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ANNOUNCEMENTS
FROM THE EDITORS

This issue of the Newsletter on Philosophy and Medicine represents the first collaboration of Mark Sheldon and new co-editor Mary Rorty, who is replacing Rosamond Rhodes. To help get a sense of the responsibilities of this new job, Rorty re-read ten years of back issues, and was struck anew by how varied and informative the Newsletter is. As my own research interests have expanded into healthcare related areas, the Newsletter has been one of my most helpful provocations and guides. Your suggestions for (and contributions to) the Newsletter will help Newbie Rorty be an adequate successor to Rhodes.

Philosophers find and express issues of interest in a variety of areas, including metaphysics and poetry, foundations and process, law and policy. Two papers from the Eastern Division Committee panel on “Philosophical Foundations of Bioethics” are included in this issue. Chalmers Clark and lawyer Jason Lee Mitchell consider the differing strictures on conflict of interest in the ethical rules governing the professions of law and medicine, and recommend stricter rules for medicine to sustain public trust in the profession in an age of increasing commercialization. An exchange at Pacific Division between Inmaculada de Melo-Martín and Rosamond Rhodes on possible conditions on a duty to participate in biomedical research is included in this issue, and two poet-philosophers, Felicia Nimue Ackerman and Andrea Nicki, contributed poems. A personal note on collaboration, increasingly common among philosophers engaging in conceptual or empirical biomedical ethics, closes this issue. Franklin G. Miller, working in the Department of Bioethics in the Clinical Center at NIH, draws on his years of academic and extramural scholarship to muse upon the pleasures and problems of working with others, including issues of adjudicating order of authorship when colleagues collaborate across disciplinary borders.

A newsletter, too, is a collaborative enterprise, and Sheldon and Rorty urge your contributions. Of particular interest: review a book you’ve recently read and liked (or, for that matter, hated).

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FROM THE CHAIR

The October meeting in Baltimore of the American Society for Bioethics and Humanities (ASBH) provided the enjoyable occasion for a number of us on the Committee on Philosophy and Medicine to meet, chat about the field, and discuss plans for future activities. The contingent included Bob Baker, Loretta Kopelman, Mary Rorty, Rosamond Rhodes, Ken Richman, and me. Mary Rorty also chaired our session at the ASBH meeting on “Genetic Testing of Minors for Adult-Onset Disorders.” The featured speakers were Ray Frey, Loretta Kopelman, Kevin Kovach, and Bonnie Steinbock.

In December 2007, Bob Baker organized and chaired our session on the “Philosophical Foundations of Bioethics” at the Eastern Division Meeting of The American Philosophical Association in Washington, D.C. There was an interesting exchange of ideas between the speakers, Tom Beauchamp and Bernard Gert, on common morality and bioethics, and how much in common the “principles approach” of Beauchamp and Childress may have with that of Clouser, Culver, and Gert. The other speakers, Rebecca Kukla, Micah Hester, and Larry McCullough, emphasized other perspectives on the foundations of bioethics, including empiricism, narrative ethics, pragmatism, and the “uncommon morality” of the medical profession. The Committee has decided to delve further into common morality and bioethics and has proposed to sponsor a narrower session on this topic at the next ASBH meeting in Cleveland, Ohio, on October 23-26, 2008. Bob Baker is organizing this session that will include Tom Beauchamp, Bernard Gert, and John Arras.

Our programs at the 2008 APA Pacific and Central Division Meetings included a session on “Persons, Human Organisms, and Bioethics” at the Pacific Division Meeting in Pasadena, California, on March 19, 2008. Speakers were Mary Anne Warren, David Shoemaker, Marya Schechtman, and David Hershenov. The panel which I chaired addressed issues at the intersection of the metaphysics and bioethics of persons. Fritz Allhoff and Kevin McDonnell organized our timely session on “Physicians at War: The Dual Loyalties Challenge” at the Central Division Meeting in Chicago on April 17, 2008. Kevin chaired the session that featured Fritz Allhoff, “Physicians at War: The Dual-Loyalties
the German Habermas, readily and classically identified with and yet finding a home in the voice of the British Schiller and philosophical tradition, maybe no more so than any other, pragmatic feminist. Pragmatism has been called a “school” of philosophical traditions; and one can be a deontological or latter two as well. Principles and rules arise from any number “communitarianism” (among other possible topics) are also of than, say, “principles” or “rules.” For that matter, “feminism” and foundations of bioethics? Pragmatism is of a different order What does it mean to speak of “pragmatism” in a panel on University of Arkansas for Medical Sciences D. Micah Hester About? — APA Newsletter, Spring 2008, Volume 07, Number 2 — Bioethical Pragmatism and Pragmatic Bioethics: What Are We Really Talking About? D. Micah Hester University of Arkansas for Medical Sciences What does it mean to speak of “pragmatism” in a panel on foundations of bioethics? Pragmatism is of a different order than, say, “principles” or “rules.” For that matter, “feminism” and “communitarianism” (among other possible topics) are also of a different order. And yet, pragmatism differs in kind from the latter two as well. Principles and rules arise from any number of philosophical traditions; and one can be a deontological or pragmatic feminist. Pragmatism has been called a “school” or “movement”; I would call it a philosophical “tradition.” And there is no question that “pragmatism” is a peculiar philosophical tradition, maybe no more so than any other, but peculiar nonetheless. Considered “distinctly American” and yet finding a home in the voice of the British Schiller and the German Habermas, readily and classically identified with the likes of Peirce, James, and Dewey though none of them profess to agree on its central characteristics, pragmatism is no singular philosophical theory. (Indeed, some say there is no “theory” at all, although they are wrong.) It is a collection of concepts and theories with a “family resemblance.” A century ago A.O. Lovejoy claimed to have discovered thirteen distinct pragmatisms. Surely with some 100 years intervening, many more exist today. I say this as if this decentralization is pragmatism’s peculiarity, and it is; and yet, cannot the same be said for deontology, utilitarianism, virtue, or narrative theory?—of course it can. Are Kant, Ross, and Rawls all the same philosophy? Are Bentham, Moore, and Singer? If so, in what ways? If not, are we wrong to call the former deontologists and the latter utilitarians? And what has just been noted about philosophical moral theories write large can surely be said of bioethics more specifically.

It is probably not surprising or unreasonable, then, to find that some have grown tired of trying to adjudicate the differences while, at the same time, finding something of value in features they take to be championed in pragmatism writ large. In this light, Susan Wolf (1994) took a cue from legal theory by championing the idea of “freestanding” pragmatism for bioethics, trying to isolate some central aspects without all the confusing conceptual baggage of differences. What I propose to do in this brief presentation is explain her insights and show why I do not think they correctly capture what pragmatism offers bioethics. What I offer, instead, will be an (insufficient) explanation of how pragmatism and bioethics relate through different philosophical sources, claiming that the conceptual frameworks they bring to bear are part and parcel of our work, for good or ill. The essay, then, is not a defense or explanation of my own work, per se, but a kind of meta-survey of a wide range of pragmatic bioethicists.

Freestanding Pragmatism

Beginning in the early 1990s a group of legal theorists attempted to ground legal and bioethical practices in “method” by developing so-called “everyday” or “freestanding” pragmatism. These authors argued that while legal and bioethical theory should, and increasingly does, rely on such pragmatic foci as induction, experiment, and fallibility, any appeal to explicitly classical or neo-pragmatic theory for support is not just unnecessary but wrongheaded. The alternative they suggest is “freestanding” in that it offers pragmatic characteristics without relying on the substantive concepts of any particular pragmatist like Dewey or James. The primary example of this approach to bioethics comes from Susan Wolf, in her article “Shifting Paradigms in Bioethics and Health Law: The Rise of a New Pragmatism” (1994). Wolf explains that bioethics’s new emphases on empirical data and taking the experiences of women and minorities seriously is a mark of a pragmatic shift in the discipline. She states, “[B]ioethics and health law have always been ‘applied’ or practical. But in shifting their respective approaches increasingly away from something principle- or rule-driven to something more inductivist and empirical, their approach to the practical becomes pragmatic” (399).

Wolf’s characterization is the description of a “trend” more than an argument for a shift in paradigm (though there is some argument in it). However, work by legal theorists Thomas Grey and Richard Posner is more explicit, making a direct argument for a “freestanding” pragmatism as the basis for legal decision-making (and, by extension, as Wolf suggests, bioethical decision-making). Grey (1998) and Posner (1998; 2003) both argue that “legal pragmatism” need not (even should not—see Posner 1998, 236 & 259) connect with the ontological and metaphysical arguments of philosophical pragmatism. Legal pragmatism
by so doing make Dewey irrelevant to the conversation, any
more than conceiving of a universal maxim of action without
reliance on Kant makes Kantian philosophy irrelevant. The
history of pragmatism offers a wealth of carefully considered
ideas (whether that be the social psychology of Mead or the
humanism of Schiller or the pragmatic a priori of Lewis),
particularly in the classical pragmatic discussion of intelligent
inquiry (normatively democratic in spirit), which, I contend, is
the glue that holds together this unique addition to bioethical
theory and practice.

Bioethical Pragmatism

The earliest explicit use of the term “pragmatism” in conjunction
with bioethics scholarship seems to have appeared in the late
1970s and early 1980s. Though it is not entirely clear what is
meant by the term in all instances of its use, in 1997, Al Jonsen,
in his presidential address to the Society for Health and Human
Values, made the following, possibly startling, claim:

Many of us have wondered how the desiccated moral
philosophy of the 1960s turned into the vigorous ethics
of bioethics…. My fantasy is that the ghosts of our two
great American philosophers, William James and John
Dewey, silently presided over the transformation…. It
is my impression that philosophers who have become
bioethicists have followed, unknowingly, the lead of
these preeminent American philosophers. (Jonsen
1997, 19)

This “fantasy” became explicit reality in the mid-to-late 1990s.

