

What Has Bioethics to Offer Health Policy?

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THE DECADE AND A HALF OF DAVID WILLIS'S editorship of the *Milbank Quarterly* coincides with the introduction and acceptance of work by bioethicists in the field of health policy. Bioethics had begun its recent flowering just before this period, but its focus, and its audience, lay for the most part in the clinics, contributing to the relationship of doctor and patient. In a marked turn of direction (Callahan 1980), bioethicists began to broaden the scope of their analysis, examining health care policies that set the context for clinical dilemmas. Those in the policy world, meanwhile, were becoming receptive to explicit discussion of the ethical dimensions of their work, as moral self-scrutiny came into fashion throughout the professions.

Bioethics and the *Quarterly* have had a reciprocally beneficial relationship. Alone among health policy journal editors, David closely monitored the progress of task forces, advisory boards, commissions, and working groups that were beginning to solicit bioethicists' analyses of health policy issues, identifying many of the most interesting and rigorous papers even before they had become "deliverables" sent to their sponsors. Some of the best of these would eventually be published in the *Quarterly*, usually after further improvement. This prospect, in turn, has motivated bioethicists to gear their work to the

health policy community and to strive further to meet the *Quarterly's* exacting standards.

Nevertheless, bioethics has not enjoyed the same status within health policy work as economics, sociology, and the other established disciplines. In the early days, up to the 1980s, policy makers and health services researchers alike often had difficulty in understanding what it was that bioethicists do, and what bioethical research could be. Occasionally one found strong skepticism, bordering on hostility: the bioethicists are simply expressing their own feelings and opinions, dressing them up as scholarship; or perhaps they are zealots who are pushing a cause and have somehow maneuvered their way into policy advisory panels. In some cases even the friendly faces were a problem, for the bioethicists' champions in health policy settings were occasionally themselves zealots, or moralists, who thought they recognized an ally. Disappointment set in when the bioethicists produced the kind of work that has been published in the *Quarterly*: short on preaching or emoting, workmanlike and careful in construction of arguments.

For many health policy workers, bioethics in the *Quarterly* mode is now more of a known quantity, and its advocates presumably favor it for the right reasons. Nevertheless, the earlier questions about the potential value of bioethics in health policy have not been entirely put to rest. Not all are convinced of its value, nor have the doubters' reservations been fully answered. If the most able bioethicists are not simple moralizers, or single-minded zealots, perhaps they are sophisticated moralizers, and perhaps they are pushing a particular program in a less obvious way. What is the claim to their expertise? What is the authority of their pronouncements and conclusions? Indeed, is their role that of the detached expert analyst, whose personal feelings are kept out of professional work, producing a "value-free" ethics? Or are they agents of change, whose measure of success is the conversion of hearts and minds to their own notions of virtue?

However common these doubts may be among those working in health policy, they are rarely voiced in public. With few exceptions (Fox 1974; Warnock 1985), neither the *Milbank Quarterly* nor its sister journals in the field have published critical articles on bioethical methodology or on the academic legitimacy of this field. Bioethicists, on the other hand, do ask these questions, and in our journals numerous symposia have been devoted to airing both doubts and reassurances. Indeed, bioethics was regarded within the established traditions, particularly ac-

ademic philosophy, as a poor and disreputable relation. “Ethicists” (the very word made proper philosophers cringe) were viewed as charlatans who impressed gullible physicians, patients, and the public with impressive words, but whose arguments failed to meet even the minimum standards of cogency. With the enormous popularity of bioethics came both cachet and financial support, and most of these academics’ doubts have been silenced. They have not, however, been answered, and within bioethics and academic philosophy the soul searching continues.

In the present article my modest project is to wash some dirty laundry in public, conveying to readers involved in health policy some of the questions being raised by bioethicists about our own legitimacy and methods. At the risk of disappointing both supporters and critics of the field, I will not go very far toward framing a response to the questions and critiques. Here I am only airing the doubts, and inviting those outside the field to join the conversation. I ask also to be forgiven for overgeneralization and some exaggeration in what follows; the qualifiers belong there, but would be tiresome to repeat, and the main points do not depend on them.

