



Methods in Medical Ethics

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CHAPTER I



The Many Methods of Medical Ethics

(Or, Thirteen Ways of Looking at a Blackbird)

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The range of scholarship falling under the umbrella of medical ethics is astounding. For instance, the disciplines of anthropology, economics, epidemiology, health services research, history, law, literature, medicine, nursing, philosophy, social psychology, sociology, and theology all have scholars working in the field of medical ethics. Some employ unique methods. Others use similar methods but have different theoretical orientations. However, it is not always clear whether, or how appropriately, work done in many of these disciplines is considered scholarship in medical ethics. Neither is it always clear how these methods and disciplines relate to each other. In this chapter we provide a general orientation to the scope of these many methods and offer what we take to be proper interdisciplinary relationships in medical ethics.

Types of Ethical Inquiry

Philosophers hold that there are three basic types of ethical inquiry: normative ethics, metaethics, and descriptive ethics (Frankena 1973). Normative ethics is the branch of philosophical or theological inquiry that sets out to give answers to the following questions: What ought to be done? What ought not to be done? What kinds of persons ought we strive to become? Normative ethics sets out to answer these questions in a systematic, critical fashion, and to justify the answers that are offered. In medical ethics normative ethics is concerned with arguments about such topics as the morality of physician-assisted suicide or whether it is morally proper to clone human beings.

Metaethics is the branch of philosophy that investigates the meaning of moral terms, the logic and linguistics of moral reasoning, and the fundamental questions

of moral ontology, epistemology, and justification. It is the most abstract type of ethical inquiry but one vital to normative investigations. Whether or not it is explicitly acknowledged, all normative inquiry rests upon a fundamental stance regarding metaethical questions. Metaethics asks, What does “right” mean? What does “ought” mean? What is implied by saying “I ought to do X?” Is morality objective or subjective? Are there any moral truths that transcend particular cultures? If so, how does one know what these truths are? Positions regarding all of these questions lurk below the surface of most normative ethical discussions, whether in general normative ethics or in medical ethics. Sometimes it is only possible to understand the grounds upon which people disagree by investigating questions at this level of abstraction. In many cases, however, there is enough general agreement that normative inquiry can proceed without explicitly engaging metaethical questions.

Descriptive ethics does not directly engage questions of what one ought to do or the proper use of ethical terms. Descriptive ethics asks empirical questions such as, How do people think they ought to act in this particular situation of normative concern? What facts are relevant to this normative ethical inquiry? How do people actually behave in this particular circumstance of ethical concern? In medical ethics the literature is replete with descriptive ethics studies, such as surveys concerning what patients and doctors think about the morality of late-term abortions, about attitudes toward completing advance directives, or about perceptions concerning the risk of being tested for BRCA1/2 (breast and ovarian cancer susceptibility genes).

While all these types of ethical inquiry are important, normative ethics seems to be at the core of ethical inquiry. This is not to suggest that normative ethics is more intellectual or more worthwhile than other disciplines. Rather, we suggest that while the other types of ethical inquiry are inherently interesting, they are most important, meaningful, and useful because of the normative questions that are at stake. One asks, “What does the word ‘ought’ mean?” because it is very interesting and important to know what one ought to do. In general one is fundamentally interested in knowing what percentage of the population thinks something ought to be done in particular circumstances or how people actually behave in such circumstances, if it is interesting and important to know how one ought to behave in such circumstances. It is relatively uninteresting to ask, “How often should men shine their shoes?” It is much more interesting to know how a physician ought to respond when a patient asks, “Doctor, will you help me die?”

Yet, even if normative ethics is at the core of scholarship in ethics, all these types of research are interesting and important. The methods employed to answer the three types of questions necessarily differ, but each contributes something. They all help to fill in the outlines of ethical inquiry. This can be metaphorically illustrated by the Wallace Stevens poem “Thirteen Ways of Looking at a Blackbird” (1951). Stevens’s poem masterfully captures both the complexity and the advantages of looking at anything from a multiplicity of perspectives. Medical ethics is like this poem. Each of the thirteen stanzas of the poem illustrates a view of the blackbird. Each view tells us something about the viewer as well as something about the blackbird. No single view tells us what a blackbird is. But in sum, at the end of the poem, the reader has a better sense of the blackbird. That sense is ineluctably incomplete. But it is ever richer and fuller after thirteen views. As Stevens writes:

The blackbird whirled in the autumn winds.
It was a small part of the pantomime.