Though an oversimplification that borders on outright
distortion, I shall use the term “bioethical pragmatism” for
the very broad category of writings that contains different
theoretical approaches—idealism of Peirce and Royce,
naturalism of Dewey, the psychology of James—as well as
everything from meta-analysis of bioethical theory to concrete,
contextual discussions of clinical practice. To get a picture of
what I mean by “bioethical pragmatism,” one need only look at
the chapters of Pragmatic Bioethics, edited by Glenn McGee
and published in 1999. It places well-known writers in bioethics—
e.g., Mary Mahowald, Jonathan Moreno, Martin Benjamin,
Glenn McGee—side-by-side with such pragmatic theorists as
John Lachs, Bruce Wilshire, or Beth Singer, to name but a few
of the nineteen different authors. The collection attempts to
bring the concerns of pragmatists to bear on medical ethics
as a focused one-volume resource. The volume served as a
“proof” (of sorts) that the spirit of pragmatism was indeed to
be found within the field of bioethics. While broad in its scope,
its pursuit is to the extent comprehensive and only purports to demonstrate some
of what can be done. The reader will find authors influenced by
a number of historically identified pragmatists—Peirce, James,
and Dewey, but also Mead, Royce, Addams, and Santayana
(among others). There are clinical pragmatists, like Fins,
and naturalists like Moreno, influenced by Dewey. Mary Mahowald
argues from a Peircean perspective against euthanasia and PAS,
while I argue that a Jamesian view would allow it under some
circumstances. Griff Trotter uses Royce to ground professional-
patient relationships, while I use Dewey and Mead.

Whatever the success of these authors and their arguments,
it would seem that, like those influenced by Aristotle, Kant,
Mill, Rawls, or Derrida, pragmatically oriented bioethicists will
probably be on the scene for years to come. And the arguments
they put forth will, like all others in the field, continue to spark
both positive and negative reactions from other bioethicists.
Of course, it is no surprise that, as one of the self-identified
pragmatists working in the field, I think much of the negative
criticism about the pragmatic approach misses the subtleties
of pragmatism and instead sketches, however unwittingly, a

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caricature of pragmatic theory and method that is a disservice to the work and its possibilities.

So what, then, is bioethical pragmatism? What I have suggested is that bioethical pragmatism is a compilation of theoretical perspectives with a family resemblance; it is a “tradition.” As explained in Pragmatic Bioethics, at least, it is an application (or, maybe, an appropriation—see Larry McCullough’s contribution to the panel) of the insights of philosophers who have been identified as having pragmatic themes in their work, to issue of ethical interest in medicine. In some cases this arises from the process metaphysics of Dewey and Mead; in other cases, it is Peircean epistemology that grounds the insights; and in yet still other situations, it is the moral philosophy of loyalty, a la Royce, from which inspiration comes.

I have also noted that there is a “glue” connecting pragmatists—namely, a concern for methods of intelligent inquiry, be it from Peirce’s “Fixation of Belief,” James’s “The Will to Believe,” Dewey’s Logic: The Theory of Inquiry, or even Rorty’s Contingency, Irony, Solidarity. In each case, some theoretical apparati or concepts are at work, anchoring the claims of each of these bioethicists. However, it is simply not the case that the same concepts are doing the work for each. So, as unsatisfactory as this is to say, I must leave you wanting for a more explicit and robust discussion of what constitutes the relationship between bioethics and pragmatism. I would argue that each is (must be, really) tied to a substantive conceptual framework, but surely my framework is not that of Mahowald nor of Moreno, save for the family resemblance and shared tradition in which we all partake.

Having said all this, one important lesson that can be drawn from “freestanding” pragmatism is that appeals to classical (or even neo-) pragmatists can often be merely vacuous appeals to authority, and mere appeals to “authority” are decidedly unpragmatic (238). Pragmatism, though a philosophy that denounces foundationalism, does care greatly about history; however, it does so in order to transform the future, not just celebrate or condone the past. “History” can quickly become “foundational” and “fundamental” when any form of pragmatism—legal, bioethical, or otherwise—simply reifies pragmatists themselves—and we far too often do. It is important that reference to other pragmatists and alliance with “pragmatism” happen within the context of good philosophical argument. Although it must continue to follow careful philosophical inquiry through reasoned processes, Glenn McGee (1999) has rightly noted that bioethics developed pragmatically will rarely need to be explicit about its theoretical sources, though (I would add) it will benefit from a deep understanding of the systematic work of its forbearers.

Admittedly, I am (and probably will continue to be) guilty of the crime I have just articulated, having far too often overtly identified myself with classical pragmatists. But it is clear that it is time simply to do the work of pragmatism, not rely pragmatists. Extrapolating from a point central to “freestanding pragmatism,” we should note that the authority of pragmatism, while well served by, is not in its founding fathers and mothers but in its ideas and methods. Pragmatists who take pragmatism seriously should understand that pragmatism need not refer to itself, but rather to the world; not to the problems of philosophers, but, to paraphrase Dewey, the problems of human living.

[For further elaboration of the issues addressed here, see the author’s “Is Pragmatism Well-suited to Bioethics?” Journal of Medicine and Philosophy 28/6 (2003): 545-61.]

Endnotes

1. Arras denounces the usefulness of classical Deweyan-style pragmatism in a more recent article with the pointed title, “Pragmatism in Bioethics: Been There, Done That” (2002).
2. Robert Talisse and Scott Aikin in their forthcoming book on pragmatism agree with Benjamin that “reflective equilibrium” is a pragmatic moral position.
3. I do not exempt my own work from this critique.

References

Gregory in his writings on medical ethics appropriated Bacon’s philosophy of medicine, Hume’s science of morals, and the medieval Highland obligation of paternalism. I will show that Gregory’s medical ethics is deeply conservative of premodern ideas: it aims to preserve the Highland obligation of paternalism, creating medicine as a kind of moral aristocracy, a life of service to patients, that does not fit comfortably into modern society of the kind that Gregory’s contemporary, Adam Smith (1723-1790), described. To our loss, “paternalism” has been transformed in bioethics from an obligation definitive of the moral life into a problem to be eliminated by respect for patients’ autonomy. But more on medieval Highland paternalism later.

**Applied Model vs. Appropriation Model of Medical Ethics**

In two recent articles Baker and I make the case for what we (the credit here goes to Baker) called an appropriation model of medical ethics, rather than an applied ethics model.¹ The late—and very much missed—K. Danner Clouser (1930-2000) concisely described the applied ethics model of medical ethics in his classic “Bioethics” entry in the first edition of the *Encyclopedia of Bioethics*, published in 1978:

> Medical ethics is a special kind of ethics only insofar as it relates to a particular realm of facts and concerns and not because it embodies or appeals to some special moral principles or methodology. It is applied ethics. It consists of the same moral principles and rules that we would appeal to, and argue for, in ordinary circumstances. It is just that in medical ethics these familiar moral rules are being applied to situations peculiar to the medical world. We have only to scratch the surface of medical ethics and we break through to the issues of “standard” ethics as we have always known them.¹⁰

As Clouser made clear, *applied medical ethics* involves two steps: (1) learning enough about the facts and circumstances of medicine to understand and explain a clinical case or research problem; and (2) applying the precepts, principles, and rules of moral philosophy to the clinical case or research problem. By contrast, *appropriation* occurs in medical ethics when we do not simply apply the precepts, principles, and rules of moral philosophy, as if they were wholly adequate to the task, but adapt concepts and components of ethical theories to clinical cases and research problems.

Appealing to the work of L. Bernard Cohen¹¹ (1914-2003), Baker and I describe a four-stage model of appropriation. The first stage occurs when an innovator begins to articulate a new concept or theory. The second stage occurs when the innovator commits to that concept or theory. The third stage occurs when the concept or theory is widely disseminated. In the fourth stage the concept or theory is widely accepted as conventional wisdom, often timely conventional wisdom.¹²

Cohen’s model of appropriation helps us to understand that figures in the history of medical ethics such as Gregory and Percival introduce philosophical concepts into medicine by recontextualizing and transforming these concepts in ways that extend or revise their original sources, giving these concepts new meanings specific to the discourse of medical ethics. Once accepted and disseminated, these transformed concepts become part of the subsequent discourse of medical ethics. When this occurs over a long enough period of time the philosophical origins of the concepts are forgotten. This is true for the status of professionalism in contemporary medicine and medical ethics and is a source of the mistaken belief in the “Hippocratic-footnote” reading of the History of Western medical ethics.
Consider, for example, the following, from the American Medical Association's Code of Ethics and its appeal to history in its use of “long”:

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. 13

The very influential Physician's Charter explicitly invokes an ancient pedigree for professional medical ethics:

The medical profession everywhere is embedded in diverse cultures and national traditions, but its members share the role of healer, which has roots extending back to Hippocrates. 14

**Gregory's Medical Ethics and the Appropriation Model**

Gregory's appropriation of Bacon's philosophy of medicine began in the 1740s, when he was a medical student at Edinburgh and then Leiden, in The Netherlands. 15 Notes in Gregory's own hand from that period commit him to adopting "Four Capitall Enquirys" that set the agenda for his life's intellectual work: 1. The Preservation of Health. 2. The Retardation of Oldage. 3. The Cure of Diseases. 4. The Improvement of our Nature. 16

The first three are Bacon's "offices" of the physician; the fourth appears to be Gregory's own and sets the stage for the book17 that, two decades later, would win him the academic and political recognition that resulted in his being appointed as First Physician to His Majesty, the King, in Scotland (1765) and Professor of Medicine in the University of Edinburgh (1766).

Baconian philosophy of medicine became one of the foundations of Gregory's medical ethics. He extended Bacon's work to emphasize the requirement that physicians be open to “conviction,” i.e., to altering clinical judgment, decision making, and practice when accumulated and carefully analyzed experience, i.e., evidence, required doing so. Bacon had some sharp comments on the inadequacies of the medicine of his day. Gregory went further and made explicit the intellectual virtue, candor, that makes openness to conviction habitual and condemns its opposite:

I may reckon among the moral duties incumbent on a physician, that candor, which makes him open to conviction, and ready to acknowledge and rectify his mistakes. An obstinate adherence to an unsuccessful method of treating a disease, must be owing to a high degree of self-conceit, and a belief of the infallibility of a system. This error is the more difficult to cure, as it generally proceeds from ignorance. True knowledge and clear discernment may lead one into the extreme of diffidence and humility; but are inconsistent with self-conceit. It sometimes happens too, that this obstinacy proceeds from a defect in the heart. Such physicians see that they are wrong; but are too proud to acknowledge their error, especially if it be pointed out to them by one of the profession. To this species of pride, a pride incompatible with true dignity and elevation of mind, have the lives of thousands been sacrificed. 18

In the 1750s Gregory was one of the founders, with his cousin Thomas Reid (1710-1796), of the Aberdeen Philosophical Society, whose members read closely and vigorously debated Hume's *Treatise*. The manuscript sources of what was also known, with not a little irony, as "The Wise Club," show clearly that Gregory embraced Hume’s moral science of sympathy (but not Hume’s irreligiosity). 19

Sympathy is what the Scottish moral sense theorists called a principle: a real, constitutive component of human moral physiology. In particular, when properly regulated by requisite moral virtues, sympathy opens us habitually to the pain, distress, and suffering of others, and powerfully motivates us both to prevent pain, distress, and suffering of others and to relieve them when prevention fails or is not possible. Hume's original scientific discovery was to explain the mechanism of sympathy, a phenomenon that Scottish moral sense scientists knew well but had not yet explained. Hume does so on the basis of the double relation of impressions and ideas.