This article will focus narrowly on bioethics as normative ethics: the attempt to determine what is right and what is wrong. Descriptive ethics—the study of what people believe or do—belongs to the field of bioethics as well, but raises different methodological issues. Within normative ethics, I will take moral philosophy as mother discipline; not in the sense that only philosophers are competent bioethicists (whether a background in philosophy is essential or even advantageous is one of the questions at issue), but because any relevant theories of ethics used in bioethics will likely be philosophical theories. These theories might be put forward by social scientists, theologians, or anyone else, but their competition and their predecessors will be the products of those working in the tradition begun by Socrates and Plato, the professional philosophers.

Bioethics as a Profession

Readers of the fine bioethics articles in the *Milbank Quarterly* (see the reference list), if they are familiar with the field as a whole, will be aware of their distinctiveness. This is due in part to David’s exacting standards as an editor. Another reason is that these essays represent a

distinctive kind of bioethics. The characterization of this approach requires a brief and selective portrait of bioethics as a field.

With its original clinical focus, contemporary bioethics attended to the proper choice of options open to individual practitioners and on the interaction of doctor and patient: whether to tell the truth, when to keep confidences, what role a doctor may have in bringing about a patient's death. Much of bioethics was offered not in the journals but at the bedside, in dialogue not with fellow ethicists but with the doctors and patients who peopled the dilemmas.

In this work, bioethics has been an activity, even a profession, as opposed to a discipline or field of inquiry. Early clinical bioethics accompanied the patients' rights movement, a social campaign not instigated or led by academics. As one of the numerous movements on behalf of the ignored and the dispossessed that arose in the wake of the civil rights struggle, the patients' rights movement sought to rectify the imbalance of authority and power in the doctor-patient relationship and to reform the practice of medicine to make it more responsive to patients' interests and preferences. This mission was carried out also by bioethicists hired by medical schools to teach the new required ethics courses; they were expected to "humanize" the next generation of doctors.

At the same time, bioethics was the subject of a rapidly growing academic literature in which bioethicist-scholars debated the fine points of clinical ethical dilemmas. Thus bioethics has had a dual character; it is a field of inquiry, with characteristic methods, and also a particular kind of advocacy. These roles do not necessarily jibe. As a scholar, a bioethicist as such does not stand for anything in particular, except for the norms internal to the profession, such as intellectual honesty. A bioethicist-scholar who does not believe in informed consent, or who thinks it proper to sacrifice the well-being of unconsenting research subjects in the interests of future patients, would be a colleague in full standing (however unpopular) with those holding the opposite, more conventional points of view. In the role of advocate, however, it is understood that bioethicists are attached to a certain set of positions on these issues—for informed consent, against sacrifice of research subjects, for example—and are not merely studying the issues according to his or her favored individual perspective. In this sense, the point of bioethics was not to study the morality of clinical practice, but rather to change it. The point of the teaching was to reform the students: the

point of the consulting was to ensure that patients' demands were listened to. To be sure, the consulting bioethicists might insist that the aim was to help the doctors and patients reach their own conclusions rather than to push their personal beliefs; but the doctor who confidently decided that patients' wishes need not be given any weight would stand in need of further bioethical counseling. Indeed, attachment to certain positions on these issues has been used as a criterion of mastery of bioethics. Moral questions, with certain responses marked as correct and others as mistaken, have appeared on medical board examinations. A committee of academic bioethicists who published, in the *New England Journal of Medicine*, a statement of the minimum content of the basic curriculum in bioethics that every medical school should offer identified a set of key tenets of medical ethics (such as the primacy of informed consent) to be taught (Culver et al. 1985).

Although academics claim dominion, bioethics as scholarship may be a less populated field than bioethics as advocacy. Survey data are unavailable, and the definition of "bioethicist" is vague, but some form of bioethics consultation seems to be occurring in every hospital in the country. Wherever there are patients relating to doctors, there the bioethicists may be practicing: working the wards, heading the hospital ethics committees, and counseling the genetics counselors.

These are practical activities, not academic ones. But the practitioners still claim to be experts. The expertise most important to their work is a skill: cutting to the core of dispute over matters of great personal importance, inducing those involved to use reason over emotion, and facilitating communication. A thorough grounding in theory—that is, ethical theory—is, in my view, neither necessary nor sufficient for success in this practice. There remains, however, the institutional problem of credentialing. The skill of practical bioethics—so-called beeper ethics, a sort of intellectual social work (and none the less valuable for that)—is seldom taught as such. There are no professional schools, no internships, no board examinations. There are, however, ethics courses, and evidence of success in one or more of these provides some kind of bona fides.

