternalism, it must be the case that "[the actor] A regards [the subject] S as believing that he (S) can make his own decision on this matter." Gert and his coauthors argue that this condition "is presupposed in many accounts of paternalism, but rarely is it made explicit."¹² They suggest that this condition is necessary since the third condition—that the agent is not acting with the subject's consent—could be satisfied in cases in which the subject is simply not capable of making her own decisions. "One cannot," they write, "act paternalistically toward infants because infants do not believe that they can make their own decision on any matters; indeed they do not believe anything about themselves."¹³ It does seem right that one cannot act paternalistically toward an infant since an infant is not the sort of thing that is capable, in any real sense, of forming her own judgments or of making choices on the basis of her beliefs. I wonder, though, whether it is right to capture this limitation on what counts as paternalism by means of a requirement that the subject believe that she can make her own decisions on the matter. This way of putting the requirement may overstate the limitation.

I should be clear that Gert is not denying that it is possible to act paternalistically towards someone that we consider incompetent to make her own decisions. What is required is that we think that *she* believes that she can make her own decision (we need not agree with her in that assessment). Moreover, it seems clear that we can act paternalistically towards agents who do not, in the moment, believe that they can make their own decisions, perhaps because they are presently unconscious. One could act paternalistically, for instance, by performing CPR on a patient that is known to have a DNR on file. But in that case, what matters is our belief that she believed she was capable of making the relevant decision at the time she expressed that desire. Nonetheless, it still seems there could be cases of paternalism in which the agent does not believe that the subject believes she can make her own decisions on the matter.

Consider, for example, the case of a toddler: old enough to express a quite willful aversion to certain interventions, but not old enough to have the conceptual framework in place to have formed beliefs about his own decision-making capacities. Given that this child cannot, obviously, make rational decisions about his own good, someone (a parent, especially) will very regularly be justified in acting paternalistically on the child's behalf. But surely there are interventions that one might choose in the service of that child's good that would be permissible if one could gain the child's assent but that are impermissible otherwise (a surgery that we think likely to have benefits that minimally outweigh the harms and risks). That is, once a child is willful, one cannot simply do what is best for her irrespective of that will. The good involved must be sufficient to override the will and to restrict the child's liberty. Again, given the exceptionally poor choices children of that age are prone to make, one will often be justified in overriding their will in order to promote their good (not to mention other goods,

though in that case, the act is not paternalistic). But regularly justified paternalism is still paternalism, and it still stands in need of moral justification. Moreover, just as in the cases of passive paternalism discussed above, these sorts of cases seem perfectly adaptable to the moral framework Gert recommends for determining the justification of paternalism.

4. Conclusion

In this paper, I have identified two sorts of acts that do seem to be instances of paternalism and yet do not seem to fall within Gert's definition of paternalism. The first are acts of passive paternalism, of refusing to satisfy a subject's request, in cases where there is no distinct duty on the part of the agent to do as requested. The second are acts that involve overriding the will of a subject that is not (or is not yet) capable of having beliefs about his own decision-making capacity. In both cases, the acts in question fit with our ordinary use of the term paternalism. They also are acts that stand in need of moral justification, and the framework that Gert suggests for deciding whether a given act of paternalism is justified may well be usefully applied in these cases.

Notes

1. Gert, Culver, and Clouser, *Bioethics*, 238. A similar definition is offered in Gert and Culver, "The Justification of Paternalism," *Ethics* 89, no. 2 (1979): 199–210. In this earlier version, condition (2), the condition that the act be one that needs moral justification, was accounted for by the condition that the act involves violating a moral rule. But this change is not as significant as it may appear since, as we will see, Gert, Culver, and Clouser (2006) argue that the act's involving the violation of a rule is implied by its standing in need of moral justification. Another difference is that in the earlier version the definition involved the condition that A believes that S believes that S generally knows what is for his own good. This is similar to condition (4), though it is not the same; one can certainly believe that she generally knows what is for her own good without believing that she can make her own decision in this case, and vice versa. I will argue that either formulation is too narrow.
2. *Ibid.*, 239. We might ask whether an act could be paternalistic if the benefit to S provided a necessary component of the motivation even if it is not itself sufficient. Imagine that a state passes a motorcycle helmet law partly to protect motorcyclists and partly to reduce the costs of liability insurance. And imagine that this law would not have passed absent the desire on the part of the legislature to protect motorcyclists even though that consideration would, absent the insurance factor, also have been insufficient to motivate passage. It is at least not clear that we should deny that this law is paternalistic. Perhaps then it would be better to say that the belief that S will benefit must be either a necessary part of the motivation or provide, itself, a sufficient motivation (even if not a necessary one, since the act may be motivationally over-determined).
3. *Ibid.*, 241.
4. Both examples are taken from Dworkin, "Paternalism: Some Second Thoughts," 106.
5. Gert, Culver, and Clouser, *Bioethics*, 245.
6. Dworkin, "Paternalism," 107.
7. Gert, Culver, and Clouser, *Bioethics*, 243.
8. *Ibid.*, 245.
9. I am here simply granting Gert's claim that there is no duty to provide money for the beggar in such a case, though that could, of course, be disputed.
10. So buying a gift for my dad (despite his protestations) would not count as a violation of this rule since it is not intended to constrain his options.
11. Gert, Culver, and Clouser, *Bioethics*, 267.
12. *Ibid.*, 248.
13. *Ibid.*