So it is, we suggest, with medical ethics. Neither the methods employed by philosophy nor theology nor anthropology nor history nor law nor any other methods that contribute to scholarship in medical ethics describe the blackbird called medical ethics in its entirety. But by examining a moral question from the vantage point of several different methods, one gains a richer understanding of that moral question and a better grasp of an answer. Under ideal circumstances, each method of medical ethics contributes something that is of importance for scholars who employ other methods to investigate the same questions. Each method looks at the blackbird from a different perspective. And ultimately, in health care, such research is vital not only to scholars, but above all to those practicing the healing professions. After all, medical ethics is, in large part, about what these people ought to do. And what these people do obviously has profound implications for individuals when they are sick.

☞ One Field, Many Disciplines, Many Methods

Is medical ethics a discipline in its own right? Jonsen (1998) has suggested that in a simple sense it is, but in the strictest sense it is not. Some might suggest that medical ethics is now really a single, unified discipline in which any scholar can employ any of the methods described in this book to address the question at hand, jettisoning the disciplinary boundaries and theoretical assumptions that otherwise keep these disciplines from communicating with each other. Witness, for example, the growth of graduate programs that offer degrees in “bioethics.” Others might suggest that the scholarly product would be better if each discipline were to use the methods proper to that discipline to practice medical ethics without ever bothering to examine how other disciplines examine questions in medical ethics, even if these other disciplines employ the same methods. The result is confusion over what medical ethics scholarship really is, or ought to be.

We would like to bring further conceptual clarity to this discussion by carefully distinguishing between field, discipline, and method. Borrowing from the *Oxford English Dictionary*, we define a field of inquiry as a subject matter or set of phenomena or questions addressed by a scholar or scholars. By contrast we define a discipline as a department of learning or knowledge, a community of scholars who share common assumptions about training, modes of inquiry, the kind of knowledge that is sought, and the boundaries of the subject matter proper to the discipline. Finally, we define a method as a systematic procedure, technique, or mode of inquiry that is employed in examining research questions.

We take the view that medical ethics is a single field of inquiry of great interest to many disciplines rather than a discipline in its own right. What medical ethicists share is a common subject matter, not a common disciplinary mode of investigating that subject. Their common subject matter is the normative aspect of health care. This is the medical ethicists’ blackbird. It is their field. However, they view it through the eyes of a wide variety of disciplines. These disciplines employ a wide variety of methods, some shared by several disciplines and some unique to a particular

discipline. Medical ethics is one field that embraces a variety of disciplines and methods. Thus, one conducts research in medical ethics as a philosopher or as a health services researcher or as a historian. One can certainly be cross-trained in more than one of these disciplines. But the quality of scholarship, in our view, will generally be best when investigators have a disciplinary home base. This will ensure a firm understanding of the assumptions and the limitations of the methods proper to these disciplines, as well as ensuring rigor and appropriate peer review of the research.

Childress (2007) has criticized our argument that all the various types of scholarship in this field can properly be called medical ethics. Childress would limit the use of the term to describing normative work, and the methods of medical ethics to the philosophical and theological methods described in chapters 3 through 7 in this book. In a certain sense the use of a term such as “medical ethics” is stipulative, and one can stipulate that it cover whatever set of studies one wishes. Narrowing the use of the term “medical ethics” to normative work alone, however, seems to deny the reality of the rich, complex, and multidisciplinary field that medical ethics has become. Many of the scholars whose work is described in this book, while using the techniques of nonnormative disciplines, describe themselves as medical ethicists. Many have worked as part of multidisciplinary teams, informing theory with data and orienting descriptive studies to help find solutions to knotty normative questions. What else should all this research be called? “Sociological studies contributing in a descriptive and cooperative way to the normative work of real medical ethics”? It seems simpler and truer to reality to call it all medical ethics. Further, a narrow approach, such as the one proposed by Childress, flies in the face of the standard division we have outlined between metaethics, normative ethics, and descriptive ethics, a description of the types of ethical inquiry that Childress has espoused in every edition of the famous textbook that he coauthored with Beauchamp (Beauchamp and Childress 2009, 2).

We agree with Childress that the normative questions are central, but if it is standard usage to call all this work forms of ethical investigation, and those who use these various methods are in serious dialogue with one another, sometimes even collaborating as part of the same multidisciplinary team, then it is unclear what is gained by restricting the use of the term to normative methods. While not denying the primacy of the normative, medical ethics has become an extraordinarily multidisciplinary field.