On what scholarly foundation is bioethics placed in these courses? Judging from the content of almost all of the textbooks, most of the term is spent in detailed examinations of particular issues—euthanasia, reproductive technology, human subjects experimentation; as the problems emerge and withdraw from the public limelight (their Warhollian

15 semesters of celebrity), they are added or dropped in successive textbook editions. The theory to be used in dealing with these problems occupies the first chapter of the texts, and presumably the first few weeks of the term. What is taught in this brief period varies widely (again, judging from the texts), but there are some unbending requirements: the material must be short, learnable, and applicable. There is no time for long meditations on the kinds of recondite issues that occupy moral theorists, such as the equivalence of the Kantian variations on the categorical imperative or on the standard utilitarian responses to the problem of interpersonal utility comparisons. Some writers, and some teachers, attempt to boil the standard material of ethical theory into a three-week reduction (in my view, achieving only brevity among the three above mentioned virtues).

A different approach has had extensive influence, one that encapsulates ethical knowledge into a set of simply stated, though elegantly named, principles: Beneficence, Nonmaleficence, and the like, which together cover nearly every dilemma the practical ethicist is likely to encounter. The skillful ethicist is to apply these principles in just the right way, giving more weight to some rather than others, and so is led to the most sound moral judgment.

This sort of bioethical theorizing has a perfectly respectable history and motivation. It resembles a twentieth-century formulation, associated with the British moral philosopher David Ross, which held that morality was not governed by any one principle or rule but by a multiplicity of them, each specifying duties that governed *prima facie*, that is, in the absence of stronger obligations to the contrary. This view did not keep many adherents for the simple reason that the theory provided insufficient guidance on how to adjudicate conflicts between these principles, which is what one must do in any genuinely difficult moral dilemma. Hence it did not seem to be much of a theory at all, at least if theory is supposed to be a reasoned improvement over intuition. Nevertheless, there is something to be said for using this framework of principles as a scaffolding on which to display the range of considerations relevant to an ethical judgment, a set of names for categories of reasons for action, each of which can be discussed in turn in the opening weeks of an ethics class.

The locus classicus for this tendency within contemporary bioethics is Beauchamp and Childress's (1989) *Principles of Bioethics*, now in its third edition. Because both authors have been associated with George-

town University's Kennedy Institute of Ethics, the set of principles the book provides is known within the trade as the "Georgetown Mantra." That nickname foretells the difficulty (amply and candidly discussed in *Principles*) with bioethics done in this way.

Understood heuristically, Beauchamp and Childress's set of concepts can indeed improve on intuition by guiding the intellect to a broader array of angles and aspects in a clinical moral problem than one might otherwise attend to. By going down the list, one seeks and often finds the telling facts that present dilemmas where one first saw simple duties. Further, by standardizing vocabulary, the presentation of the case—a ritualized act of reportage that the practical ethicist learns in homage to the physician's mode of consultation with colleagues—can be done more efficiently and less ambiguously.

A theory, however, this is not. The appearance of theory dissipates like the morning fog when the names of the principles are translated into colloquial English: for what sort of "philosophy" is a set of commandments beginning "Help people" (the Principle of Beneficence); "Don't hurt people" (the Principle of Nonmaleficence); "Be fair to people" (the Principle of Justice); "Let People Do What They Want" (the Principle of Respect for Autonomy). When faced with a dilemma, say one in which the only way not to hurt people is not to let some of them do what they want, it is no profundity to point out that this involves a conflict between the Principle of Letting People Do What They Want and the Principle of Not Hurting People (although it may sound like wisdom if one uses the Latinate labels). These are names of considerations, names of good reasons for choosing one course or another, but neither singly nor in combination do they constitute "a philosophy"—at least, not in the sense that knowing the names of the Principles provides one with a kind of moral expertise that would qualify one to provide moral counsel, as opposed to other good souls not similarly educated.

For pure practitioners of practical bioethics, it is of little importance that this sort of "theory" may not be a theory. The clarity it provides in helping to sort out elements in a moral dilemma can only be useful; and quick wits, a clear head, and interpersonal skills might be much more important to success than theoretical sophistication in any case.