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Revisiting the Definition and Criterion of Death

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I. Background

I am grateful to Professors Deni Elliott and Stuart Yoak for inviting me to present this paper at the Bernard Gert Memorial Symposium at the annual meeting of the Association for Practical and Professional Ethics. I agree with the conference organizers that my long scholarly collaboration with Bernie Gert exemplified a successful model of cross-disciplinary work.

Bernie and I began our collaboration in 1977 when I approached him to help me understand the philosophical justification for why patients whom I declared "brain dead" were actually dead. The following year our Dartmouth psychiatry colleague Chuck Culver joined our discussions. The analysis we developed became the subject of our first two papers in 1981 and 1982.¹ Since then, our positions have evolved as we refined our definitions of death, and more recently they have diverged modestly.²

The refinements in our formulation were stimulated by attacks from critics. Scholars criticized our definition of death,³ the imprecise correspondence between our definition and criterion of death,⁴ the perceived inadequacies of our advocated whole-brain criterion of death,⁵ and the impossibility of stating a uniform definition of death.⁶ Most critics accepted the sequential format of our analysis: assumptions → definition → criterion → tests. Alan Shewmon launched the most penetrating criticism by showing the limitations of the bodily integration rationale that we used to justify our criterion of death.⁷ The power of his criticism appeared to be the principal reason that the President's Council on Bioethics restudied the conceptual basis of "brain death" in 2008.⁸

Shewmon demonstrated the inadequacy of the integration-coordination rationale as the sole justification of a brain-based criterion of death by showing that certain control systems are integrated by the spinal cord and other structures outside the brain. In their report *Controversies in the Determination of Death*, the President's Council on Bioethics accepted Shewmon's critique and responded to it by offering an alternative rationale for the whole-brain criterion of death. The council argued that irreversible cessation of brain functions counted as death because it caused "the inability of the organism to conduct its self-preserving work."⁹ Shortly thereafter, Shewmon criticized this account by arguing that the President's Council's new rationale contained the same flaw as the one it replaced.¹⁰

In our articles in the early 1980s, we relied on the integration rationale for the criterion of death because then it was impossible for patients properly declared brain dead to have their circulation supported for more than a few days or weeks. The loss of brain stem and hypothalamic functions produced profound hypotension, diabetes insipidus, hypothermia, and inevitable asystole. As is well known, improvements in critical care technology since then now permit each of these problems to be treated, thereby allowing some young and previously

healthy brain-dead patients to have their circulation supported successfully for weeks or months, and in one apparent case for years.¹¹ Many of the functions of integration and control that are ordinarily controlled by the brain now can be performed by critical care physicians using advanced technology.

Although the force of the bodily integration justification for the criterion of death has been diminished by technologic advances, the underlying definition remains intact, and there are additional rationales for the whole-brain criterion. Even Shewmon, who disagrees with the whole-brain criterion of death, concurs with our definition of death as the irreversible cessation of the critical functions of the organism as a whole.¹² Yet, the concept of the organism as a whole remains vague and in need of clarification, particularly in the delineation of criteria for its absence. In this paper, I clarify the biological concept of the organism as a whole that Gert, Culver, and I cited in our advocated definition of death by discussing the importance of the concept of emergent functions, and by briefly discussing the findings of an important contribution from a little known Viennese biophilosophical analysis.

II. The organism as a whole

The concept of the organism as a whole was first proposed by the German-American biologist Jacques Loeb in a classic monograph in 1916.¹³ The essence of the concept of the “organism as a whole” is its distinction between the life of the organism itself from the life of its component parts or subsystems. A definition of death must address the level of the life-state of the organism, not merely of its component parts. I show that in “brain death,” once the organism as a whole has permanently ceased functioning, the human organism is dead despite the continued survival of many of its component parts through technological support. To further explore this concept, it is necessary first to clarify a few fundamental facts about the biological nature of living organisms.