☞ Medical Ethics as an Interdisciplinary Field

Multidisciplinarity, however, is not interdisciplinarity. Although there is constant chatter about interdisciplinary research on university campuses, medical ethics is a field of inquiry with enormous potential to make that chatter real. Normative questions, as stated above, are inherently interesting. These questions are of interest to scholars in many disciplines. Sadly, however, what often seems to be missing is genuine interchange between these scholars. For example, the eyes of a lawyer or philosopher often glaze over when someone describes the statistical methods used in a research project about informed consent. Or a health services researcher can be overheard muttering something about “fluff” when a theologian begins to expatiate

about the relationship between the concepts of dignity and justice in health care. In this book we hope to move beyond these stereotypes. We realize that we cannot make a casuist into a decision-scientist in a few pages. However, part of what we hope to make possible for medical ethicists is enough of a rudimentary understanding of the other disciplines in the field to help facilitate a richer, genuinely interdisciplinary conversation in medical ethics.

If we are correct in our contention that medical ethics is an interdisciplinary field, then it is incumbent upon us to suggest how these various disciplines and methods should relate to one another. The focus of this discussion will be on the relationship between normative and descriptive methods. Although metaethical questions are important in medical ethics and often lie just beneath the surface of important normative arguments, metaethics is more part of ethics in general than part of the field of medical ethics. We therefore do not discuss metaethics further. We instead describe the proper role and the limitations of some of the methods commonly employed in normative and descriptive ethics, a topic that has received scant attention in the literature.

We begin by discussing the fact/value distinction. We believe it is critical to understand this distinction if one is to understand the role and limits of various kinds of medical ethics scholarship. We then propose a series of guidelines for the proper conduct of genuinely interdisciplinary scholarship among the various empirical and normative disciplines that contribute to medical ethics. In so doing we hope to spark further conversation, collaboration, and investigation.

☞ The Fact/Value Distinction

There is probably no single principle in ethics that is more important to discuss with respect to the relationship between descriptive and normative studies in medical ethics than the so-called fact/value distinction (Beauchamp 1982). Most (but not all) ethicists subscribe to this distinction, which is also called “the naturalistic fallacy” and the “is/ought distinction.” It was originally proposed by David Hume in *Treatise of Human Nature*, in which he noted that many ethical arguments, particularly in scholastic philosophy, consisted of a series of factual statements using the verb “is,” leading to a conclusion using the verb “ought” (Hume 1978). This struck Hume as peculiar. He wondered whether any set of facts ever added up, by itself, entailing any normative conclusion.

Over the ensuing centuries there have been many discussions of this principle. Some who have attacked the fact/value distinction have noted that certain social facts do appear to entail normative conclusions. For example, Searle (1969) points out that the fact that one has made a promise to do something does seem to imply a normative conclusion, namely, that one ought to do it. Others have argued that certain facts about the role and purpose of something or someone also seem to entail normative conclusions. MacIntyre (1984), for example, points out that the fact that something is a knife does entitle one to draw certain conclusions about what an object said to be a knife ought to be like. What makes a knife good has to do with such characteristics as sharpness and sturdiness. Likewise, he argues, the fact that someone occupies a role as the practitioner of a certain human practice does entitle one to draw conclusions

about what makes that individual a good practitioner (e.g., the fact that someone is a soldier implies that if he or she is a good soldier, one can expect courage, loyalty, dependability, and so forth). Similarly, one might say that the fact that someone is a physician entitles one to draw certain conclusions about what makes that person a good physician (e.g., competence, compassion, respectfulness, and so on).

One counterargument to both Searle and MacIntyre might be that these human purposes and social facts are already implicitly moral. These sorts of facts are different from brute facts about the world that seem to entail no normative conclusions. On this view social facts and human purposes would not truly violate the fact/value distinction because these sorts of facts already contain implicit moral premises. In reply it could be argued that there really is a purpose to being a physician. If one could better understand what it means to be an excellent physician, one would be well on one's way to having a system of medical ethics (see, for example, Pellegrino and Thomasma 1981). Although this discussion cannot be concluded here, it is important to note that questions of fact and value enfold discussions about the relationship between normative and descriptive work in medical ethics (Pellegrino 1995).

☞ Illicit Inference in Medical Ethics Research

Putting these arguments aside, even defenders of the possibility of drawing normative conclusions from certain special facts would tend to agree that the fact/value distinction holds over a variety of important sets of facts. This allows one to conclude that there are some kinds of inferences in medical ethics research that are illicit and can be avoided.