In scholarship, however, the kind of "theory" that labels rather than explains can stand in the way of accomplishment. To be sure, Beauchamp and Childress themselves do illuminate the cases and policies that they

discuss. However, just as Tibetan masters enrich their chanting with harmonic overtones lacking in the flat recitations of neophytes, so too does “mantra”-driven ethical analysis in less expert hands become a routinized, mechanical straitjacket in which novel insights and turns of argument are virtually ruled out.

The word “mantra” connotes masses of the naively faithful repeatedly intoning a small set of magical words in hopes of achieving a short cut to enlightenment. At times, this seems to describe practical bioethics all too literally; at least, so one might decide after reading hundreds of practice-oriented bioethics articles that approach hundreds of different issues by brandishing the same set of labels.

Where Is Bioethical Theory?

That none of these formulaic treatments of bioethical issues appeared in the *Quarterly* under David Willis’s editorship is no surprise, given David’s editorial acumen. We must ask what the bioethical papers that met his standards offered. Put differently, what can health policy and health services researchers ask of bioethicists who wish to contribute to their fields?

One difference between many of the *Quarterly*’s bioethics papers and the formulaic papers appearing so often elsewhere was in their policy focus. This focus by no means assures that the treatment will be academically sound. It does, however, make it difficult to get anywhere with a mantralike approach. The latter can be useful in guiding clinicians through an interpersonal clinical encounter; but for questions of social and governmental practice we need brighter theoretical illumination. The mantra may light the path immediately in front of the clinician, who can fall back on his or her personal morality, or on society’s mores. The questions posed for policy debates, however, usually affect more people in more contexts, and must draw responses that transcend the personal bent of individuals.

Ideally, one would like to be in a position to claim that bioethicists writing on health policy can and do draw from a well-established body of ethical theory, which then permits applications to particular issues. Some do make this claim. Aside from the occasional attempt to construct an overarching theory of bioethics itself (Veatch 1981), writers on bioethical issues consciously proceed in the main from one of the well-

developed theories or traditions of morality and justice. Daniels (1983), working from a generally Rawlsian position, and Gibbard (1982), proceeding from utilitarianism, can point to elaborate theory if asked to supply foundations for their policy directives. The rigor of their arguments is sufficient to rebut the skeptic's claim that moral argument cannot proceed through logic, or that moral argument can only consist in the parading of personal feelings.

The application or development of leading theories of justice and political philosophy to health policy issues is in its infancy. Much of bioethics until recently has, as mentioned, been dominated by people who engage in a professional practice rather than in theoretical studies. In the capacity of "staff philosopher" of the President's Commission for the Study of Ethical Problems in Medicine (1979–1984), I attempted to spur the interest of these academic philosophers by organizing the Philosophy Advisory Committee, which was composed of social and political philosophers, and by commissioning papers from a broad range of their colleagues. Their contributions (President's Commission 1983b), some of which David published in the *Quarterly* (Daniels 1982, 1983; Gibbard 1982; Gutmann 1981), addressed problems of access to medical care and allocation of medical resources in a philosophically sophisticated way. Since that time, a slowly growing literature has popularized their insights and added others (Dougherty 1988).

Some of the reasons for the lack of scholarly attention to health policy on the part of the theoretically sophisticated are internal to social and political philosophies. John Rawls's hugely influential *A Theory of Justice* (1971), for example, idealizes the community as peopled by individuals with roughly equal needs. The first publication on this subject by Norman Daniels (1979), a pioneer in Rawlsian theories of distributive justice in allocation of health care resources, actually denied the possibility of marshaling theories of justice in support of a right to health care (his work in the *Quarterly* [Daniels 1982, 1983, 1990] and elsewhere stemmed from his reconsideration of these conclusions). Libertarianism, a rival contemporary theory, does have obvious bearing on health policy questions, but the efforts of several authors notwithstanding (Buchanan 1984; Engelhardt 1981; Lomasky 1981), little development of the theory is needed: health care entitlements would be swept away with the rest of the welfare state.

Another cause of the paucity of theoretically sophisticated work on the ethics of health policy lies in the disciplinary divisions of the acad-

emy. Very few—barely more than a handful—of this country’s social and political philosophers have more than a passing knowledge of the health care system. Years of acquaintance are required if the applications are to match the theoretical work in academic soundness, and the rewards for this retraining are few. One’s philosophical peers, in particular, are unlikely to see the health policy work, let alone appreciate it. No articles on the ethics of health policy akin to those published by David in the *Quarterly* have ever appeared in the *Journal of Philosophy* or *Philosophical Review*, the discipline’s leading journals, although philosophers whose articles David has included in the *Quarterly* publish other kinds of work there. One of the leading ethics journals, *Philosophy and Public Affairs*, has served this function on a few occasions, but its editors must cope with the fact that not many of its readers have the background or motivation to absorb intricate, empirically situated analyses of health policy.