An organism is comprised of hierarchically arrayed interdependent units and subsystems that have evolved over many millions of years. Although each unit and subsystem is living, none alone constitutes an organism. Living cells comprise living tissues, which in turn comprise living organs, which in turn comprise living organ systems. The organism’s cells, tissues, organs, and organ systems are arrayed in functional groups and clusters of groups (ensembles) displaying hierarchies of functions. The complex interrelationships of the many hierarchies of ensembles create an integrated, coordinated, unified whole. That whole is the organism itself, the highest and most complex life form whose life is a result of the functioning of all its living component subsystems.

Each ensemble creates a unique phenomenon known as an emergent function. An emergent function is a function of a whole entity that is neither present in nor can be reduced to any of its component parts.¹⁴ A function is called “emergent” because, given the normal presence of the components within an ensemble, the new function emerges spontaneously. Thus, tissues have emergent functions beyond those of their component cells, and organs have emergent functions beyond those of their component tissues. Each emergent function is a more complex behavior than those of its component subunits. Given our current scientific understanding and mathematical modeling, emergent functions cannot be predicted or easily understood merely by studying the component subunits, their interrelationships, and their functions.¹⁵ The most exquisite example of an emergent function is that of human conscious awareness, a unique but ineffable phenomenon that emerges spontaneously from the integrated functioning of the ensemble of multiple distributed parallel hierarchical networks of brain neurons.¹⁶

Each of the organism’s components comprising the functional subunits is itself alive. But the life of the cellular, tissue, or organ components, while often necessary for the life of the organism, is not equivalent to the life of the organism. The life status of the organism is the proper focus in a definition of death. Because the life of its component parts is not equivalent to the life of an organism, an organism can die despite some of its component parts remaining alive, as a consequence of technological support. The key to understanding the definition of death is the separation of the life of an organism from that of its component parts.

The “organism as a whole,” then, thus refers not to the whole organism (the sum of its component parts), but rather to the emergent functions of the organism that are the consequence of but greater than the mere sum of its component parts. An organism may lose some of its parts, such as a leg or a kidney, and continue to function as a whole. Intrinsic to the concept of “organism as a whole” is that the interrelatedness of the component parts and ensembles produces emergent functions that create the coherent unity of the organism.

For many years, biologists have attempted the task of identifying the criteria of life. For example, the French biologist and Nobelist, Jacques Monod, summarized the characteristics that separate living from nonliving entities: (1) teleonomy, the correspondence between structure and function that suggests purpose; (2) autonomous morphogenesis or self-reproduction of form; and (3) reproductive invariance, the phenomenon in which the source of information expressed in the structure of a biological form results entirely and only from a structurally identical form.¹⁷ Other prominent biologists have created similar lists.¹⁸ All scholars acknowledge that it is easier to describe the functions of life than to define life, and that all lists of characteristics of life inevitably create ambiguities and exceptions (such as the classification of viruses and prions).

The specific criteria of life forms and higher organisms were analyzed by Raphael Bonelli and colleagues.¹⁹ They observed that all life forms have a delimited unity that is characterized by four criteria: (1) dynamics, or signs of life, such as metabolism, regeneration, growth, and propagation; (2) integration, the requirement that the life process derives from the mutual interaction of its component parts; (3) coordination, the requirement that the interaction of the component parts is maintained within a certain order; and (4) immanency, the requirement that the preceding characteristics originate from and are intrinsic to the life form. These are characteristics of all life forms, including the component parts of organisms.²⁰

Bonelli and colleagues then offered four criteria that make a life form an integrated, unified, and whole organism: (1) completion, the requirement that an organism is not a component part of another living entity but is itself an intrinsically independent and completed whole; (2) indivisibility, the condition of intrinsic unity such that no organism can be divided into more than one living organism; and, if such a division occurs and the organism survives, the completed organism must reside in one of the divided parts; (3) self-reference or auto-finality, the characteristic that the observable life processes and functions of the component parts serve the self-preservation of the whole, even at the expense of the survival of its parts, because the health and survival of the living whole is the primary end in itself; and (4) identity, the circumstance that, despite incremental changes in form and the loss or gain of certain component parts (that even could eventually result in the exchange of all component atoms), the living being remains one and the same throughout life. Bonelli and colleagues point out that “the essential difference between derivated life [living component units] and a living being is that

the living being is in itself a finally completed whole . . . [whose] life processes are of a self-preserving character.”²¹

Bonelli and colleagues argued that the death of an organism is the loss of these four characteristics that render an organism no longer capable of functioning as a whole. They pointed out that in higher animal species, with the irreversible cessation of all functions of the entire brain (“brain death”), the organism has permanently lost the capacity to function as a whole and therefore is dead. The organism has lost immanency because its life processes no longer spring from itself but result from external intensive care support. The organism has lost auto-finality because whatever control over the component organ subsystem parts that remains now is directed at the level of the surviving parts and no longer at the whole. The organism has lost self-reference because the continued functioning of its parts no longer supports the function of the whole. The organism has lost completeness and indivisibility because its separate component parts and subsystems no longer belong to each other and no longer constitute a whole.²²