HISTORICAL FACTS DO NOT ENTAIL NORMATIVE CONCLUSIONS

One might call this the historicist version of the naturalistic fallacy. The historicist fallacy in moral argument differs from the mistakes of anachronism and essentialism in historical research (Baker and McCullough 2009). Anachronism means interpreting past events as if they had occurred in the present context. Essentialism means treating certain ideas as if they were timeless and ahistorical. The historicist fallacy, by contrast, means concluding that the moral judgments of the historical past are true merely because they are old. For example, the mere fact that infanticide was practiced in the early Mediterranean world does not entitle one to conclude that all societies should be free to decide for themselves whether to permit this practice. Likewise, the mere fact that payment for health care has never before been organized with financial incentives for physicians to provide fewer services does not entitle one to conclude that such payment structures are immoral. Whether something has or has not been done in the past does not mean that it is moral or immoral.

MAJORITY OPINIONS AND BEHAVIORS DO NOT ENTAIL NORMATIVE CONCLUSIONS

The opinion survey, which is a commonly used empirical technique in medical ethics, should never be construed to give "the answer." For example, 75 percent of young physicians in a poll might approve of sexual relationships occurring between

physicians and patients provided the physician–patient relationship, as such, is terminated once it turns sexual. However, this would not imply that the practice ought to be considered morally permissible. Likewise the fact that many physicians are willing to endorse or justify the falsification of medical insurance claims to obtain medically indicated treatments for patients does not imply that such practices are morally appropriate (Freeman et al. 1999; Wynia et al. 2000). The mere fact that almost everyone says that something is proper, or that almost everyone acts in a certain way, does not make it proper to act that way. The appeal to popular opinion can sometimes amount to an example of the informal logical fallacy of the *argumentum ad populum* (see also chapter 6).

As described in chapter 14, quantitative surveys are best viewed as tools to examine what clinical or social factors might be associated with particular opinions about moral issues, pointing out, for example, significant cultural divides. For instance, African Americans are less likely to want to forgo life-sustaining treatment than are Caucasian Americans (Barnato et al. 2009; Blackhall et al. 1999). But it is critical to understand the limitations of such survey research in ethics. Individuals may not share group beliefs, and whole cultures can be mistaken in their moral beliefs.

THE MERE FACT THAT SOMETHING IS LEGAL OR ILLEGAL DOES NOT MAKE IT MORAL OR IMMORAL

In general the moral goodness of a just society will be reflected in its laws. Even Thomas Aquinas, however, thought it unwise for a government to pass laws regarding all aspects of the moral life (*Summa Theologia* I-II, q.94, a.4, c). Such an effort would probably be impossible. And so, questions about the proper relationship between law and morality will be operative even in morally homogeneous societies.

In an increasingly multicultural democratic republic like the United States, however, in which the rule of law is predicated upon majority rule, it sometimes can be forgotten that laws do not give normative answers. Democratic procedures such as referenda, majority votes of elected representatives, or judicial decisions might settle the legal aspects of certain moral questions, but not everything that is legal is moral, and not everything that is moral is legal. Laws can be immoral. Segregation in the United States was once legal, but this does not mean that the practice was moral once and then became immoral after the law changed. Majority rule, even by free election, can commit moral error. Adolf Hitler, for example, was made chancellor of Germany by the vote of elected representatives in a democratic republic. Ethics judges the law; the law does not judge ethics.

Neither does the fact that one might be sued constitute a moral argument. The threat of a lawsuit does not render a proposed course of action moral or immoral. Legal consequences should be given the same moral weight that one generally gives to other types of consequences in making moral decisions. For instance, if one is a strict deontologist, which is basing decisions solely upon doing one's duty, legal consequences will have no bearing on the decision whatsoever. For others, the threshold might vary for taking a moral stand depending upon practical concerns. For example, under threat of lawsuit, one might not want to make a moral issue out of a patient's refusal to be weighed daily, even though one might beneficently think that from a

moral point of view, daily weighings are in the patient's best interest. On the other hand, fidelity to patients and professional integrity do sometimes demand doing what one thinks morally correct even under threat of lawsuit. Legal liability concerns are not a reliable guide to morally correct action.

To illustrate this, there are cases in which one can be sued no matter which course one pursues. For example, if a patient clearly expresses her wishes not to be placed on a ventilator and then goes into a coma, and her husband the lawyer then demands that she be intubated when she develops respiratory distress, one could be sued no matter what course one were to pursue. Successfully resuscitating the patient could invite legal action for battery. Failure to attempt resuscitation could invite legal action for negligence. The law does not settle the moral matter. One must rely on moral analysis and do what one determines to be morally right.