Gregory understood better than Hume that sympathy-based moral philosophy requires moral exemplars. Gregory found his in two “women of learning and virtue,” Elizabeth Montagu (1718-1800) of London, founder and hostess of the Bluetscoing Circle, and his own wife, Elizabeth. 20 Women of learning and virtue provided exemplars of two cardinal virtues of sympathy, tenderness and steadiness. Women, Gregory knew, understood constant loss very well, especially of parents, children, and siblings. Given the frightful rates of intrapartum mortality, awareness of one’s early death was part and parcel of daily life for women, who married and died young. Gregory’s own wife was typical. They were married only nine years when she died delivering their sixth child and had already experienced the death of three of her children.

Sympathy for human loss can result in emotional loss of control, which was known as hysteria in women and hypochondria in men. The moral virtue of steadiness provides the antidote and Gregory made it essential to the proper regulation of sympathy. The natural self-protection of oneself against constant loss can result in a loss of sympathy, which was known as dissipation in women and hard-heartedness in men. The moral virtue of tenderness provides the antidote and Gregory made it, too, essential to the proper regulation of sympathy. Acting on properly regulated sympathy, physicians were to become tenderly but steadily engaged in patient care. This is in striking contrast to current accounts of empathy, a kind of detached concern, and to Sir William Osler's (1849-1919) aequanimity. 21

It is well recognized that Hume's science of morals and the moral philosophy built on its foundations has a feminine dimension. Gregory explicitly feminizes sympathy and its two moral virtues, tenderness and steadiness. 22 Here is the key passage in his lectures on medical ethics in which he sets out his account of sympathy and defends its clearly feminine character.

I come now to mention the moral qualities peculiarly required in the character of a physician. The chief of these is humanity; that sensibility of heart which makes us feel for the distresses of our fellow-creatures, and which, of consequence, incites us in the most powerful manner to relieve them. sympathy produces an anxious attention to a thousand little circumstances that may tend to relieve the patient; an attention which money can never purchase: hence the inexpressible comfort of having a friend for a physician. sympathy naturally engages the affection and confidence of a patient, which, in many cases, is of the utmost consequence to his recovery. If the physician possesses gentleness of manners, and a compassionate heart, and what Shakespeare so emphatically calls “the milk of human kindness,” the patient feels his approach like that of a guardian angel ministering to his relief: while every visit of a physician who is unfeeling, and rough in
his manners, makes his heart sink within him, as at the presence of one, who comes to pronounce his doom. Men of the most compassionate tempers, by being daily conversant with scenes of distress, acquire in process of time that composure and firmness of mind so necessary in the practice of physic. They can feel whatever is amiable in pity, without suffering it to enervate or unman them. Such physicians as are callous to sentiments of humanity, treat this sympathy with ridicule, and represent it either as hypocrisy, or as the indication of a feeble mind. That sympathy is often affected, I am afraid is true. But this affectation may be easily seen through. Real sympathy is never ostentatious; on the contrary, it rather strives to conceal itself. But, what most effectually detects this hypocrisy, is a physician’s different manner of behaving to people in high and people in low life; to those who reward him handsomely, and those who have not the means to do it. A generous and elevated mind is even more shy in expressing sympathy with those of high rank, than with those in humbler life; being jealous of the unworthy construction so usually annexed to it.—The insinuation that a compassionate and feeling heart is commonly accompanied with a weak understanding and a feeble mind, is malignant and false. Experience demonstrates, that a gentle and humane temper, so far from being inconsistent with vigour of mind, is its usual attendant; and that rough and blustering manners generally accompany a weak understanding and a mean soul, and are indeed frequently affected by men void of magnanimity and personal courage. [in order added in errata] to conceal their natural defects.\textsuperscript{21}

Gregory had earlier presented a lecture to one of Edinburgh’s intellectual societies, the Poker Club, on women of learning and virtue, to a hostile reception. He responded in his medical ethics lectures. He was also responding to his student audience—all men at the time—who would have been, to say the least, skeptical.\textsuperscript{24}

Gregory’s foundations in Hume’s moral science and moral philosophy of sympathy are plain. It is also plain that Gregory goes well beyond his source. In the process of doing so, he writes the first feminine, modern, medical ethics in the English language. In the course of doing so, he addresses many topics in clinical medical ethics with which we are familiar, including confidentiality, giving patients bad news, sexual abuse of female patients, and end-of-life care, including an explicit endorsement of suicide in the face of death and an implicit acceptance of physician-assisted suicide. He also took up what is mistakenly labeled medical etiquette, disputes among physicians, which were then all too common. Such disputes, he pointed out, are antithetical to candor, tenderness, and steadiness and thus predatory on patients and ethically impermissible.\textsuperscript{25}

**Gregory’s Conservative Professional Medical Ethics**

Gregory’s appropriation of sympathy made him, correctly, profoundly opposed to predatory attitudes and behavior. He thought that these were epitomized in city life and commerce, which were functions of the pursuit of self-interest as the primary concern and motivation of men. Women of means were sheltered in the home—the summer home and, during the season, the city home. In Gregory’s view, this social arrangement conferred a moral advantage on women: they were not daily exposed to a culture animated by and rewarding the pursuit of self-interest. It would be a mistake, Gregory would say to us, to judge women oppressed by men. Men were morally oppressed, by city life and commerce, because they turned men into predators, the exact opposite of what sympathy properly regulated requires.\textsuperscript{26}

It should therefore come as no surprise that Gregory makes a strong distinction between medicine as an art and liberal profession, on the one hand, and medicine as a trade, on the other hand. His account of the effect of the passage of years in medical practice, i.e., struggling to compete successfully in a wholly unregulated and wholly unforgiving medical marketplace, is telling in this respect.

We sometimes see a remarkable difference between the behaviour of a physician at his first setting out, and afterwards, when he is fully established in reputation and practice. In the beginning he is affable, polite, humane, and assiduously attentive to his patients: but afterwards, when he has reaped the fruits of such a behaviour, and finds himself independent, he assumes a very different tone; he becomes haughty, rapacious, careless, and often somewhat brutal in his manners. Conscious of the ascendency he has acquired, he acts a despotic part, and takes a most ungenerous advantage of the confidence which people have in his abilities.\textsuperscript{27}

Such physicians have willfully corrupted themselves by becoming the opposite of women of learning and virtue. Such physicians have also morally corrupted themselves by becoming modern, epitomized, and commercially successful practitioners of the “illiberal” trade of medicine. As a consequence, they have joined the ordinary run of men (physicians then were all male) and have detached themselves from the ancient Scottish obligation of paternalism: the unyielding obligation of those with power to protect those subordinate to power. Paternalism was epitomized in the role of the Highland clan chief, who lived a life of service to and sacrifice for, the men, women, and children of his clan. The reader is altogether correct, I think, to hear the echoes of Plato’s philosopher king and of the life of service and sacrifice of Jesus Christ—remember that the Highland clans had been Roman Catholic before the Protestant Reformation.

I read Gregory to be appealing to the Highland obligation of paternalism, attempting to conserve this medieval virtue, even as it was passing out of existence in the modern world of Scottish cities and commerce. The Highland obligation of paternalism forms the basis for a kind of moral aristocracy, a phrase that would not have troubled Gregory but will, I suspect, trouble the reader. Highland paternalism, recast as Baconian openness to conviction properly regulated by candor in synergy with Humean sympathy properly regulated by tenderness and steadiness, makes Gregory’s medical ethics conservative of a moral concept that is not only premodern but antimodern.

This has an important implication for contemporary professional medical ethics. It is conservative, at its core, of the premodern and also antimodern paternalism, an intellectual and moral aristocracy of the life of service to the sick. In its conservative nature the profession of medicine transforms the sick (which is what they had been for centuries) into patients (the sick now protected by those with power over them). Indeed, the use of “patient” comes into regular use in the history of Western medical ethics only with Gregory and Percival.

The profession of medicine also displays an uneasy relationship to and therefore uneasy fit with modern, commercial society. For example, from this perspective we can see that, consensus belief notwithstanding, markets are not neutral, but predatory on lives of service. Gregory would warn us that those who call for market-place reform of medicine fail to appreciate that, if such reform succeeds,
it will destroy medicine as a profession—if it has not already been destroyed by the misguided choices of physicians and healthcare organizations in response to the changing financing of U.S. healthcare.

I add that, when we read Hume through the perspective of his appropriator, Gregory, we discover that Hume was also conserving Highland paternalism by discovering in sympathy the metaphysical basis for fellow feeling among Scots. This fellow feeling responded to a profound political crisis: the loss of the Scottish state with the Act of Union of 1707 and the lived experience of still being the Scottish nation. Hume’s account of sympathy is also conservative, making its fit with modern society uneasy.

Conclusion
What does an appropriation model of medical ethics contribute to an examination of the philosophical foundations of bioethics? Gregory started with Baconian medicine and Baconian science of morals because they produce a true and therefore reliable scientific discovery: the principle of sympathy—the constitutive component of human moral physiology. Gregory built on the moral science of sympathy a moral philosophy for medicine, expressed in the intellectual virtue of candor and the moral virtues of tenderness and steadiness. Gregory transmuted masculine moral exemplars of paternalism into feminine moral exemplars, women of learning and virtue. The result was a professional medical ethics, with modern foundations and premodern moral concepts. To use an older philosophical discourse, appropriators such as Gregory blend the logic of discovery and the logic of invention. On reliable, scientific foundations, Gregory, with Percival, invented the ethical concept of medicine as a profession. Gregory meant this to function as a feminine antidote to medicine of the Lady Macbeth type, self-interested and predatory, that had by then prevailed in the history of Western medicine for many centuries. The history of Western medical ethics and therefore bioethics pivots on Gregory and Percival, master appropriators.