The irreversible loss of the functions of the brain that are responsible for the organism as a whole indicates that the brain-dead patient is a mechanically supported, living component part of a dead body because the organism as a whole is gone forever. Bonelli and colleagues also address the limited role of the integration rationale by showing that the brain is not simply the organ responsible for the organism’s critical system that conducts most of its central integration and control, it also is the organism’s organ of final totality.²³

III. Refinements in the definition and criterion of death

In our contemporary technological era in which skilled physicians can maintain the life of component parts of organisms outside or inside the body, the separation of the continued life of the organism from that of its component parts has become ambiguous. The essence of the death of a higher animal species is the irreversible cessation of the functioning of the organism as a whole. Once an organism has irreversibly lost its totality, completion, indivisibility, self-reference, and identity, it no longer functions as a whole and is dead.

The irreversible cessation of whole-brain functions therefore serves as a criterion of death because it is a necessary and sufficient condition for the cessation of the organism as a whole. A “brain dead” patient whose visceral organ functions are maintained only as a consequence of physiological support of circulation and respiration has lost the functions of the organism as a whole and is a technologically supported, living component part of a dead organism.

The growing international acceptance of the medical practice of “brain death”²⁴ provides evidence that physicians and the public intuitively accept the idea that a person whose brain functions have ceased irreversibly is dead irrespective of mechanically supported circulation and respiration. Although surveys over the past few decades have shown that professionals and the public remain muddled over many of the technical issues of “brain death,” such as its definition and criterion, they seem to accept the concept of “brain death” as human death.²⁵ The enactment of more or less uniform laws stipulating the standards for “brain death” determination among diverse jurisdictions is further evidence for its acceptance by societies.

The goal of a definition of death is to make explicit the ordinary meaning of death implicit in our common, non-technical usage of the word that has been made ambiguous by advances in technology. Although, admittedly, the organism as a whole is a technical concept with vague boundaries (even with the Bonelli et al. criteria), I believe that the idea of its

irreversible cessation resonates with our intuitive concept of death in our contemporary technological era when critical care support has the capacity to maintain the life of component parts of human organisms. The whole-brain criterion of death thus satisfies the definition of death as the irreversible cessation of the critical functions of the organism as a whole irrespective of sole reliance on the integration rationale.

The account of death as it currently stands remains incomplete. Further analysis is necessary to determine more precise criteria of the organism as a whole and clarify which functions of the organism as a whole are critical for life—that is, those the loss of which is death—and the reasons for these determinations. While the integration of bodily subsystems remains a part of this concept, its contribution is only necessary and not sufficient.

Notes

1. James L. Bernat, Charles M. Culver, and Bernard Gert, “On the Definition and Criterion of Death,” *Annals of Internal Medicine* 94 (1981): 389–94; James L. Bernat, Charles M. Culver, and Bernard Gert, “Defining Death in Theory and Practice,” *Hastings Center Report* 12, no. 1 (1982): 5–9.
2. For a more detailed explication of my current account, see James L. Bernat, “The Biophilosophical Basis of Whole-brain Death,” *Social Philosophy and Public Policy* 12 (2002): 324–42. Gert’s final definition of death is “the permanent (irreversible) cessation of all observable natural functioning of the organism as a whole and the permanent (irreversible) absence of consciousness in the organism as a whole and in any part of that organism.” Bernard Gert, “Definition of Death,” *American Philosophical Association Newsletter on Philosophy and Medicine* 9, no.1 (2009): 6–9.
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9. *Ibid.*, 60–65.
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13. Jacques Loeb, *The Organism as a Whole* (New York, G. P. Putnam’s Sons, 1916).
14. Martin Mahner and Mario Bunge, *Foundations of Biophilosophy* (Berlin, Springer-Verlag, 1997), 29–30.

15. Philip Clayton and Stuart A. Kauffman, "On Emergence, Agency, and Organization," *Biology and Philosophy* 21 (2006): 501–21.
16. See Philip Clayton, *Mind and Emergence: From Quantum to Consciousness* (Oxford, Oxford University Press, 2004); Christof Koch, *The Quest for Consciousness: A Neurobiological Approach* (Englewood, CO: Roberts & Company Publishers, 2004), 10–11.
17. Jacques Monod, *Chance and Necessity: An Essay on the Natural Philosophy of Modern Biology* (New York, Alfred A. Knopf, 1971), 3–22.
18. See, for example, Lynn Margulis and Dorion Sagan, *What is Life?* (New York, Simon and Schuster, 1995); Francis Crick, *Life Itself: Its Origin and Nature* (New York, Simon and Schuster, 1981).
19. Raphael M. Bonelli, Enrique H. Prat, and Johannes Bonelli, "Philosophical Considerations on Brain Death and the Concept of the Organism as a Whole," *Psychiatria Danubina* 21 (2009): 3–8.
20. Bonelli et al., "Philosophical Considerations," 4.
21. *Ibid.*, 4–5. Because lower animal forms such as planaria may be successfully divided into two independent organisms, the criteria enumerated here pertain only to higher animal species.
22. *Ibid.*, 5–6.
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24. Eelco F. M. Wijdicks, "Brain Death Worldwide: Accepted Fact but No Global Consensus on Diagnostic Criteria," *Neurology* 58 (2002): 20–25.
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In Memory of Bernie Gert