THE OPINIONS OF EXPERTS DO NOT NECESSARILY ENTAIL MORAL CONCLUSIONS

As Edmund Pellegrino argues in chapter 6, under certain specified conditions, tradition and opinion can form important parts of sound moral arguments. There is practical value to reliance upon expertise and tradition. But it is sometimes appropriate to be certain that reliance upon this authority is justified. For example, the mere fact that a clinical ethics consultant has recommended a course of action does not mean that this is the morally correct course of action. Expert advice can and should be obtained in morally troubling cases. The opinions of experts should be taken quite seriously. But experts often disagree, and experts can be wrong. So-called expertise among ethicists, for example, is limited by their training, knowledge, practical wisdom, and potential biases. Appeal to expert opinion represents the informal logical fallacy of the *argumentum ad verecundiam*. At times it is appropriate to challenge expertise.

THE MERE FACT THAT SOMETHING IS BIOLOGICALLY TRUE DOES NOT ENTAIL AUTOMATIC MORAL CONCLUSIONS

The mere fact that human beings do not have wings does not imply that it is immoral for human beings to fly. Likewise, the mere fact that brain wave activity begins at a certain stage of fetal development does not, in itself, imply anything about the morality of abortion at one stage of development or another.

An often-misunderstood moral theory relevant to this issue is known as natural law. It is a misconstrual of natural law theory to think that it states that morality is to be read off human biology as if one were reading a script. Properly understood, natural law ethics has more to do with a broad understanding about what it means to be a good human being and what constitutes human flourishing (Finnis 1980). Brute biological facts do not imply immediately clear moral truths.

☞ Empirical Studies and Normative Ethics

Carefully conducted empirical studies can help elucidate facts. But as discussed in detail above, the fact/value distinction precludes moral inference from brute facts. This might appear to make empirical studies irrelevant. However, such a conclusion

would be premature. There are at least eight ways in which empirical studies can be important in medical ethics.

PURELY DESCRIPTIVE STUDIES

Purely descriptive studies of what human beings believe about morality, how their beliefs change with time, and how they behave in situations of moral concern can be of enormous intellectual interest in and of themselves. Anthropological studies of how human societies differ with respect to the treatment of elderly people, for instance, can be fascinating. Differences in sexual morality can be interesting. Differences in the ways in which cultures pay for medical care, whether by government insurance, private for-profit managed care organizations, or the payment of chickens to the local shaman, can be very stimulating to learn about. Such studies need have no normative purpose.

Yet descriptive ethics studies are interesting precisely because they illuminate human responses to normative questions. To study how different cultures grow rice would be of interest to an anthropologist but not necessarily to an ethicist. When anthropologists or other social scientists apply their techniques to the study of normatively interesting questions, they are doing descriptive ethics. In many cases the relationship between normative ethics and descriptive ethics is only that normative ethics has raised the questions of interest for empirical study.

It is of interest to know, for example, why certain persons have the opinions they do about certain disputed normative questions even if the answers one gathers through survey research are acknowledged to have no normative implications. If Southerners, for example, were to be less concerned than Northerners about the ethics of vaccinating military recruits with an experimental vaccine without their consent, and this were to be found independent of race and religion, this would be an interesting empirical fact. It might lead one to ask further empirical questions or further normative questions. It deals with an interesting normative issue about research ethics but has no normative implications in itself.

An important new area of investigation in descriptive ethics is neuroethics (Illes 2005). Neuroethicists are examining the psychology, neurology, and genetics of moral decision making, especially by making use of new brain-imaging techniques. Whether these studies will have an ultimate impact on normative ethics, especially with respect to issues such as mind/brain reductionism, or freedom and determinism, is a matter of intense debate (Glannon 2009; Reichlin 2007).

A good deal of empirical research in ethics is of this nature, carefully describing anthropological, sociological, psychological, neurological, and epidemiological facts that are of interest. They are of interest because the subject is normative. But the techniques are descriptive, and the conclusions have no immediate normative implications. Nevertheless, empirical findings may introduce facts not already being considered in reaching normative conclusions, thereby better informing this work.