Professional medical ethics appears no longer able to start with the advantage that Gregory and Percival had: foundations that are scientifically established, sciences of man and of morals, although emerging work in moral psychology might recover those foundations for us. Meanwhile, professional medical ethics relies on the logic of invention alone. As an invention, professional medical ethics will not sustain itself but must be willed into existence in the collective clinical judgments, decisions, and behaviors of physicians. Philosophy contributes powerful tools with which physicians can do the important work of sustaining professional medical ethics, but not its foundations.

References


9. See notes 7 and 8.


12. See note 7.


19. See note 15.

20. See note 15.


22. See note 15.


25. See note 15.


27. See note 3, p. 25.
Aunt Vera

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Brown University

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Aunt Vera seemed frail while I was growing up. Every year, she had colds and laryngitis. She could not swim. She had allergies; She could not enter our cat-filled home. But when I moved back to New Hampshire After my divorce, I saw that my parents were aging; Aunt Vera was not. With a scarf over her gray hair, She could pass for thirty-five. For so long she was young, but now she is old. Her hair is white. Her eyes are cloudy. Her face is lined. Her fingers are gnarled. She looks every day of eighty. She is ninety-six.

On a Putative Moral Duty to Participate in Biomedical Research

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Introduction

It seems uncontroversial to claim that biomedical research offers important benefits to humankind. From vaccinations to organ transplants to powerful drugs, many results of medical research contribute to decreased morbidity and mortality. Such benefits, however, would be difficult to obtain without the help of research participants. Hence, some have argued that people have a moral obligation to participate in research. Some have defended the stronger claim that research participation ought to be mandatory.

Because autonomy and voluntariness are considered central to research participation, most scholars have rejected a putative moral duty to participate in research. A variety of reasons have been offered to call into question the existence of such a duty. But discussions of a presumed moral obligation to participate in biomedical research have usually disregarded the social context in which research takes place and where such an obligation will be discharged. Such neglect is problematic for several reasons. First, discussing moral duties in a decontextualized manner is unhelpful to the real, situated human beings to whom such duties purportedly apply. Second, neglecting the social context where a putative duty to research participation will be binding runs the risk of reinforcing injustices against already disadvantaged groups. Third, when a moral duty to participate in research is defended without attending to the social context in which biomedical research takes place, one fails to identify those factors that must be altered if we are to fulfill such a duty in ways that do not disadvantage some individuals or groups.

Most people hold biomedical research in high regard. Thus, it seems imperative that in discussing a moral duty to participate in such research we carefully reflect on those factors that might perpetuate injustices against some people. The purpose of this paper is to call attention to the social context in which a putative duty to participate in research obtains. I will focus on several institutional aspects of the research enterprise: compensation for injury-related research; access to biomedical research products; and practices affecting the scientific and social value of biomedical research.

I will focus this paper on clinical research in the U.S. context. Thus, some of the concerns raised here might not be applicable to other countries. Also, I do not claim that the discussion here constitutes an exhaustive evaluation of all the contextual factors that might be relevant in assessing the duty to participate in research. Many other aspects of our social structures, political institutions, scientific practices, or public policies also might need to be taken into account. Finally, my arguments should not be taken as a rejection of a duty to participate in biomedical research. That duty might well exist, but my concern here is to call attention to some factors that must be considered if such a duty is going to be discharged in ways that are unlikely to further injustices against some people.

Compensating Subjects for Research-Related Injuries

Although evidence about the severity, types, costs, and frequency of injuries that are the result of participating in clinical trials is scarce, such injuries do happen. Research-related injuries might be minor, such as bruises from injections, or devastating ones such as those suffered by research subjects in the recent trial of the monoclonal antibody TGN1412, where six healthy volunteers were affected by multiple organ failure. In some cases such injuries might require emergency care only, but other injuries might result in chronic diseases or a disability that might require medical care for a number of years or the rest of the subject’s life. Given the emotional and economic consequences for subjects of a research-related injury, it seems important that considerations about a duty to participate in research take into account present practices on compensation to subjects who are injured as a result of participating in biomedical research.

Unfortunately, in spite of considerable discussion on this issue over the last twenty years, and despite the fact that compelling ethical arguments for providing compensation for research-related injuries exist, current federal policy on compensation for a research-related injury is far from desirable. Calls from national ethics commissions and the Institute of Medicine to develop a federal policy to compensate research participants who are injured as a direct result of participating in research have been disregarded. Indeed, under current federal regulations, research centers are not required to offer compensation to human subjects who suffer injuries caused by research. This non-compensation policy extends to reimbursement for medical expenses. The Common Rule only calls for informing subjects who participate in research involving more than minimal risk as to whether any medical treatment will be available if injury occurs, and, if so, what that treatment is.

Not surprisingly, recent studies have shown that compensation policies in U.S. medical schools are both quite variable and inadequate. A survey of 113 schools revealed that when the research is sponsored by NIH funding, a majority of
the schools (78 percent) offer no compensation for medical care costs, or their financial responsibility is left unclear. Many of the policies that offer some financial support for medical costs resulting from research-related injuries pay only for emergency medical care. Similarly, none of the schools surveyed offers to compensate subjects for lost wages, or pain and suffering.

Although in some cases insurance companies may cover the medical bills that result from a research-related injury, many of them might not. Because of insurance deductibles, co-payments, and lifetime benefit limits, injuries in clinical trials can be a very costly experience for injured subjects even if they have medical insurance. Furthermore, because millions of people lack insurance or are underinsured, if they are injured as a result of their participation in research they will be responsible for medical bills and associated costs. Unfortunately, lack of or insufficient financial support for medical or other costs is not the only problem subjects face when dealing with compensation policies. The language of plans for such research-related injury policies is also excessively complicated.\(^9\) The mean reading grade level of liability text in consent forms is even higher than that in other paragraphs of the consent document. Indeed, although federal regulations require that the information given to research subjects must be in a language understandable to the subject (8th grade reading level), in 75 percent of the schools surveyed the reading level for this section of the consent was at least at 12th grade. Furthermore, although federal regulations ban the use of exculpatory language from consent forms, few of the policies indicate that subjects have a right to obtain legal advice if they are injured in a study.

As these data indicate, current compensation policies for research-related injury fail to protect subjects from the financial burden of such injuries. Although subjects who are injured as a result of research participation can bring lawsuits against different parties involved in the research, many of them will lack the means to do so. Furthermore, civil liability requires proof of fault.\(^10\) But research involves unknown risks and thus subjects might suffer injuries that are not the result of negligent behavior. It might also be difficult to prove causation, as many research subjects also suffer from particular diseases.

It seems clear, then, that by arguing for a duty to participate in research without attending to our policies for compensating subjects for injury-related research, we run the risk of overburdening research subjects with costs that arguably ought to be shouldered by sponsors. In particular, such neglect might have especially undesirable results for those who already are economically disadvantaged.

**Benefiting from Biomedical Research**

The duty to participate in research is often grounded on beneficence arguments. Because we are all beneficiaries of the medical and public health advances brought about by biomedical research, the argument goes, we have a duty to participate. Such arguments, however, must consider whether our current social context, where access to biomedical benefits depends in part on ability to pay, makes some people, especially minorities and the poor, less likely to benefit from the results of biomedical research than others. Lack of money, inadequate or nonexistent access to preventive healthcare services, the inability to access adequate information about medical innovations, and a basic distrust of healthcare and research institutions by disadvantaged groups might prevent people from benefiting from biomedical research.

Consider, for instance, the fact that poverty rates for minority households are much higher than in the population as a whole. Thus, while 8.3 percent of non-Hispanic whites were below the poverty line in 2005, the percentages for Hispanics and blacks were 21.8 percent and 24.9 percent, respectively.\(^11\) Statistics from the U.S. Census Bureau show that in 2005 black households had the lowest median income with $30,858, while the median income for Hispanic households was $35,967. Non-Hispanic white households had a median income of $50,784 (p. 5). Minorities also have higher levels of unemployment and more often work part time, in service jobs, or in temporary jobs. In early 2007, for example, the unemployment rate for Hispanics was 5.7 percent, and that for African-Americans was 8 percent, while the rate for non-Hispanic white people was 4.1 percent.\(^12\)

Inadequate healthcare coverage is also more common in minority populations. Hispanic persons and non-Hispanic black persons are more likely to lack health insurance than non-Hispanic white persons. In 2005, over 11 percent of non-Hispanic whites were uninsured. However, the uninsured rates for blacks and Hispanics were 19.6 percent and 32.7 percent, respectively.\(^13\) In a recent report, the Institute of Medicine estimated that 18,000 preventable deaths each year are directly attributable to a lack of healthcare coverage.\(^14\) This is so because people who lack insurance are less likely to receive preventive and screening procedures or to have them in a timely manner.

About 47 million people in this country lack healthcare coverage.\(^15\) Additionally, the number and percentage of people covered by employment-based health insurance is decreasing, while private insurance coverage is becoming more and more expensive. Uninsured people are often unable to see a physician when they need to do so. They are also less likely than the insured to receive cardiovascular risk reduction, diabetes management, and recommended care services for cancer prevention.\(^16\) For instance, although the insured population met or exceeded the Healthy People 2010 target goals of 90 percent for cervical cancer screening, 70 percent for breast cancer screening, and 50 percent for colorectal cancer screening, those who are uninsured reported a much lower use of these preventive tests, with a 77 percent, 52 percent, and 29 percent use, respectively.\(^17\) Adults suffering from breast or colon cancer are more likely to die of the disease if they lack health insurance. Similarly, uninsured adults with diabetes receive fewer preventive services than individuals with health insurance.\(^18\) These patients are predominantly minority and low income. Furthermore, people without insurance are less likely to be admitted to the hospital when they are acutely ill. Those who are admitted require greater intensity of care and have worse outcomes.