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I met Bernie in the fall of 1967 when I was a philosophy graduate student at Johns Hopkins trying to develop a doctoral thesis proposal, and he a young visiting professor from Dartmouth for the 1967–68 academic year. From that starting point a relationship developed lasting forty-four years, until Bernie's death in December of 2011, in which Bernie was my teacher and mentor, and then later my colleague and dear friend. No words I'm capable of expressing could convey the fullness and depth of my intellectual debts to him, my gratitude for his supportive encouragement, and my realization of how much I both loved and liked Bernie. The recollections that follow, however, I hope provide at least a good example of all the above.

By way of background, on April 19 and 20 of this year I had the immensely gratifying and joyful experience of taking part as a judge in the first National High School Ethics Bowl. I was invited to participate because I created and, for many years, was both the principal organizer and developer of the Association for Practical and Professional Ethics Intercollegiate Ethics Bowl (APPE IEB), upon which the National High School Ethics Bowl is closely modeled. I originated the ethics bowl, which, as the APPE IEB, has become a national academic competition in which more than one hundred thirty colleges and universities take part, at the Illinois Institute of Technology (IIT) in 1993, first as an on-campus intramural activity. A few years later my colleagues in IIT's Center for the Study of Ethics

in the Professions and I expanded it into a small competition with three other schools besides IIT located within or near the greater Chicago area. Bernie participated as a judge the second time we conducted that local intercollegiate ethics bowl at IIT. On the day the competition ended Bernie expressed with great enthusiasm how much he had enjoyed participating. The next morning at the breakfast table (he was staying for the weekend with me and my family as our guest) he spoke animatedly about his positive reaction, describing the high points of his experience as a judge and offering ideas about how the ethics bowl could be adopted effectively in contexts other than undergraduate education.

At the time I was, of course, enormously pleased by Bernie's positive reinforcement. Looking back now, though, I recognize something deeper had registered in my consciousness. Long before I invited Bernie to be a judge in our local intercollegiate ethics bowl he had come to regard me as a colleague instead of as only a former student. In my mind, however (albeit unconsciously, or, at most, semi-consciously), the enthusiasm Bernie expressed was the ultimate validation of both the ethics bowl's intellectual depth and its educational value. Only recently has it occurred to me that it was shortly after the validation in terms of Bernie's enthusiasm that I contacted Brian Schrag, the executive secretary of APPE, to propose that APPE host a national intercollegiate ethics bowl at its annual meeting. The rest is history—a history that would not have unfolded but for the combination of my high esteem for Bernie's intellectual achievements, his supportive encouragement of my efforts to develop the ethics bowl, and our strong friendship.

I was honored and touched deeply by being asked to make the keynote presentation at the APPE Gert Memorial Symposium. The paper I prepared, forthcoming in *Teaching Ethics*, does not deal with the ethics bowl. Instead, it utilizes Bernie's moral theory to analyze the moral limits of the judicial duty of fidelity to law. I struggled with this topic throughout twenty years that I served as a special education due process hearing officer in Illinois, a domain of activity that had a huge impact upon both my scholarship and teaching in practical and professional ethics, including the ethics bowl. Writing the paper, and delivering a presentation based upon it, was a great consolation for the loss of my teacher, mentor, colleague, and dear friend Bernie Gert. They brought home to me that although I no longer can send Bernie emails, talk with him on the phone, and be with him at professional meetings, the opportunity to learn from him, which I treasure, continues.

Gert on Rationality

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My aim in this paper is to question the account of rationality offered by Bernard Gert in all editions of *The Moral Rules* and *Morality* and to defend in its place a more traditional, formal, means/end or "cool moment" view.

Gert's view of rationality is a substantive account that, among other things, holds that certain listed beliefs and desires are irrational, whether or not someone holds them in a cool moment and following deliberation. Acting on these beliefs and desires without an adequate reason is irrational. Among the irrational desires is the desire to die, to suffer pain, to be disabled, or to be deprived of pleasure or freedom (all without an adequate reason). An adequate reason refers back to the list of irrational desires. Thus, it may be rational to want to die (and refuse medical therapy or attempt suicide) in order

to avoid severe physical or psychological pain. But in the absence of an adequate reason, the desire to die or to suffer pain is irrational.