TESTING ESTABLISHED OR NEW NORMS

Another way in which descriptive studies can be related to normative ethics is through studies that describe compliance with existing moral norms. Again, such studies do

not answer the normative question. But provided there is widespread acceptance of a moral norm, it is of interest to study actual behavioral adherence to this norm. In studies of this type, there is no question about the norm itself. What is of interest is the extent to which human beings live up to it or the extent to which it is legally or socially enforced. For example, in the United States today, almost everyone thinks that if patients do not wish to be connected to a ventilator, they should not receive ventilator therapy. Yet, a multicenter study of critically ill patients has shown that patients' preferences are often overlooked and they frequently receive therapy they do not want (SUPPORT 1995).

In other cases new policies or procedures designed to operationalize certain moral norms are introduced into clinical settings. Descriptive studies can help to decide whether or not the plan for operationalizing the norm has been successful. For example, studies have shown that between 11 percent and 29 percent of scientific authors and presenters at conferences fail to disclose publicly discoverable financial conflicts of interest (Mayer 2006; Okike et al. 2009). This does not imply that conflicts of interest are either morally trivial or a profound moral evil. It does suggest that if one considers them morally wrong and wishes to reduce them, voluntary disclosure may be an ineffective means of doing so.

DESCRIPTIONS OF FACTS RELEVANT TO NORMATIVE ARGUMENTS

Good ethics depends upon good facts. Failure to understand thoroughly the facts of a situation will clearly lead to perils in moral decision making. Further, many normative arguments depend upon factual information, even though these facts themselves do not confer normative status upon the arguments. For example, one might argue that liver transplantation should be withheld from alcoholics because the chances of relapse of alcoholism are so high that the prognosis will be poor. In fact, it turns out that the survival of alcoholic patients who have been sober for six months and undergo liver transplantation is equivalent to that of patients transplanted for other conditions (Berlakovich et al. 1994; Björnsson et al. 2005; Hwang et al. 2006). The moral argument against transplants for alcoholics, based on a presumption of poor prognosis, is thus falsified by the facts disclosed in a descriptive study.

Reliance upon the facts in these sorts of arguments does not violate the fact/value distinction. The premises in these arguments are moral and factual, not simply factual. Such arguments are not only permissible but essential to moral reasoning.

Ethics is concerned with what to do (Aristotle *Nichomachean Ethics* 1 103b.28–31). Ethics is, in this sense, the most practical of all branches of philosophy. Moral premises relate facts to duties and virtues. Moral arguments often take forms such as the following:

1. Whenever situation X occurs, it is permissible to do Y.
2. If Z is true, then I am in situation X.
3. Therefore, if Z is true, it is permissible to do Y.

Proposition 1 is a moral premise. Proposition 2 is empirical. Empirical studies can make important contributions to ethics if they can show whether a proposition in

the form of proposition 2 is always true, or under what conditions *Z* obtains. Knowing this empirical information is critical to determining whether one is bound by the obligation in proposition 3.

For example, proposition 1 might be the moral rule known in medical ethics as therapeutic privilege (Beauchamp and Childress 2009, 124). This states that it is morally permissible to withhold information from patients (*Y*) if disclosing that information would cause the patient very grave harm (*X*). The key to applying this moral rule will be to determine under what conditions situation *X* is true. Someone might argue (as generations of physicians in the United States did up until the 1970s), that whenever patients have cancer, informing them would cause the patients great harm (Oken 1961). Physicians were constructing a moral argument based upon a proposition of the form of proposition 2: If the patient has cancer (*Z*), this is a situation in which disclosing the facts will cause the patient great harm (*X*).

This is precisely the sort of situation in which descriptive ethics can play an enormously important role in medical ethics. In the 1970s empirical studies were undertaken to show that patients with cancer overwhelmingly wanted to be told of their diagnosis and felt that they had the coping skills to handle it (Alfidi 1971). Further studies were then performed to demonstrate that patients, by and large, felt much better when they were informed of their diagnoses and perhaps even evidenced better cooperation with treatment and better outcomes. Descriptive ethics studies showed that proposition 2 was false when *Z* was cancer. Therefore, the moral conclusion, proposition 3, could not be inferred. Physicians' practices changed. By the late 1970s, 90 percent of American physicians reported that they routinely informed their patients with cancer of their diagnoses (Novack et al. 1979).

SLIPPERY SLOPE ARGUMENTS

Another way in which empirical studies can uncover facts that are relevant to normative arguments is when so-called slippery slope arguments are invoked in moral debates. Slippery slope arguments are those that suggest that if a certain moral rule is changed, other, untoward moral consequences will follow.