Even when minorities overcome these difficulties and have access to health care, they still face other problems. Thus, a variety of studies have shown that when minorities are in the healthcare system they receive a lower quality of care.\(^19\) For instance, some studies have revealed that African-Americans with coronary syndromes receive less aggressive medical therapy, they are less likely to be treated with implantable cardioverter defibrillator therapy, and are less often referred for cardiac catheterization, percutaneous coronary interventions, and bypass surgery than whites.\(^20\) They are also less likely to be referred for cardiac rehabilitation programs that have resulted in a reduction of the recurrence of myocardial infarctions, as well as risk factors, and associated comorbidities.\(^21\) Other studies have shown that when African-Americans, both children and adults, have end-stage renal disease they are less likely to undergo renal transplantation than whites.\(^22\) Recent studies have also shown that African-American women with breast cancer suffer more under-use of appropriate adjuvant therapy, and greater delays in diagnosis and institution of treatments.\(^23\) Minority patients have poorer access to pain assessment and treatment in postoperative and emergency room settings,
and across all types of pain from acute, to cancer, to chronic nonmalignant pain.  

Given the fact that millions of people in the U.S. have little or no access to the benefits of biomedical research and that minorities are particularly affected by it, defending a duty to participate in research without taking into account this issue can also further injustices against already disadvantaged groups.

**Scientific and Social Value of Biomedical Research**

The production of reliable and valid data that can generate knowledge and/or lead to improvements in health or well being is an essential goal of biomedical research. There is thus a general agreement that only if research is scientific and socially valuable can we justify using scarce resources and exposing subjects to the risks that accompany biomedical investigations.  

But such an aim is unlikely to be achieved without an adequate control of the research that takes place and appropriate dissemination of research results. If this is the case, then considering whether there is a moral obligation to participate in research requires that we reflect on current institutional arrangements that might impinge on both the scientific and the social value of biomedical research. Arguably, if current arrangements fail to ensure such values, then it seems difficult to see why people would have a duty to become research subjects.

A significant amount of funding for biomedical research comes from private, for-profit companies. A recent survey of medical research centers in the U.S. shows that industry sponsored 79 percent of all clinical trials.  

It is not surprising, then, that industry sponsors have significant control over several aspects of the research process. In many cases, sponsors are able to impose, and medical colleges and investigators accept, restrictive provisions about design, use of data, and publication.  

For instance, according to some studies academic institutions fail to ensure that their investigators have full participation in the design of the trials. Indeed, a majority of medical schools and clinical trial researchers are willing to agree to provisions barring investigators from altering the study design. They also might accept contractual provisions that give ownership of the research data to the sponsor and that constrain access to trial data in multicenter studies. Although medical schools secure investigators’ access to data from their individual sites, they fail to guarantee access to all data from a multicenter trial. In this type of trial, however, analysis of data from an individual site alone is scientifically unsound. These restrictions might compromise both the scientific and the social value of the research.

Moreover, contractual agreements rarely allow researchers to publish their findings without restrictions. Although the overwhelming majority of medical schools and investigators do not accept provisions permitting the sponsor to determine whether results should be published, they do, however, allow sponsors to review manuscripts for a limited time before publication. A significant number of institutions and researchers also agree with provisions that grant a sponsor the right to add its own statistical analyses into manuscripts or the right to draft manuscripts reporting the research results, with the investigators’ role limited to reviewing and offering suggestions for revision.

Restrictions on a broad dissemination of research findings, both positive and negative, prevent other researchers from using evidence that might affect clinical care and precludes the critical evaluation of such findings. In many cases sponsors are allowed to prematurely terminate a study for financial or public relations reasons. It is certainly acceptable to stop studies prematurely because of efficacy, safety, or feasibility concerns. However, terminating a study for reasons such as apparent lack of commercial viability, marketing changes, or a lack of positive results upsets the risk-benefit balance of the trial because subjects would have been exposed to risks without the prospect of obtaining valuable scientific knowledge.

**Conclusion**

The debate over a presumed duty to participate in research might be useful in undermining the all-too-common practice of neglecting the importance for our ethical evaluations of the social and political conditions in which biomedical research takes place. I have argued here that we cannot afford to ignore such contextual factors when defending a moral duty to participate in biomedical research.

**Endnotes**


7. 45 C.F.R. § 46.116(a)(6).


14. Institute of Medicine, *Care without Coverage. Too Little, Too Late* (Washington, DC: National Academy Press, 2002);


Response to de Melo-Martín: “On a Putative Duty to Participate in Biomedical Research”

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My 2005 paper, “Rethinking Research Ethics,” is one of two targets of Professor de Melo-Martín’s critical remarks. I therefore want to begin today by pointing out that in my reply to critics which was published along with my article, I explicitly made the point that she is making today. There I wrote, my argument is about justice in the allocation of research risks and burdens in the context of a reasonable expectation to have a share in the rewards. In the U.S. today, in numerous explicit and veiled ways, medical resources are not distributed in accordance with justice. So long as the benefits of research are unjustly allocated here, we lack the justification for allocating the risks and burdens of research based on equality.

That said, I still believe that the duty to participate in research is neither vanquished nor diminished by existing injustice. The most that I would concede is that the prima facie duty to participate in research may be overridden by competing duties. Our ability to fulfill duties to ourselves and others is certainly sometimes compromised by the existing U.S. healthcare system, which leaves millions without access to healthcare and fails to indemnify research participants for harms incurred through their research collaboration.

Allow me to review the three inter-related arguments for a duty to participate in research so that I can go on to explain how those arguments are untouched by Prof. de Melo-Martín’s points about the social context of U.S. biomedical research.

1) The Argument from Justice - We are all vulnerable to death, pain, disability, and the loss of pleasure and freedom that may be consequent to disease. These are conditions that we all would prefer to avoid, and when we or our loved ones are afflicted, we would all want a remedy to be available. Almost everyone and almost all of their loved ones has medical needs at some point in their lives. Yet, we must acknowledge the need for improving on the standard of care for numerous conditions such as Alzheimer’s disease, Parkinson’s disease, sickle cell disease, end-stage renal disease, schizophrenia, and stroke. We need to learn about the causes and natural development of diseases, and the effectiveness of treatment for conditions such as burns, cancer, and severed spinal cords. That advance in treatment can only be achieved by studying our bodies. Study involves some sacrifice of our flesh, our privacy, our safety, our comfort, and our time. Because these basic goods are precious to everyone, non-instrumental basic principles of justice, such as equality and the anti-free-rider principle, require each to do her fair share to advance the common good. Because we each expect ourselves and our loved ones to share in the benefits
of future medical advances, at least to some degree, each of us must participate.

2) The Argument from Beneficence - Our obligation to do unto others as we would be done by leads to the same conclusion. Because we would each want effective treatment when we had a medical need, and because such medical advances require the cooperation of many in the research enterprise, non-instrumental basic principles of universalization and mutual love dictate that we should give of ourselves to help advance medical science. Our emotional and genetic interrelatedness, the lack of an adequate alternative, and the commonality of the desire benefit from medical knowledge create the participatory duty.

3) The Argument from Self-Development - We each should live our lives by taking responsibility for ourselves, in Kantian terms, as good rulers over ourselves. Looking into the future with awareness of the fragility of our bodies, we owe it to ourselves to take steps that would make it most likely that we could fend off disease and disability so as to retain our autonomy. Because biomedical research offers our best chance for achieving that end, and because we cannot will an end without also willing the necessary means to achieve it, we are duty-bound to participate in research.

De Melo-Martín’s Narrow View - Professor de Melo-Martín’s position appears to derive from focusing attention on a narrow set of examples, specifically, clinical studies of pharmaceutical agents. Looking instead at the broad spectrum of biomedical research and the emerging work on personalized medicine yields different conclusions about the duty to participate in biomedical research.

Although approximately 45 million uninsured Americans have no access to primary care, we all have access to emergency medical care and to some measure of charity care, and the children of many uninsured households are covered by S-CHIP. Beyond that, many of us are hopeful that the intolerable status quo will be corrected in the not too distant future. This amounts to saying that although the current distribution of healthcare is far from just, we all do have a stake in advancing the field. In addition, even at present, a good deal of biomedical research helps everyone or everyone with a similar medical need. Public health research, disease control research, preventive medicine research, mass casualty medical research, quality assurance research, health policy research all focus on populations, leaving no one out. This amounts to saying that the social disparities are not so significant as to defuse the duty to participate in biomedical research.

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presenting arguments for this duty is the main focus of Dr. Rhodes’ comments, I will, very briefly, address her arguments. I have to confess that I do not find them very compelling. It seems to me that neither justice, nor beneficence, nor what Dr. Rhodes calls a Kantian duty of self-development can ground such an obligation to participate in research.

I think we can dismiss the claim that those who benefit from medicine without contributing to research are free riders or are acting unjustly. This is so because people pay—either through taxes, medical insurance, or out of pocket—for just about every medical benefit that one might enjoy.

Furthermore, justice might require that we each do our fair share to advance the common good, but it would be strange to say that the only way one has to advance the common good is through promoting medical research. Obviously, one can do a multiplicity of things that would serve that end.

One could argue that maybe the duty is not to advance the common good in general but a particular aspect of the common good: the prevention of disease and disability. But even if this is the case, it is clear that becoming a research subject is not the only means to contribute to morbidity and mortality prevention. Clearly, one could participate in activities that lead to a reduction of poverty, reduction of unjust inequalities, access to exercise facilities, or access to nutritious food, and so on. All of these factors, i.e., poverty, unjust inequalities, lack of nutritious food and exercise facilities, play a part in people’s health. Hence, activities that contribute toward changing these factors in adequate ways are also likely to contribute to the good of health.

Similarly, beneficence cannot ground a duty to participate in research either. As just mentioned, at most beneficence requires that we benefit others in the community, and we can do that in many ways. Even if the requirement is to benefit others in ways that can prevent morbidity and mortality, we can also do that in a variety of ways. Moreover, if the claims in my paper are correct, there are good reasons to call into question the belief that we all benefit from biomedical research in our present social context. The evidence I present in the paper shows that the benefits of biomedical research are not enjoyed by everyone. This is so both because of lack of access to such medical benefits and because current contractual practices might actually prevent possible benefits from accruing to people.

Finally, I am skeptical that biomedical research as practiced today is the best way to fend off disease and disability. I am reminded of a recent article in the American Journal of Public Health, for instance, where the authors show that correcting disparities in education-associated mortality rates would have saved more than a million lives rather than about 178 thousand that were averted by medical advances. A multitude of studies have shown, eliminating or reducing poverty would also be a very good way to fend off disease and disability. Hence, even if we accept the so-called Kantian duty of self-development, we could discharge it in other, maybe even more effective, ways.