What first caused me to question Gert's account was a medical case report I encountered some years ago. The case concerned a young woman in Great Britain who had been hospitalized following several failed suicide attempts. The woman explained her behavior as stemming from the fact that "she simply had no desire to live." Psychiatrists examining her found that she had not recently suffered any severe trauma that was causing her pain, and she exhibited no signs of clinical depression (apart from suicidal ideation). After a period of observation, she was released from the hospital. She finally succeeded in taking her own life.

On Gert's account, this woman acted irrationally. Her very desire not to live (in the absence of suffering severe psychological pain) was irrational and, presumably, required, at a minimum, her continued surveillance and/or confinement. However, the cool moment view that I wish to defend leads to a different conclusion.

This formal, means/ends or "cool moment" view understands rational choice as involving the maximal satisfaction of one's desires. It insists that to be rational the calculation of these satisfactions must be made in an objective manner. This means that they must be based on accurate available information about the consequences of one's choices and freed from the influence of overwhelming passions or emotions that can distort the proper assessment of the strengths of one's desires or the implications of pursuing them. This account also holds that rational choice normally involves no strong time preference. Unless there are good reasons for discounting a future satisfaction, it has as much weight as a present one. This view is desire-neutral and "person-relative." Rationality involves the maximal satisfaction of one's plan of life and system of desires, regardless of what those desires may be. It follows that what is rational for one person may not be rational for another. Finally, this account assumes that the basic rules of reasoning apply: that the reasoning individual is able to exercise consistency in reasoning and avoid self-contradictions, and that the individual prefer outcomes that are inclusive in the sense that in choosing between several outcomes one chooses the outcome that contain all of one's desired ends and more, over one that contains fewer ends.

This cool moment, maximal satisfaction of desire view, I believe, better explains the case of the suicidal young woman I have described. It explains why, after medical review to see that her reasoning processes are in order, she is best treated as rational and allowed to act as she wishes.

I further want to suggest that when the operation of the cool moment view is clearly understood, Gert's account is not needed. A formal account can do much of the work of his position, and do it better. It can, with fewer assumptions, explain the presence of most of the items on his list in cases of rational prudential choice and moral choice.

To understand this better, we must perceive a step in rational deliberation here that I call "regressive impartiality." This requires a conceptual movement that expresses our notion of objectivity in judgment. It calls on us, in the face of conflicting desires and beliefs, to step back—regress—from the immediate considerations facing us in order to undertake an impartial assessment of those same considerations. Thus, if I am experiencing deep despair over the unwanted ending of a romantic relationship, rationality requires me to step back from this emotion and array myself, with no time preference, before all the possible emotions and satisfactions I am likely to want to experience in different life plans ahead. I am irrational if I

refuse to do this and, acting merely on the pain of the moment, choose to take my life.

Gert is right, therefore, to hold that it is *generally* irrational to want to die, to suffer pain, or to be deprived of pleasure or opportunity (all without an adequate reason). He is also right to believe that persons expressing these desires normally require medical attention, or even paternalistic confinement until the desires pass. But he is wrong, I think, to explain these facts simply by calling such desires irrational. Rather, they are desires that no would want to act on or be allowed to act on until they have gone through a full process of rational deliberation.

Roughly the same mode of reasoning applies to moral choices.¹ The aim of morality is to facilitate social life by reducing conflict through reasoned appeal to mutually agreed upon principles or rules. The difference from prudential deliberation is that moral reasoning requires us to render ourselves impartial not only before the array of our own life choices, but also among the array of life choices prevalent among different individuals in society. To achieve this purpose, moral reasoning employs the same method of regressive impartiality. It asks us to back away from any matters about which there are disagreements, render ourselves impartial with respect to the array of desires or interests in conflict, and choose impartially among them. We must privilege the satisfaction of those desires that are most compelling, that are most likely to maximize our satisfactions (whatever they may be), that invite the least conflict with other likely important desires, and that are most inclusive of satisfaction within a total life plan. In this case, however, as opposed to instances of prudential choice, the likely satisfactions are experienced not by (or within) one individual, but are distributed among different people in society.

No less than in prudential choice, impartial persons engaging in moral reasoning must rely on accurate, available information about themselves and human beings generally. They know, for example, that the vast majority of people do not want to die (unless they have an adequate reason), or suffer pain, disability, or be deprived of freedom or opportunity. It is not surprising that this list of beliefs looks just like Gert's list of rationally required ones. Almost all human beings, in fact, share these beliefs and desires. But a key word here is "almost." Not every human being holds every one of these beliefs or desires. Some people may want to die for no good reason. Nevertheless, the existence of this small number of aberrant people has almost no impact on impartial rational persons' deliberations about the appropriate beliefs and desires on which to base the choice of moral rules. Since the overwhelming majority of human beings do not want to die, and since not being killed by others is compatible with virtually any plan of life (including a life that includes the wish to die), it makes good sense to prohibit killing. It is not necessary to read out of the moral deliberative process people with wildly aberrant desires, since rational persons rendered uncertain about what are their own desires significantly discount such eccentric preferences. Nor is it necessary to brand these aberrant desires (and the people that hold them) as irrational. They are merely abnormal. They may even be "crazy" in a loose popular use of the term. But they are not irrational. That term is best reserved for beliefs and desires that result from illogical modes of thinking, modes that violate the formal principles of reasoning.

If this is correct, we can see that nothing is added to the accounts of prudential, medical, or moral decision-making by insisting on a substantive view of rationality. A formal account, combined with the method of regressive impartiality and the brute facts of human nature, does all the work of the substantive view without requiring labeling as "irrational" some of the odd desires I mentioned.

To this point, this may seem a small achievement: I have offered an understanding of “rationality” whose results almost entirely overlap Gert’s but that also makes room for the small number of people presenting with bizarre but nevertheless rationally arrived at desires. However, now I want to suggest that the two accounts of rationality exhibit important differences in the process of moral deliberation and can, on occasion, lead to very different moral conclusions. My illustration concerns abortion, one of the most vexing moral issues in our society.

Gert’s view of abortion remained remarkably consistent across all editions of his books. The framework afforded by morality, he argues, “will yield many universally accepted decisions and judgments, but it will not settle almost any controversial moral issue such as abortion.”² This is so because of the role of reason in determining the scope of morality: whom it is that the moral rules protect; whom must we include in the group about whom we reason impartially. If we confine ourselves for the moment to first trimester abortion, this question focuses on the moral protectability of the embryo or fetus, a class that includes beings who are pre-sentient or sentient and who represent potential moral agents. On Gert’s account, morality offers no answer to this question.

This is because moral reasoning requires basing one’s thinking solely on the beliefs all rational persons share. These include the beliefs required by reason: that I can die or suffer pain and do not want to (all without an adequate reason). This limitation is needed, Gert observes, because it is not clear that rational persons would ever agree on anything if they could draw on all the beliefs allowed by reason—that is, the many beliefs that are not irrational.³

But the beliefs required by reason contain nothing relevant to settling the question of whether embryos or fetuses should be protected. Furthermore, the much larger set of beliefs allowed by reason (all beliefs that are not irrational) varies greatly among rational people on this matter. Some rational persons have reasons for wanting to accord embryos and fetuses the same degree of moral protection given to neonates, children, and adult moral agents. Others disagree and would withhold such protection, giving women the liberty to terminate pregnancies at an early stage. Gert concludes, “I know of no argument that would persuade all rational persons either to include or not to include all presently existing sentient beings who are potential moral agents in the group toward which a person should impartially obey the moral rules. Common morality is undecided on this matter, and arguments do not seem to determine most people’s attitude on this issue.”⁴

Gert believes that the issue of abortion, like many on which rational persons do not agree, is best settled by the political processes of a democratic society.⁵ In making law, people are free to seek enforcement of their rationally allowable beliefs about proper conduct. As he says in *Morality*, in a society where the majority believes it right to bring embryos or fetuses fully within the scope of morality, laws would be passed prohibiting abortion, except perhaps in cases of rape or where there is a direct threat to the mother’s life.⁶ These laws would not, for Gert, be unjust.

I should note here that although Gert insists his views offer an adequate account of common morality, in this case they contradict the thinking evident in the Supreme Court decision *Roe v. Wade*, which held that the non-prohibition of first trimester abortion is an expression of a woman’s basic constitutional right to privacy, and should not be made a function of the legislative part of the political process.

A formal account of rationality as used in moral contexts proceeds differently on the matter of abortion and, I think, yields more definite moral conclusions not subject to determination by

a society’s political majority. The notion of regressive impartiality is key. We have seen that whenever rational persons find themselves confronted by a conflict of willing (whether within themselves or within society), reason requires them to back off and assess the dispute impartially, using the basic tools of the cool moment view, including maximization, inclusiveness, and non-contradiction. Crucial here is the further understanding that in practical matters reason cannot permit disagreement. Practical reasoning must always lead to a single, univocal solution for practical action. One cannot have a society where some persons are free to kill other persons who do not consent to be killed or where some feel they can kill non-rational entities and others believe they may use force to stop, even by killing, those who are doing such killing. Morality exists to peacefully adjudicate just such disputes, and it can never leave them unresolved. This requirement drives the regression to impartiality in the face of all serious practical disputes.

That morality requires a univocal solution does not mean that impartial rational persons must always agree on which specific beliefs and desires should prevail. It only means that they must come up with a way of settling the dispute that rules out destructive conflict. In relatively trivial matters, this can take the form of agreeing that the issue should be settled by the flip of the coin. (We often do this in determining traffic rules, such as which side of the road to drive on.) For more serious matters, where parties are moderately affected and may reasonably be prepared to yield ground in the name of social peace, they may choose to turn the matter over to political settlement by some form of majority rule. (Gert is right in seeing this as a mode of settlement; he is wrong in seeing it as the only or most allowable one in all cases of rational disagreement.)

Sometimes, the issues are too pressing to permit any of these strategies. Rational persons perceive in others’ policies the threat of grave evils for themselves or those they care for. When this happens, impartial rational persons invoke every bit of relevant and undisputed factual information they can to resolve the dispute. Even when all this is done, rational persons may still find themselves disagreeing about the weight, likelihood, or significance of possible evils or factual matters relevant to the decision. In such circumstances, practical reasoning uses a further tactic to achieve agreement. It reapplies the procedure of regressive impartiality to any matter in dispute, asking the deliberators to back away from it and impartially consider the entire array of positions concerning it. For example, looking at the issue of fetal suffering, deliberators might find that rational people disagree about the extent of their emotional concern for the early fetus, some feeling a high degree of concern, others much less so, and some none at all. Rational deliberators may hold one or another of these positions. But, when reasoning morally, they must regress from their own position, relinquish whatever attitude they have toward fetuses, and, using the formal tools of practical reasoning, see which attitude it is reasonable to privilege here given other known facts.

In this instance, *all* impartial rational persons (persons who do not know whether they are male or female) would agree that denying a woman the ability to terminate an unwanted early pregnancy exposes her to grave and often irreversible harms, including the physiological risks and inconveniences of pregnancy, the severe life disruption of unwanted parenthood, or the emotional trauma of relinquishing a full-term child for adoption.⁷ The principal concerns arrayed against these evident and serious harms to rational persons are some rational persons’ emotional identification with fetuses, the possible physical suffering by the fetus in the process of abortion, and the fetus’s loss of the value of a future life. No one would deny that many

fewer people identify emotionally with fetuses than they do with newborns. I believe that this array of considerations would lead impartial rational persons to adopt a policy here not of protecting all fetuses (as they do newborns) but one respecting the wishes of all persons who want to protect their own fetuses from others' assault (i.e., a policy prohibiting compulsory abortion). The physical suffering of aborted fetuses is clearly not relevant to the very early embryo or fetus, since a functioning nervous system is not yet in place, but this reason for concern grows as the fetus develops. At no point in early pregnancy is it reasonable to assume that this suffering approaches that of an adult woman forced to continue a pregnancy. Finally, the excellent criticisms advanced against Don Marquis's defense of the seriousness of the loss of the value of a "future like ours" strongly suggest that this loss is not a pressing concern.⁸

This sketch suggests that rigorous application of the tools and methods of formal rationality can help us make reasoned progress through a difficult debate, one that Gert repeatedly declares to be irresolvable. In addition, the considerations presented here suggest a conclusion very close to the *Roe v. Wade* decision, holding that women have a constitutionally established right of privacy during the first trimester of pregnancy. The agreement here with an expression of common morality lends further support to my claim that a purely formal account of rationality is more accurate and more useful than Gert's substantive one. A formal account not only explains all of Gert's prudential and medical conclusions (without requiring the labeling of some odd desires as irrational), but it also helps us make our way through very difficult issues of moral choice better than does Gert's.

Notes

1. Rawls anticipates the application of a concept of regressive impartial reasoning in his essay "Kantian Constructivism in Moral Theory," *Journal of Philosophy* 77, no. 8 (August 1980): 549f when he argues for the distinction between a thicker and thinner veils of ignorance, and identifies his preferred Kantian approach as removing all particular information except that necessary to achieve agreement.
2. Gert, *Morality*, 219; also, p. 4. This position is reiterated in Gert, Charles M. Culver and K. Danner Clouser, *Bioethics: A Systematic Approach* (New York: Oxford University Press, 2006), 65–75.
3. Gert, *Morality*, 161.
4. *Ibid.*, 143–44.
5. *Ibid.*, xii.
6. *Ibid.*, 397, n. 7.
7. There is no corresponding objective information supporting the psychological trauma of abortion, despite the efforts of anti-abortion activists to allege such harms.
8. "Why Abortion Is Wrong," *Journal of Philosophy* 86, no. 4 (April 1989): 183–202. Gert seems to join these criticisms when he observes, against Marquis, "that killing deprives a being of a future like ours is not a property that makes killing wrong but one feature of some killing that leads rational persons to advocate having a rule prohibiting killing" (*Morality*, 398, n. 9).