These sorts of moral arguments have an empirical form. The facts to which they refer, however, are facts about a possible future that has not yet been realized. Therefore, empirical studies cannot answer the question of whether or not a slippery slope *will* occur, but they can contribute to an understanding of the *likelihood* that the slippery slope will occur. Descriptive studies that can contribute to an understanding of the likelihood of slippery slopes include historical studies of similar situations, studies of other settings in which the change in moral norms has already taken place, psychological studies of those likely to be affected by the slippery slope concerns, and legal studies of statutes and case law precedents that might be relevant.

For example, important studies have been conducted about the psychology of the slippery slope. A famous example is the experiment by Milgram (1963) in which students, responding to an authority figure, were willing, gradually, to increase the voltage of what was unbeknownst to them a feigned electrical shock they delivered to a subject who responded with cries of simulated pain. This experimental evidence of a psychological slippery slope has recently been invoked to help explain how it

is that psychologists or other health professionals could become involved in torture (Olson, Soldz, and Davis 2008). And while some have demurred at pursuing so-called harm-reduction strategies with respect to drug use, arguing that such strategies will lead to increased abuse, few empirical studies have been conducted regarding the effect of such programs on the attitudes of the intended audience, giving some indication of the likelihood that such a slippery slope might come to pass (Whittingham et al. 2009).

Empirical studies thus can contribute indirectly to slippery slope arguments. Slippery slope arguments often envisage a likely future so fraught with moral danger that one ought not to engage in the social experiment of finding out whether the predicted slippery slope will come to pass, so that even pilot trials might be precluded. Slippery slope arguments can be bolstered or attacked, however, by indirect examinations of related facts that help to clarify how realistic such fears might be. Descriptive studies in ethics can thus play a key role in assessing the plausibility of slippery slope arguments.

ASSESSING LIKELY CONSEQUENCES

Empirical studies can also suggest the consequences of certain courses of action in a manner that helps moral decision makers. One need not be a utilitarian to pay attention to consequences in making moral decisions. For example, if the chances of a patient surviving an operation are only one in five thousand, the argument that it would be unjust to withhold the treatment seems much less persuasive than if the chances were one in five. Similarly, data showing that cardiopulmonary resuscitation is unlikely to be effective in patients with widespread metastatic cancer may help those who must make decisions about whether it would be appropriate to use this procedure.

THE EMPIRICAL TESTING OF NORMATIVE CLAIMS

Sometimes the relationship between normative and descriptive ethics can be very tight and very direct. This is particularly the case when normative theory prescribes practices whose components can be empirically tested. One important technique for performing such tests is based upon the moral principle, attributed to Kant, that “ought implies can” (Rescher 1987). This means that a normative argument that someone “ought” to do something necessarily entails that it is possible for the person to do it. Thus, if one can demonstrate empirically that what has been proposed as normatively required is actually impossible, one can invalidate the normative claim. Say, for example, someone has argued that all premature infants must be resuscitated, regardless of how small or premature they may be. Such a norm is invalidated by the empirical findings that for infants less than twenty-two weeks’ gestational age (Lorenz 2000) or less than 500 grams’ birth weight (Kaiser et al. 2004), survival after attempted resuscitation is virtually impossible.

Hypothetically, an interesting empirical study might be to test whether the norm of aiming for consensus truly is, as some have argued, the best decision-making strategy to use in performing ethics consults (Dubler and Liebman 2004; Moreno 1995).

A mathematical argument can be made that this will often lead to incorrect answers (Jansen 2009). If a “gold standard” correct answer could be established, ethics consults could then be modeled under two different approaches to see which gives the gold standard answer more often.

CASE REPORTS

As in other aspects of medical practice, case reports play a role in medical ethics. Careful descriptions of unusual situations can serve as a springboard for substantial normative discussion. Others who encounter similar situations in the future can benefit from having read and considered the ethical issues in a case encountered by a colleague at another institution. Those who subscribe to the theory of casuistry (moral reasoning by analogies between cases) as their sole method of approaching cases in medical ethics depend heavily upon good case descriptions (Jonsen and Toulmin 1988). Those who appeal to narrative and care-based theories of ethics depend upon “thick” descriptions of the case, including details about interpersonal dynamics and emotions that are often excluded from more traditional case discussions. Since case reports are now generally frowned upon as anecdotal and unscientific in the standard medical literature, in some ways, the case report has experienced something of a revival with the advent of medical ethics. As Jonsen points out eloquently in chapter 7, in ethics there is no escaping the case.