To end, I want to address some of Dr. Rhodes’ comments that are directed towards the claims I do make in my paper. Let me begin by pointing out that what Dr. Rhodes calls my “narrow view” involves billions of dollars. Indeed, in 2005, the total funding from both private and public entities was approximately $111 billion. Industry support accounts for 57 percent of funding for biomedical research, followed by the NIH that funds 28 percent of such research. Certainly research on pharmaceutical agents and medical devices is a noteworthy part of what we call biomedical research. Indeed, the new “personalized medicine” involves a significant amount of research, and resources, in pharmacogenetics. Also, though it might be the case that research on genetics and genomics can bring about significant health benefits, it is important to also consider that many of these benefits are likely to be the result of developing new drugs and diagnostic tests. Hence, concern about the risks of biomedical research cannot be dismissed as unrelated to the so-called genetic revolution in medicine.

Dr. Rhodes also argues that although the current distribution of health care is far from just, we all do have a stake in advancing the field. If by this she means that we all have a stake in advancing fair access to health care, I certainly agree. But it is unclear in which way this supports a putative duty to participate in biomedical research. The intolerable status quo that she mentions is not the result of a lack of participants. Rather, it is the result of a variety of factors including a lack of political will to address the problem and an unjust distribution of resources. Indeed, I don’t see how advancing the field of medical research can have any effect on the problem of lack of access.

I do believe that biomedical research contributes to the common good and I think that people should consider participating in such research. But I think it is very important that, when arguing for a moral duty to participate in research, we take a careful look at the social context in which such a duty is going to be discharged. Not to do so runs the risk of furthering injustices against already disadvantaged individuals and groups.

Endnotes


Going Legal in Medicine: Financial Conflicts, Medicine, and the Public Trust

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1. Introduction

On ABC’s Nightly News Dr. Tim Johnson recently remarked that patient referrals to business entities owned by referring physicians—blood testing laboratories, ultrasound, MRI, etc.—creates a conflict situation that should be made illegal. That such a statement needs to be made at all should attract our attention. In law, the same issue simply would not arise. Financial arrangements that conflict with a lawyer’s duty to advocate for a client are both well defined and backed by enforceable sanctions. In this essay we argue that the leadership of the medical profession should visibly advocate for similar standards being placed upon themselves. Self-advocacy for more stringent legal regulations to protect patients will promote needed public trust and reinforce confidence in the leadership’s will and commitment to put patients first.
2. Financial Conflicts: Law and Medicine

In the American Bar Association's Model Rules of Conduct, Rule 1.8 states that:

(a) A lawyer shall not enter into a business transaction with a client or knowingly acquire an ownership, possessory, security or other pecuniary interest adverse to a client unless:

(1) the transaction and terms on which the lawyer acquires the interest are fair and reasonable to the client and are fully disclosed and transmitted in writing in a manner that can be reasonably understood by the client;

(2) the client is advised in writing of the desirability of seeking and is given a reasonable opportunity to seek the advice of independent legal counsel on the transaction; and

(3) the client gives informed consent, in a writing signed by the client, to the essential terms of the transaction and the lawyer’s role in the transaction, including whether the lawyer is representing the client in the transaction. (American Bar Association, 2008)

It is significant to note that one can find similar language expressed in the ethics literature of the medical profession. For example, in the American Medical Association’s (AMA) Code of Medical Ethics, we read:

Under no circumstances may physicians place their own financial interests above the welfare of their patients. The primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. For a physician unnecessarily to hospitalize a patient, prescribe a drug, or conduct diagnostic tests for the physician’s financial benefit is unethical. If a conflict develops between the physician’s financial interest and the physician’s responsibility to the patient, the conflict must be resolved to the patient’s benefit. (American Medical Association, Code of Medical Ethics: 8.03)

The AMA Code carries the point further in its section on biomedical research saying, “avoidance of real or perceived conflicts of interests in clinical research is imperative if the medical community is to ensure objectivity and maintain individual and institutional integrity” (AMA Code of Medical Ethics: 8.031). This yields the ethical standard that not only should conflict of interest be avoided, but even the appearance of such conflict.

While there is thus an ethical parallel between law and medicine, the ethical position in medicine is largely advisory rather than enforceable as it is in law. But at this point, we might want to ask why these professions should be held to a higher standard of ethical conduct than is the case in the free market generally.

3. A Higher Ethical Standard

In his book, Medicine, Money & Morals: Physicians' Conflicts of Interest, Marc Rodwin addresses our question directly. "The law considers many other professionals—lawyers, federal government officials, certain financial professionals—fiduciaries, that is, individuals obligated to work for the benefit of others and held to a higher legal standard of conduct. Fiduciary law aims to protect the party for which fiduciaries act” (Rodwin, p. xvi).

In medicine and in law, the patient, client, or fiducie is typically in a position of considerable vulnerability, both in his or her need and by the asymmetrical dimensions of the professional relationship. Regarding the vulnerability of client, patient, or fiducie in a professional relationship, the asymmetry in abstract knowledge and practical application skills is stark and evident. Typically the average citizen, even if well educated, does not possess sufficient competence to manage legal or medical affairs for himself or herself. In the area of criminal law, the point of the asymmetry was made clear by Justice Sutherland in Powell v. Alabama [287 U.S. 45 (1932)]. Sutherland writes:

Even the intelligent and educated layman has small and sometimes no skill in the science of law. If charged with crime, he is incapable, generally, of determining for himself whether the indictment is good or bad. He is unfamiliar with the rules of evidence. Left without the aid of counsel he may be put on trial without a proper charge, and convicted upon incompetent evidence, or evidence irrelevant to the issue or otherwise inadmissible. He lacks both the skill and knowledge adequately to prepare his defense, even though he has a perfect one. He requires the guiding hand of counsel at every step in the proceedings against him. Without it, though he be not guilty, he faces the danger of conviction because he does not know how to establish his innocence. (287 U.S., at 68-9)

Certainly the vulnerability of a patient in circumstances of illness and physical distress is parallel. While the example above is taken from criminal law, Sutherland’s language draws an apt analogy between the perils of a layman being left to fend for herself in the field of criminal law and the perils of a patient being left to fend for himself or herself in the field of medicine.

Rodwin writes, “...many writers on medical ethics refer to doctors as fiduciaries and espouse a fiduciary ethic. The main contribution of fiduciary law, however, is to introduce standards and institutional approaches where individuals would otherwise have to rely on trust or the market. The problem for the future is to develop means to hold doctors accountable to their fiduciary ideals” (Rodwin, p. xvi). The point again underlines the striking difference in legally defined fiduciary requirements between medicine and other professions like law. Rodwin continues to say, “[t]he organized medical profession still does not accept the need for public or enforceable standards or for measures to preclude doctors from entering into situations subject to abuse. It frames the issue as a problem of individual physicians and patients: mere personal ethics” (Rodwin, p. xvi). Tim Johnson’s opening point reveals that the same issue remains vitally alive today.

While we argue that a trust relation is the appropriate direction to pursue, rather than market controls, we also contend that market forces have undermined the physician’s role so deeply as to require further institutional sanctions for the protection of patients in legally wrought fiduciary terms. If the profession expects to maintain both the trust of the public and a healthy measure of its professional autonomy against the juggernaut of commodification, a clear message needs to be sent that the professional leadership will stand up for the soul of the profession: the priority of patients’ interests first and foremost. Our trust model thus engages a mixed approach that puts volitional trust and enforceable sanctions in a more demanding interrelationship that will require greater reflective equilibrium.

In moral terms, the profession of medicine has gone some way in meeting patient vulnerability with an oath of service and an implicit social covenant grounded in consent to such a role. The covenant also has reciprocal features that provide
societal compensation to the members of the profession for such service. In this medical-social covenant, the profession has negotiated and accepted a social arrangement that is neither market-based nor politically driven. It is a fiduciary ideal that is aimed at caring for the medical well being of persons before considerations of profits, politics, or personal self-interest. Persons as patients thus are to be regarded as logically prior to other interests and concerns, though not independent of them. This person-based priority is to be held largely in trust rather than as a relationship fully crafted and defined by law. All this is not to say that the medical profession, as public trust, does not have crucial economic, political, and legal dimensions. What it does indicate is that when a variety of factors are in conflict and cannot be reconciled equitably, the priority of patient must trump competing interests and concerns.

Fidelity to trust is the source of the medical profession’s special standing in society, and physicians, nurses, and other medical professionals are stewards of that trust. It must be noted, however, that the contractual features of the covenant have favored physicians as the greatest beneficiaries of the social largess. Physicians thereby must carry the greatest burdens of responsibility; noblesse oblige.

This trust orientation might sound a bit lofty at some, but we have outlined some real world terms that have kept this trust relationship in place. In return for maintaining the priority of patients, the profession has been remunerated by the public with the advantages of professional autonomy and the attendant goods that flow from such standing; principal among them are control over one’s work, high social status, and sizable income (Clark 2001; 2005). Similar things could of course be said about the legal profession. Our question thus reemerges: Why then the difference between medicine and law on financial conflicts?

One suggestion is that the medical profession has enjoyed a level of public trust that has far exceeded trust in the legal profession. In his book, *The Social Transformation of American Medicine*, Paul Starr details how the medical profession ascended to what he calls our “sovereign profession.” But today, there is no doubt that the medical profession has lost considerable social traction. It is also clear that business pressures have played a critical role in the medical profession’s slide from sovereignty.

Our overarching purpose is to argue that the medical profession should work vigorously to regain that stature, perhaps not under the failed model of naive trust that existed in the mid-twentieth century, but rather to “upgrade” the model with a more healthy and mature vision. Such a reinvestment will benefit not only the profession, but all of us. We believe that healthy institutions of public trust are crucial for democratic functioning, especially in our American “democracy cum capitalism.” Following thinkers like Alexander de Tocqueville (Tocqueville), we urge that institutions of trust are a crucial means of generating the civic glue that must be in place to maintain a vital democratic society; all the more so in a democracy that is concurrently rooted in the market ethos of *caveat emptor* as well as in social-political norms of litigiousness, *quid pro quo*, and adversariality.