In any case, even the best work in this vein—that is, rigorously argued, informed by theories of justice, and well situated within health policy debates—faces a number of unanswered questions concerning its utility as a contributing discipline for *Quarterly* readers.

If the best work on ethical issues in health policy proceeds from a well-developed body of theory, each contribution runs the risk of being theory bound: its development and conclusions are of interest only if the reader accepts the underlying theory. A utilitarian approach to age rationing, for example, will interest utilitarians, but not antiutilitarians. For the reader to appraise the argument of one of these scholars, the reader would need to have a prior appraisal of the range of leading theories of justice. Thorough grounding in contemporary social and political philosophy, however, is not part of the basic training of the social scientists and policy makers who read the health policy journals. Even if it were, the trainees could hardly expect to achieve such a command of the subject that they could confidently second-guess the expert philosophical contributors to these debates—who, of course, disagree profoundly with each other on these very questions.

The problem of theory-bound conclusions is, I believe, more troubling in ethics and health policy than in the social sciences, where it also occurs. In macroeconomics, for example, a given author may proceed on monetarist, Keynesian, or Marxist assumptions, and the conclusions reached may be interpretable primarily as developments of those approaches. However, on microeconomic matters, these differ-

ences matter much less; there is a commonly accepted reality of finance, incentive, and price, which permits convergence of views among scholars who differ on many of the larger theoretical questions.

In ethics, one might expect to find something similar: although theorists may disagree on whether morality comes from God (and which God), or from a natural sympathy for fellow humans, or from a social contract, almost all of us accept a common code of right and wrong for daily conduct; without it, social life would be impossible. Dispute remains over the details, in this view, but this fact should not obscure the overall consensus. We all agree that one generally should not lie, although we disagree on which exceptions are permissible; we think people should be treated as equals, although we do not define equality in precisely the same way. Thus it seems that although there will never be an end to moral disagreement on details, we find a moral agreement on the central questions.

Unfortunately, this promised core of agreement is not as reassuring as it sounds. The analogy with economics, for one thing, is inexact. Health economists may not need to dwell on macroeconomics, where theories diverge, but bioethicists contemplating the ethics of health policy issues find themselves squarely in the contested domain of social and political philosophy. The libertarians and the utilitarians and the Rawlsians disagree, not only in theory, but also on many of the central policy questions, and bioethicists cannot appeal to everyday moral intuitions and mores to provide arguments that all are bound to accept (although the President's Commission [1983a], in its report on access to care, did attempt this).

A deeper source of difficulty stems from the (alleged) distinction between facts and values. The nature of this distinction, and indeed its very existence, is itself a central issue in moral philosophy; but some version of it is commonplace. The economic effect of lowering the level of a hospital's charity care is a material fact, one that in principle, and often in reality, is determinable by social scientists regardless of their theoretical allegiances. The morality of reducing charity care, however, is not a fact, but an evaluation, and it is at least arguable that there is no reason to expect equally perceptive observers to agree on its rightness or wrongness, no matter how many data they gather. Even if agreement is found on both "fact" and "value," moreover, the explanation is different. The hospital's actual finances, that is, the "fact" itself, plays a role in bringing about the common perception of itself

(different observers agree that a hospital is solvent because the hospital is in fact solvent and the observers perceive this). When different evaluators share moral conclusions, however, we are more likely to refer to the observers' similar socialization, or to their common allegiance to a culture or group. To some theorists, this reflects the very different foundations of empirical and moral belief (Harman 1977).

The theme of theoretical indeterminacy occupies center stage in contemporary moral philosophy. The works of MacIntyre (1981), who points to the diverse sources of moral belief and value in our pluralistic culture, and Rorty (1979), who attempts to counter the search for foundations of philosophical belief generally, have convinced thinkers in a wide range of disciplines of the essential incoherence of moral theory in this modern age, and a less extreme argument by Bernard Williams (1985) has been influential among philosophers. Although their arguments differ, they join in their skepticism of the idea that underlying the variety and diversity of moral questions and moral viewpoints there exists a single value or group of values that inheres in all right or just policies and actions. Whether this is due to the lack of a commanding tradition, as MacIntyre has argued, or because modern philosophers have misguidedly pursued the goal of finding a common element or property in all right and just evaluations, as Williams seems to allege, these authors caution us to expect no more progress toward rational solutions of moral problems than we have of settling, say, the abortion question by means of logic alone.

To be sure, the hope of achieving a comprehensive solution of the largest questions of morality still motivates many scholars; Derek Parfit (1984), for example, has argued that the number of secular thinkers who have applied themselves to these profound and difficult questions is very small, the long history of the subject notwithstanding, and that genuine advances are now achievable. In the day-to-day terms of reference for health policy debates, however, these are questions best left to be pondered on a rainy day. For the moment, the bioethicist writing in a theoretically informed manner can only provide full disclosure, labeling results obtained as bound to the theory with which the writer began.

There is, in principle, one way to transcend the sectarian limitation. If all theories that are at all plausible support a given conclusion, we can believe in the conclusion without believing in any one of the theories. The President's Commission, for example, seemed to argue in this way for the limited endorsement it delivered of the government's obligation to act, at a minimum, as health insurer of last resort (President's

Commission 1983a). This kind of convergence, however, is rare (in health policy, for example, the libertarians usually fail to fall into line). In my own opinion, the President's Commission report papered over some seriously divergent implications of the theories it invoked. Moreover, the commission report implicitly claimed that conclusions supported by $n + 1$ theories are more credible than those supported by n ; but this is not true if, as in social and political philosophy, nearly every theory holds that if it is true, none of its rivals can be.

Bioethics Without Theory

For all their colleagues' skepticism over the (near-term) possibility of progress through philosophical research, philosophers and bioethicists contributing to health policy debates tend to be more optimistic than other scholars, who may be unfamiliar with the activity of theory construction in philosophy and unsympathetic to its claims of rigor. At the same time, we are compelled to offer some sort of basis for our moral evaluations and recommendations. One alternative to a priori philosophizing is to attempt to build a moral critique upon values embedded in our culture, history, and tradition. This approach does not claim that our particular heritage is closer to some abstract truth than any other heritage, but that these values should guide our policies because they are ours. Michael Walzer (1987, 1988) has argued that the social critic does not discover moral truth by theorizing via transcendent moral knowledge, but rather reminds her society of its basic commitments and how these have been forsaken.

A personal anecdote points to the difficulty with this view of bioethics as a contributor to health policy. When the President's Commission was appointed in 1979, its leadership decided to appoint a "staff philosopher" in recognition of the potential contribution of this discipline to the commission's task. My role was as unique within the federal bureaucracy as my business card, the only one in Washington to bear that title along with the presidential seal, and there was considerable confusion over what my contribution would be. At the first meeting of the commissioners, there was some discussion of the source of the values that could guide the commission's recommendations—which, indeed, were moral prescriptions, in keeping with the word "ethics" in the commission's formal name. One commissioner insisted that the body's

work be based, not on any of the commissioners' personal beliefs, but on "American values"; he then turned to me with a request to state precisely what these values were.

It was as obvious to most of the commissioners as it was to me that any reply would have been fatuous. Our heritage encompasses a great variety of values (and interests), many inconsistent with the others, and often in great tension. Any recitation of a coherent value scheme would reflect more on my personal agenda—the values I wished to emphasize—than on any reading of history and sociology.

The President's Commission did not, in the end, claim that its recommendations on health policy were rooted in a genuine American consensus. Nor (fortunately, in my view) did it follow its earlier predecessor, the National Commission for the Protection of Human Subjects (1978), in attempting to develop an overall moral theory to support its work. Neither did it simply choose one of the existing theories of morality or justice and attempt to show that its policy directives flowed therefrom.

Were the President's Commission's recommendations and findings, then, entirely *ad hoc*? No and yes. The commission, in its best reports, avoided the intuitive, on-the-fly justifications that often appear in bioethics through (mis-)appropriation of the old word "casuistry." That sort of moral arguments lends little support to its conclusions because the premises are adopted and dropped as necessary to argue for the conclusions reached independently. The commission's better work, in my view, operated in three modes, which also represent the best hope for bioethical contributions to the health policy literature: conceptual clarification, logic monitoring, and argument from common assumptions.

Bioethicists who seek to provide conceptual clarification avoid the need for a theory of their own, for the goal is not ordinarily to present a positive view, but rather to "disambiguate" concepts in common currency in health policy circles. Daniels (1982), for example, teases apart several quite different notions of equity in access to care, the confusion of which bedevils attempts to devise measures of access. By "logic monitoring" I mean internal contradictions and fallacies in arguments one wishes to criticize. The President's Commission report on care for the dying (President's Commission 1983c), for example, argued that the policy of viewing the withdrawal of life supports as forbidden and the withholding of life supports permissible is self-defeating; the classification of treatments as "extraordinary" and "ordinary" was viewed as conceptually empty. Once again, a bioethicist can effectively argue against

a position through criticisms of its internal logic or coherence without having to produce an alternative, theory-based point of view.

Lacking a foundation for bioethics, a moral policy analysis can proceed from some beliefs shared by author and reader, or that the author asks the reader to accept, without attempting, in turn, to show these beliefs to be well founded. Daniels's (1985) well-known argument for entitlements to health care, for example, is premised on the acceptance of a "principle of fair equality of opportunity." That principle is a broadened version of one by that name in Rawls's (1971) *A Theory of Justice*, but Daniels uncouples his argument from Rawls's and argues that his conclusions are compelling for those who accept any theory of justice that entails the principle. Similarly, Gibbard (1982) draws out the implications of an "ex ante pareto principle" for allocation of health care resources. In both cases, the authors go part of the way to make the principles plausible (and their projects therefore worthwhile), but the principles are expressly treated as assumptions for argument's sake, and most of their attention is given to making the statement of the principles precise and to demonstrating that substantive policy directives are entailed. This strategy may be especially fruitful for a public commission whose members can agree on some set of substantive postulates, since they would not be expected to deliver a moral theory in any case.

These three kinds of contributions can be fully rigorous and academically sound, even though they use no data and have no particular study design. Soundness, however, is not enough to guarantee import. I will close by noting what this kind of work can offer and what it cannot.

The limitations on these modes of argument for bioethical contributions to health policy are apparent. Sinking a doctrine by pointing out its internal illogic is not enough to establish the truth of any positive thesis, except in the rare case in which only two alternative views are possible. The bioethicist, therefore, is better at showing what not to believe than what one ought to believe. Conceptual clarification may be a necessary step on the way to formulating and arguing for a positive thesis, but it clarifies the terms rather than establishing the best alternative. Finally, an argument from shared assumptions is of interest only if one accepts its premise; it does not provide a reason for accepting its premise, nor are there many fruitful starting points that all of us are likely to accept.

Bioethics, at least in the form of social and moral philosophy applied

to health policy, can be a more precise discipline than health policy scholars may generally recognize. Paradoxically, its apparent usefulness and its soundness may be inversely related. An intuitive style of argument all too common in clinically oriented bioethics, one that brandishes "Principles" of all sorts on an as-needed basis, does result in immediate pay-offs in the form of action-oriented conclusions closely supported by premises. The problem is that the premises are themselves unsupported, and the arguments are worth no more than the conclusions they entail. The more exact and painstaking work that is typical of the articles chosen by David Willis for the *Milbank Quarterly* tends to make smaller, more qualified, and narrow points, and may remain at a higher level of abstraction; but its results are less easily challenged.

Can this closely argued, policy-oriented bioethics usefully inform health policy debates? In view of the reservations provided in this article, it is safer to commend the techniques of the best in bioethics than its substance. Moreover, the problematic status of positive arguments in bioethics must make one suspicious of any scholar who asks the reader to accept his or her recommendations because he or she is a bioethical expert. Lacking ground-up foundations for these prescriptions, they will be at some level merely personal, not professional, a product of the individual, rather than the bioethicist. The current popularity of bioethical sound bites in the news media, unfortunately, presents bioethicists with frequent temptation to disregard this distinction.

In defense of bioethics as a contributing discipline in health policy, however, it is worth noting that the task of moral evaluation and prescription is an inescapable one. As David Willis has recognized, we have no choice but to seek to identify the morally preferable policy choices, and the best bioethical studies improve on common sense through their care in argument, their conceptual clarity, and the breadth of vision that comes with being theoretically informed. We may not know quite what we are doing, with common sense or with philosophy, when we argue the ethics of health policy, but whatever it is, it is worth doing well.

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