DEMONSTRATION PROJECTS

Descriptive ethics studies can be conducted to demonstrate the implementation of a normative idea or standard. The empirical project thus can function as a vehicle for the promulgation of a normative idea. This happens frequently in medical ethics. It is particularly common in ethics education. Few people will argue against teaching ethics to medical students or nurses, for example. But it is sometimes important simply to demonstrate that such programs can be successfully implemented (Sulmasy et al. 1994). The content of the program might be shared so that others can benefit by comparing that content with their own program’s content or that others might be inspired to start a program of their own. Pitfalls in the implementation of the program can be discussed for the benefit of others. Such empirical descriptions might also include simple survey data about the acceptability of the course and its perceived value and importance.

Similar descriptive reports can be generated regarding other programs, such as ethics consult services, ombudsperson programs for medical students experiencing ethical conflicts in relation to faculty or residents, or programs on research integrity. All of these can contribute substantially to advancing the field of medical ethics.

Finally, as described by Danis and colleagues in chapter 15, it is possible to conduct controlled trials of new policies or programs. For example, one might test the effectiveness of a new policy regarding orders not to resuscitate patients (e.g., Sulmasy et al. 2006). Causal inferences about the effectiveness of such programs are most securely made in randomized controlled trials. Even having a concurrent nonrandomized control group is much better than having no control group. Such

studies represent an important contribution of empirical research to medical ethics. They provide the best way to assess the impact (including the unintended ill effects) of new programs.

☞ Normative and Descriptive Ethics: Two-way Feedback

Based on the discussion above, it should be clear that the relationship between normative and descriptive research in medical ethics is one of two-way feedback (Pearlman, Miles, and Arnold 1993). Such work is not easy. It is important for scholars from different disciplines, when engaged in interdisciplinary work of any sort, to strive to understand each other's techniques and assumptions, and to work in an integrated way, striving to avoid the pitfall of merely working in parallel while talking past each other (Leget, Borry, and De Vries 2009). It is also true that all ethical decision making is empirical in the sense that it requires attention to empirical data about the real world (Musschenga 2005). Yet the autonomy of research disciplines must always be respected and understood in authentically interdisciplinary research. Some have called for a blurring of the autonomy of the various disciplines in favor of an integrated empirical ethics (Molewijk et al. 2004). The authors, however, appear to be conflating the necessary integration of the empirical into the making of concrete ethical decisions with the proper cooperation and mutual understanding tempered by respect for boundaries that ought to guide interdisciplinary research in ethics.

Normative and descriptive scholars can work with each other in a variety of ways. Normative ethics can generate claims that are associated with empirically testable hypotheses or set normative standards that must be operationalized and can be studied in educational or practice settings. The empirical lessons gained from such studies can, in turn, feed back upon and influence normative theory. Normative arguments may also depend upon facts that can be garnered from empirical inquiry, thus sustaining or refuting the empirical basis for the normative arguments. Descriptive ethics studies can also generate new material for normative study. Anthropological and sociological studies can raise questions about the universalizability of normative claims. Surveys can identify areas of disagreement that are ripe for ethical inquiry. Case studies can give rise to new questions that have never been addressed in normative inquiry, or can supply the entire basis for casuistic, narrative, and care-based work.

The two types of ethical inquiry are thus mutually supportive. Good studies in normative ethics will be grounded in good empirical data. Good descriptive studies will be shaped by ethical theory, providing a framework in which the data will be interpreted. Ethical reflection is enhanced when these two types of investigation are undertaken in an interdisciplinary and cooperative fashion.

☞ Conclusion

In this chapter we have tried to present a broad overview of a rather extensive field of inquiry—medical ethics. We have distinguished studies in descriptive ethics from studies in normative ethics and metaethics. We have described medical ethics as a single field of inquiry that involves multiple disciplines and multiple methods. We

have discussed the importance of the fact/value distinction and delineated how this distinction helps us to understand some illicit inferences in medical ethics research. We have suggested some norms governing the proper relationship between normative ethics and descriptive ethics and how empirical studies can properly contribute to medical ethics.

Scholarship in medical ethics is exciting, dynamic, and growing. If normative and descriptive work in medical ethics can be pursued in a truly synergistic fashion, we believe there will be extraordinary research opportunities that neither approach could fulfill alone (Singer, Siegler, and Pellegrino 1990). Medical ethics is among the few academic fields in which truly interdisciplinary study is flourishing. It would be wonderful if the flavor of this interdisciplinary field were enriched further.

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