Public trusts are neither market entities nor political institutions. Fundamentally, public trusts are person-centered rather than market-based or politically motivated. The medical profession is rooted in patient care; the legal profession in client advocacy. Public trust in the priority accorded to this relationship is the hub that holds the spokes of market and political influence on the profession in place. Similar points could be argued about education as student-centered, or divinity as parishioner-based.

Inspired by John Rawls, our contention is that a philosophical concept of the basic structure of a free society, within a scheme of social justice, refers to those economic, social, and political arrangements that define our rights and duties and influence our life prospects most when taken as a whole (Rawls). It should be obvious that our relationship to illness and disease affects our life prospects as crucially as other fundamental economic, social, and political arrangements. Consequently, the medical profession, as holders of public trust, occupies a central position in this philosophical vision of a basic structure.

So viewing the medical profession adds urgency to the issue. Aside from its obvious importance in providing medical care, we need to recognize that a society’s structural institutions teach attitudes by example. Institutions that inspire trust provide valuable civic glue and yield a largess of social capital and moral resources. Stephen Macedo of Princeton University argues that trust relations promote what he calls “substantive morality.” In economic terms, Nobel Laureate Kenneth Arrow argues that healthy trust relations function not only in moral terms, but as “social lubricants” with significant economic implications. In law, Mark A. Hall has argued that present healthcare law suffers from irreconcilable themes and principles which lead to a haphazard legal framework. This framework, Hall argues, could profit from deeper reconsideration of the role that trust plays in the structure and content of healthcare law (Hall).

The upshot is that if the medical profession is marginalized from its role as public trust into free market commodification or becomes a socialized institution (a medical utility?), we ultimately face a costly moral and economic shift in our vision of the basic social structure itself. We believe that such a shift would be a serious mistake for all of us.

4. Going Legal

Our positive suggestion, regarding the problem of trust and financial conflict of interest, is to urge the professional leadership to take it upon themselves to press for more stringent legal and policy constraints that closely parallel those already found in the legal profession. In addition to the argument above, we invoke two more lines of argument: (1) a welfare principle, and (2) an argument by analogy.

4.1. The welfare principle

If the medical profession were to lobby for more stringent regulations to be placed upon itself, it might be objected that such a move would damage the profession in its functioning, as well as in its attractiveness for future professionals. We believe just the opposite. Things have reached such a difficult stage, especially in financial conflicts of interest, that it is appropriate to invoke a welfare principle to stem the tide of commodification that threatens to engulf the medical profession. The welfare principle tells us *it is appropriate to restrict autonomy in small amounts if significant general benefits are expected to follow*. By restricting the possibility of financial conflicts with patients, the direct benefit in protections for patients and the public is apparent. But there are other benefits.

To begin with, there is what is called the expressive function of law, whereby such self-imposed legal action is likely to send a message conveying the profession’s earnest commitment regarding the vaunted claim that the benefit of the patient is first and foremost. We have all heard—in days gone by—“the customer comes first.” Today, the point might seem hollow, but backing a slogan or an ethical principle with legal teeth certainly isn’t a hollow pronouncement. What such a sanction would say is, “the patient stands first and foremost, no kidding.”

While this much clarity and force on the patient-first principle might be a problem for some in the profession, it would put those same folks on notice regarding behavior that stretches...
medical practice away from its institutional and moral center. At
the same time, it gives those more readily inclined to follow the
precept a clear grounding in law to invigorate their commitment
to patients, even if the “hidden curriculum” in their institution is
in tension with the patient-first principle. It thus seems that by
yielding a modicum of autonomy on this issue, the profession
(like the rest of us) ultimately stands to gain a lot more in the
bargain.

4.2. An Analogy
Rawls doesn’t spend much time giving examples of what he
takes to be part of the basic structure of society, but one example
he does provide is that of “the institution of monogamous
marriage.” We believe there are important features of our
argument that can be fruitfully compared to the institution of
marriage. Indeed, similar questions might arise over the case
of “going legal” in marriage as in our question for the medical
profession. If a given relationship is going fine, why go legal?
Otherwise put, “If it ain’t broke, don’t fix it!”

But how is the medical relationship doing really? Perhaps it
isn’t yet entirely broken, but the strain is everywhere apparent.
There are a variety of reasons why folks decide to marry, but
often there is a desire to make a public commitment declaring
the strength and firmness of the relationship. The marriage
partners, as it were, stand before their family and peers and
their God, declaring that they have chosen to take the bond of
their prior relationship to a higher level of public commitment.
They declare a public oath and freely accept its legally binding
implications. True, doing so involves relinquishing a degree
of autonomy; but the expectation is that it is a proper price
for this higher good. Also, there might be in the minds of the
parties involved a concern for the welfare of children that might
arise from the union, and other advantages from elevated
expectations of trust among the partners.

Overlaps in the marriage analogy and the trust relation
in medicine should be fairly apparent. But the analogy is not
a tight fit. In the medical situation the role of the patient is the
overriding and unifying theme, but certainly some persons enter
into marriage without the expectation or possibility of natural
children being produced. It is also the case that marriages are
sometimes matters of families joining for enhancement of
property considerations. Nonetheless, the analogy contains
fruitful clarifications and comparisons that aid in illuminating our
increasingly fragile public trust with the medical profession.

5. Conclusion
We have argued that closer approximation to the legal
profession on the question of conflict of interest would provide
a reinvestment in the medical profession as our sovereign
public trust. Such a move, if spearheaded by the professional
leadership, would yield a net gain not only for the profession,
but for the patient, and, perhaps, for the structural health of our
basic social structure. While much of the ethics of our argument
has focused on balancing vulnerabilities through principles of
justice, it should be noted that the core professions, as person-
based institutions, make a contribution not only toward a more
just society, but also toward a society that aspires to further the
good of its citizens. So by deploying the distinctive responsibility
that professionals have for the benefit of persons first and
foremost, there arises an institutionalized ethics of care amid
the jousting ways of the free market and the social-political
structure. That posture strikes us as a distinct move in the
direction of a greater social good.

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Therapist
Andrea Nicki
University of British Columbia
You pay 22 dollars out of pocket
the therapist’s face like a round clock
the minutes that tick away
miniscule steps that reach 50
and a buzzer goes off
she has forgotten my story

Collaborative Research in Bioethics
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(The opinions expressed are those of the author and do not reflect the
position or policy of the National Institutes of Health, the Public Health
Service, or the Department of Health and Human Services.)

Collaboration is common in bioethics research, but this mode of
working has received little attention in the literature. Bioethics
research comes in two forms. Conceptual or normative
research applies methods of ethical inquiry, analysis, and
argument to topics in medicine, biomedical research, and
health policy. Empirical research employs methods of social
and psychological inquiry to ethically relevant topics in these
domains. As nearly all my bioethics scholarship has been
conceptual, I focus here mainly, but not exclusively, on this type
of collaborative bioethics research.

The most obvious reason for collaborative research in
bioethics is the interdisciplinary nature of the field. Bioethics
research draws on traditions of ethical thought studied by
philosophers and theologians; it is applied to areas of expert
knowledge and practice—medicine and medical research; it is
associated with institutional practices such as IRBs and ethics
committees; and when it takes the form of empirical research,
it adopts methods of psychosocial inquiry. Although there is
plenty of room for the solo inquirer, joint ventures drawing on
different disciplinary backgrounds and practical experience are often desirable, and sometimes necessary.

To some extent, the degree of collaboration in any given field of research is conventional. Being affiliated with the medical world, bioethics has adopted the collaborative mode characteristic of biomedical research. Collaboration is practically necessary for empirical research; however, as explained below, it is optional for conceptual research. But just as bioethicists giving presentations to medical and bioethics audiences use slides even when they have nothing graphic to convey, so they find it natural to resort to collaborative conceptual research when a given project might just as well be accomplished as a solo production. Those scholars who come from disciplines like philosophy in which collaboration is rare may need to learn how to collaborate.

For junior scholars seeking to develop a professional reputation, teaming up with an established bioethicist may boost the chance of publication by taking advantage of the mentorship of a senior scholar, and also his or her name recognition in the case of publication sources that do not use blind review. An initially advantageous strategy, however, may turn into a disadvantage, insofar as other members of the field tend to attribute the work to the senior author or wonder to what extent the junior author is responsible for the creativity and rigor of analysis that a collaborative article displays.

This latter consideration suggests that there is a political dimension to collaborative research—manifested in a drive to influence others and in the potential for jockeying for position within the collaboration. In medical journals, where bioethics scholarship is increasingly being published, two positions in the chain of listed authors carry special weight: the first author, who is considered to be the leading figure in the production and coordination of the research project, and the “senior” author, who traditionally is listed last. The expectations associated with this convention may or may not reflect the internal dynamics of a particular bioethics collaboration, especially when there are only two authors.

Two-author papers may be produced by an equal division of labor, although usually one of the authors will have had the initial idea to undertake the research—and this is often, but not necessarily, the first author. First authors usually take responsibility for writing the first draft of research papers, which may turn into a rather different paper when other authors have their turn. Sometimes the first author will have done virtually all the work, or one of the authors in a group larger than two will have contributed little if anything to the research plan, the analysis, or the final product.

Where there are issues of power and influence, ethical considerations go with the territory. “Collaboration” means working together. Hence, each author should push his or her oar, but it is not always clear what type or level of contribution merits authorship. In any case, it is awkward to exclude someone enlisted as part of a collaborative project who fails to make a meaningful contribution. Professional integrity would suggest that reputable scholars would decline to be listed as an author without having made a contribution that merits authorship, but bioethics scholarship is not immune from normal human motivations and self-deception. There are no clear rules regarding the ethics of authorship, and diverging expectations may give rise to bitter feelings. A spirit of charity helps. Perhaps every collaborative scholar should be entitled once in a while to say, “I get by with a little help from my friends.”

Yet, integrity remains important and deserves respect. Circumstances arise in which one author decides he or she must pull out of a collaboration because the work is taking a direction that can’t be endorsed. Perhaps one’s views have changed, or the stance taken conflicts too strongly with a previous intellectual commitment. One finds that there is less of a meeting of the minds than was anticipated.

It is natural that, having collaborated successfully with a colleague on a particular topic, the invitation for another joint venture will be extended if one of the collaborators is inspired to pursue a related issue. Past collaborations may give rise to a sense of obligation or entitlement with respect to future collaborations, and feelings may be hurt when such expectations are defeated. Is there a genuine moral obligation at stake here? The rules of the game are even less clear in this situation than with respect to the level of contribution that merits authorship. Navigating this terrain may call for delicate judgments; however, scholars should feel free to choose the process of inquiry, including solo authorship or a different collaboration, which seems most appropriate to the task at hand. One can legitimately claim ownership to collaborative work, but not entitlement to future collaborations that have not been agreed upon in advance.

In my experience of numerous collaborative research projects with over forty-five different colleagues, what is most distinctive and rewarding about collaborative research is a sense of teamwork and sharing in an intellectually stimulating joint venture. Few bioethics scholars, I suspect, write without receiving some comments from colleagues asked to read a draft. However, modification of one’s work based on the comments of peers or mentors, no matter how thoughtful and challenging, is qualitatively different from joint authorship. For in the latter, each author is, or ought to be, fully invested in the project. One puts one’s name to the work, signifying ownership within the collaboration and in the community of scholars. The shared commitment creates comradeship—the collaborators are in it together, sharing the joys and the frustrations of scholarship. Robert Nozick notes that romantic love creates a we relationship. There is nothing romantic about collaborative scholarship, but it does forge a bond, strengthened by a shared published product. Collaborations work best when authors forget about who contributed what and rest content in the plural voice, naturally expressed by locutions such as “We think,” “We argue,” etc.

At its best, collaboration in bioethics research is synergistic. The respective contributions of the collaborative partners are not just additive; they are interactive. Thinking is clarified, sharpened, strengthened, tested, and developed in conversations, including comments and revisions of outlines and drafts, at all stages of the project. Computer technology and email have greatly facilitated the “conversational” development of ideas, in formulations of thoughts, rapid exchange of electronic documents, and track-change revisions. At the end of the day, no paragraph, or even sentence, may remain that reflects the thought and expression of a single author.

Collaborative research necessarily involves give and take. If you want to have it only your way, then you should do it yourself. Indeed, collaborative authors are apt to think about the views of their colleagues as they write, making formulations different than they might be if written alone. Inevitably, there is compromise in the search for consensus. The parties may find themselves somewhat stretched or inhibited by virtue of the need to reach a shared and coherent perspective.

It is said that two heads are better than one. At the very least, one may have a measure of confidence that an idea or line of argument that excites the enthusiasm of a collaborating colleague has the potential to make a valuable contribution. The conversational development of ideas involves taking the perspective of another and thus challenging one’s own native
perspective. Within the collaborative relationship constructive criticism can improve one’s thinking without an all-too-natural defensiveness and dismissal of competing points of view.

Whereas dyads are easy to coordinate, three (or more) is a crowd, at least in the sense that accomplishing collaborative work is more complicated as the number of colleagues increases. The first author takes on more of the role of negotiator and team leader. Because too many cooks spoil the broth, collaborations of multiple authors may work best when one or two take a lead role in developing the key ideas and in writing the manuscript.

Are there downsides to collaborative research in bioethics? In the case of conceptual projects, where there may be no need for a division of labor in research or writing, the collaborative process may be more time-consuming and thus less efficient, other things being equal, than solo work. However, the stimulus to creativity and the pleasure of the process may well compensate for any loss of efficiency. As mentioned above, the credit that one receives in the professional community for any given collaborative paper may be diminished as compared with a solo-author contribution of comparable quality. In addition, collaborative work may suffer aesthetically, as there is less opportunity to write with a distinctive and consistent personal voice. Collaborators who are not the leaders of a joint venture will often acquiesce in the style of the lead author, with editorial modifications that seem appropriate. Work that is grafted together from separate written contributions may show signs of stylistic divergence. There are times when the lead author responsible for the first draft of the research paper finds the thoroughly revised finished product displaying a different style. This may seem strange, particularly if the first author has a strong sense of ownership; but what matters is whether the style is well-suited for conveying the message. Given the constraints of collaborative research, my favorite works of scholarship from a stylistic perspective are solo-author products.

Collaborations get started in diverse ways. Often an initial idea for a project will occur to one scholar, who then invites a colleague to join in exploring its implications, with an eye to a joint venture. In other cases, a conversation with a colleague about an interesting topic may spontaneously lead to an agreement to pursue the idea in collaborative research. One scholar might express an interest in collaborating with another, and they may search separately or together for a suitable topic. Those who are in the business of research and enjoy collaborative work are on the lookout for researchable topics and good colleagues. For example, a recent collaboration emerged from a probing query directed to me during the question and answer portion of a public presentation. Reflecting on this encounter suggested to me the potential fruitfulness of a collaboration relating to this topic with the source of the intellectual challenge—a collaboration facilitated by the magic of email. In my department, which is devoted primarily to research in bioethics, collaboration not only emerges informally along these lines, but is a planned activity of the program. Annually, fellowship candidates are recruited and selected for bioethics training. These fellows are assigned to faculty mentors who are responsible for finding suitable, often collaborative, research projects. From an institutional perspective, this commitment to collaborative research expands the reach of established scholars at the same time as it produces mentored research opportunities for scholars in training.

Collaborations proceed logistically in different ways. One of my longstanding collaborations has operated almost entirely by exchange of text, in email messages and electronic documents (formerly by regular mail and fax), without any interpersonal communication in real time. In others, the collaborative dimension of the work has occurred almost entirely in face-to-face meetings. Still others take place by means of the full range of available communicative media. There is no one best way. It depends on the personalities and preferences of the collaborative parties and their interpersonal dynamics.

I have focused on the process of collaboration in conceptual bioethics research rather than on analytical methods or suitable topics. This is precisely because there is nothing about ethical diagnosis, analysis, and argument that demands collaboration. Likewise, there are no topics of bioethics inquiry that are unique to collaborative research. In conceptual bioethics research, in contrast to empirical research, collaboration is optional. To be sure, a variety of extrinsic reasons motivate collaborative bioethics research. For example, philosopher-bioethicists can gain confidence and credibility in writing about ethical issues related to technical aspects of scientific and clinical practice by joining forces with colleagues who possess the requisite expertise. However, access to technical knowledge necessary to conduct competent bioethics research can be obtained by reading scientific and clinical literature and by talking with or observing expert practitioners. Knowledgeable colleagues can be asked to vet solo-author work for contextual accuracy.

While collaboration is rarely required in conceptual bioethics research, no topic is unsuitable for being pursued as a joint venture. Hence, the disposition to choose the collaborative mode of research is likely to reflect personal predilections and contingencies of professional life. Being only loosely affiliated with academic and research institutions during the first half of my bioethics career, and working a good deal at home, I found collaborative research a useful and rewarding antidote to professional isolation. Once the habit of collaborative research was formed, it stuck.

Bioethics collaborations fall into a variety of patterns. Empirical research in bioethics shares the division of labor characteristic of biomedical research. Different tasks and skills are required to plan and execute a project: initiating the idea, developing the research plan, designing a data collection instrument, collecting the data, providing statistical consultation and analysis, analyzing the data, writing it up. These tasks are often allocated to particular collaborators, based on their expertise, though some may be shared. In conceptual research where the bioethicist seeks to tap scientific or clinical expertise, the collaborating expert colleague may function for the most part as a consultant and sounding board, along with review and revision of the resulting manuscript. However, colleagues of very different backgrounds may work together in developing and executing the project in a more interactive mode. Fruitful collaborations also may emerge among colleagues who have similar disciplinary and professional orientations. Whenever ideas excite mutual interest among competent bioethics researchers, or other professionals interested in ethics, there is the opportunity for a profitable joint venture.

The mentorship collaboration has its own dynamic. A scholar in training or junior scholar links up with a senior bioethicist. Typically, but not always, the latter will provide the initial creative spark by selecting the topic and suggesting an approach worth pursuing. The junior colleague will execute the project under the guidance and supervision of the mentor. Although this arrangement is hierarchical, there is also genuine collegiality. Some of my most satisfying collaborations have involved working with young colleagues the same age as my children. The lines of authority are clear, but the teamwork proceeds without parental baggage. Collaborations between more senior and more junior colleagues, or between those more and less experienced in bioethics or philosophical analysis, may informally take on some of the character of
mentorship collaborations. As one gets older, generative collaborations with younger scholars may become increasingly valuable. Helping younger colleagues succeed enhances the rewards of scholarship at a time when personal ambition has diminished force.

Collaborations often have a trajectory over time, extending beyond an initial research project. When a particular collaboration proves successful, additional collaborative efforts are bound to follow. The synergy carries over to pursuing a given topic in greater depth and exploring related issues. For those who make a habit of collaborative research, polygamy is likely to prove more fruitful and rewarding than exclusive or serial monogamy. Diminishing returns of creative endeavor may set in for any collaborative team, as the familiarity and mutual reinforcement of a shared perspective may limit the development of new insights. New collaborators and multiple ongoing collaborations offer fresh perspectives and analytical approaches.

The bioethics scholar often has little sense of whether his or her work has made a valuable contribution to the thinking of others. Published work, even in the best journals, may receive little overt recognition among professional colleagues. To receive citations doesn't necessarily mean that one's work has been understood, appreciated, or even read. Nonetheless, collaborative research has interpersonal value and meaning apart from the degree of recognition by the community of scholars. It helps assure that the serious business of scholarship also is an enjoyable activity. Having fun is not insignificant, especially since the monetary rewards of bioethics research, and the opportunities to do good, are limited. Fortunate is the bioethics scholar who has an opportunity to collaborate with friends. Indeed, collaborative research is most satisfying when it creates and maintains friendship.

## ANNOUNCEMENTS

### July 25-26, 2008
The Fourth Annual Pediatric Bioethics Conference
[http://bioethics.seattlechildrens.org](http://bioethics.seattlechildrens.org)
Predicting Our Future: Genetic Testing in Children and Their Families
Bell Harbor International Conference Center
Seattle, WA

### September 25-27, 2008
Quandaries in Health Care: A Life Worth Living?: Bioethics and Disability
The Given Institute
Aspen, CO

### October 23-26, 2008
10th Annual Meeting of the American Society for Bioethics and Humanities
“Future Tense”
Renaissance Cleveland Hotel
Cleveland, OH

### 3rd November - 5th November 2008
6th Global Conference
Making Sense Of: Dying and Death
Salzburg, Austria
For further details about the conference please visit: