

CRITICAL BIOETHICS: BEYOND THE SOCIAL SCIENCE CRITIQUE OF APPLIED ETHICS

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ABSTRACT

This article attempts to show a way in which social science research can contribute in a meaningful and equitable way to philosophical bioethics. It builds on the social science critique of bioethics present in the work of authors such as Renée Fox, Barry Hoffmaster and Charles Bosk, proposing the characteristics of a critical bioethics that would take social science seriously.

The social science critique claims that traditional philosophical bioethics gives a dominant role to idealised, rational thought, and tends to exclude social and cultural factors, relegating them to the status of irrelevancies. Another problem is the way in which bioethics assumes social reality divides down the same lines/categories as philosophical theories.

Critical bioethics requires bioethicists to root their enquires in empirical research, to challenge theories using evidence, to be reflexive and to be sceptical about the claims of other bioethicists, scientists and clinicians. The aim is to produce a rigorous normative analysis of lived moral experience.

I. INTRODUCTION¹

This article attempts to bridge the gap between traditional, philosophical bioethics, and the social sciences. The central thesis is that while bioethicists might pay lip-service to empirical social science's role in assessing the ethics of new technologies, they still

¹ Thanks to the members of the Genomics, Anthropology & Technology seminar group (UCL), Mike Parker, Richard Ashcroft and two anonymous referees for comments on this paper.

have some way to go to fully accept the implications of the social sciences. Consequently, there is a significant difference between ethics as presented in bioethics, and the way in which ethical reasoning takes place in the clinic, as shown by an increasing number of sociological and anthropological studies. This gap isolates bioethics from practice, undermines the validity of its claims, and reduces its contribution to policy debates surrounding bioethics topics. Building on the so-called 'social science critique' of bioethics, this article suggests ways in which empirical social science can be used in bioethics.

Often, the response from bioethicists to criticism from the social sciences is either indifference or over-defensive irritation.² I hope that this article will generate more constructive reactions. It seems to me that bioethicists are not 'anti-' the social sciences, but that sometimes the way in which the social science critique of bioethics has been presented has been overly antagonistic, and the benefits of engaging seriously with the social sciences have not always been clear.

This paper remedies these problems by proposing a moderate version of the social science critique, outlining the features of the kind of bioethics that might take social science seriously, and the gains that can be had through adopting such changes. This paper does not discuss or propose a sociology of bioethics, i.e. an analysis of the social construction of bioethical problems, and the role of social structures in shaping the way in which bioethics has developed over the past thirty years.³ Rather, it focuses on the

² E.g. M.A.M. de Wachter. Sociology and Bioethics in the USA. *Hastings Center Report* 1998; 28: 40–42. See also Renée Fox's account of bioethicists' reactions to her criticisms in: R.C. Fox. More than Bioethics. *Hastings Center Report* 1996; 26: 5–7.

³ See: R.C. Fox & J.P. Swazey. Medical Morality is not Bioethics – Medical Ethics in China and the United States. *Perspective in Biology and Medicine* 1984; 27: 336–360; P.R. Wolpe. 1998. The Triumph of Autonomy in American Bioethics: A Sociological View; and J. Guilleman. 1998. Bioethics and the Coming of the Corporation to Medicine. In *Bioethics and Society: Constructing the Ethical Enterprise*. R. DeVries & J. Subedi, eds. Upper Saddle River, NJ. Prentice Hall; C.L. Bosk. Professional Ethicist Available: Logical, Secular, Friendly. *Daedalus* 1999; 128: 47–68; J.H. Evans. A Sociological Account of the Growth of Principalism. *Hastings Center Report* 2000; 30: 31–38; M.L. Stevens. 2000. *Bioethics in America: Origins and Cultural Politics*. Baltimore and London. The Johns Hopkins Press; P.R. Wolpe. From the Bedside to Boardroom: Sociological Shifts and Bioethics. *HEC Forum* 2000; 12: 191–201; C.M. Messikomer, R.C. Fox & J.P. Swazey. The Presence and Influence of Religion in American Bioethics. *Perspective in Biology and Medicine* 2001; 44: 485–508; J.H. Evans. 2002. *Playing God?: Human Genetic Engineering and the Rationalisation of Public Bioethical Debate*. Chicago. University of Chicago Press. More conventional histories can be found

relationship between the social sciences (specifically sociology and anthropology) and bioethics.⁴ As such, this paper can be seen as a complementary piece to Erica Haimes' recent work, which addresses issues of value from a broader sociological perspective.⁵

Definitions

This paper uses the term 'bioethics' to cover a range of areas which might be described by others as 'medical ethics', 'clinical ethics', 'research ethics', and 'biomedical ethics.' While there might be arguments about the overlap of topics covered in these terms, they all conform to Daniel Callahan's definition: 'the application of ethical theory to the dilemmas raised by the practice of modern medicine, especially those problems raised by the applications of new technologies.'⁶ Many of the authors I cite in this paper focus their criticism on the very American 'four principles' approach to bioethics espoused by the Belmont Report and Beauchamp and Childress,⁷ which has itself undergone a great deal of criticism from within philosophical bioethics.⁸ But the social science critique also applies to other, meta-theoretical approaches to bioethics such as Utilitarianism or Kantianism. From this perspective, the problems of bioethics are related to its

in: A.R. Jonsen. *The Birth of Bioethics. Hastings Center Report* 1993; 23: S1-S4; D.J. Rothman. 1991. *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making*. New York. Basic Books.

⁴ Of course the social sciences are far broader than just these disciplines: one could easily include ideas from political science, economics or even history. The fact that my examples are drawn from such a limited range of disciplines is a comment on my own expertise rather than the limits of the social sciences.

⁵ E. Haimes. What can the Social Sciences Contribute to the Study of Ethics? Theoretical, Empirical and Substantive Considerations. *Bioethics* 2002; 16: 89-113.

⁶ Cited in Bosk, *op. cit.* note 3, p. 56. I don't think this view is idiosyncratic: 'With few exceptions, writers in the field who have reflected on this issue consistently affirm that both medical ethics and the somewhat broader field of "bioethics" . . . involve the self-critical application of modes of moral reasoning, in the form of ethical theory or fundamental moral principles, to the new range of questions raised by the biomedical sciences': R.M. Green. Method in Bioethics: A Troubled Assessment. *Journal of Medicine and Philosophy* 1990; 15: 179-197, p. 180. See also Evans, *op. cit.* note 3, pp. 193-195.

⁷ National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. *1979 Belmont Report*. Washington, DC. US Government Printing Office. T.L. Beauchamp & J.F. Childress. 2001. *Principles of Biomedical Ethics*. Fifth edition. Oxford. Oxford University Press.

⁸ E.g. K.D. Clouser & B. Gert. A Critique of Principlism. *Journal of Medicine and Philosophy* 1990; 15: 219-236.

grounding in applied philosophy and moral theory, not the details of which particular theory has been chosen.

One objection to this definition of bioethics is that it ignores the alternative philosophical approaches that have grown up over the past ten years, partly as a response to principlism: casuistry, narrative ethics, and pragmatics for example.⁹ Yet these are all still minority views. As the sociologist and seasoned bioethics-watcher Renée Fox notes, despite attempts to ‘break through the domination of the field by the abstract “principlism” of analytic philosophy’, and to ‘incorporate other philosophical systems into the matrix of bioethical thought . . . relatively little change has occurred in the contours, context, style of thought, or the ideology of bioethics.’¹⁰ The very fact that these approaches have appeared as challengers confirms principlism as the dominant way of doing bioethics, in the US at least.¹¹ Consequently, although the ‘applied ethics’ model (as represented by principlism) may not represent *all* opinion in bioethics, it is the mainstream approach, both in academia, the clinic, and in media representations of bioethics.¹²

Outline of paper

Section 2 presents a version of the social science critique of philosophical bioethics, constructed from the writings of a number of sociologists and anthropologists while Section 3 outlines possible responses to the critique from a bioethics position, and discusses their limitations. This is followed by the presentation of what I call ‘critical bioethics’, an alternative to the social science critique, that incorporates social science research into philosophical thinking. Finally, the conclusion speculates about the benefits to be gained from adopting this approach.

⁹ Casuistry: A.R. Jonsen & S. Toulmin. 1988. *The Abuse of Casuistry: A History of Moral Reasoning*. Berkeley and London. University of California Press. Narrative: H.L. Nelson, ed. 1997. *Stories and their Limits: Narrative Approaches to Bioethics*. New York and London. Routledge. Pragmatics: G. McGee. 1997. *The Perfect Baby: A Pragmatic Approach to Genetics*. Lanham, MD. Rowman & Littlefield Publishers.

¹⁰ R.C. Fox. Is Medical Education Asking too much of Bioethics? *Daedalus* 1999; 128: 1–25, p. 11.

¹¹ C. Bosk. 2000. The Sociological Imagination and Bioethics. In *Handbook of Medical Sociology*. C.E. Bird, P. Conrad & A.M. Fremont, eds. New Jersey. Prentice Hall.

¹² Evans, *op. cit.* note 3; Evans suggests that the dominance of principlism in American bioethics debates is a result of ethics committees’ need for a formal ‘ethical calculus’ which would allow quick, easily justified decisions.

II. THE SOCIAL SCIENCE CRITIQUE

The nature of bioethics

The critique starts by defining bioethics as ‘a highly rational, formal, largely deductive mode of argumentation’¹³ which revolves around the ‘view that moral norms are binding or prescriptive solely in virtue of their rational justification.’¹⁴ While this description might seem alien and unfamiliar when stated so baldly, a review of the literature covering mainstream approaches such as preference utilitarianism,¹⁵ rights-theory,¹⁶ and principlism¹⁷ suggests that it is fair. Applied ethics justifies its theories in terms of their rationality (rather than emotive strength, say), and from this they gain their binding force. These characteristics stem from bioethics’ origin in moral philosophy,¹⁸ and the view that good moral practice in medicine can be achieved by the application of pre-prepared ethical theories to specific situations – hence the ‘applied ethics’ model.

At this point, it is enough to note the singular nature of this relationship between theory, practice and the solution of problems. As Charles Bosk notes:

there are not many areas where we equate theoretical and practical wisdom . . . the idea that moral theory can be used to solve practical problems cuts against so many beliefs prevalent in the medical, academic, or larger political culture that we might wonder about its centrality to the bioethics enterprise.¹⁹

It is not clear why such a crucial foundation of the applied ethics model as the theory/practice divide is so under-examined, but as a result: ‘Philosophical morality concentrates on developing and

¹³ Fox, *op. cit.* note 10, p. 8. Bosk, *op. cit.* note 11, p. 401.

¹⁴ B. Hoffmaster. The Forms and Limits of Medical Ethics. *Social Science and Medicine* 1994; 39: 1155–1164, p. 1155.

¹⁵ P. Singer. 1993. *Practical Ethics*. Second edition. Cambridge. Cambridge University Press.

¹⁶ A. Gewirth. 1978. *Reason and Morality*. Chicago. University of Chicago Press.

¹⁷ Beauchamp & Childress, *op. cit.* note 7.

¹⁸ One obvious objection to the critique is that bioethics has always involved more than just philosophers. While it is certainly true that a number of different disciplines contribute to bioethics, they do so within a framework laid down by moral philosophy: ‘this system of thought was brought to bioethics . . . by its founding generation of philosophers, and reinforced by the scientific positivism of biologists and physicians, and the analytical jurisprudence of the lawyers who accompanied them’ (Fox, *op. cit.* note 10, p. 9).

¹⁹ Bosk, *op. cit.* note 3, p. 55.

justifying theories and pays little attention to the practical utilization of those theories.²⁰ Hoffmaster goes on to suggest that this leads to one of two assumptions. Either moral theories can be applied to situations with little effort, or that what problems there are in the application of theories are not worth bothering with or are at least beyond philosophical consideration. As I suggest later, it is in the application of ethical theory that the true test of bioethics comes; yet application is the area where bioethics is least vocal.

Other results of bioethics' philosophical origins are: 'that the individual is the proper measure of all things ethical, that tools for measurement transcend culture, and that there is a single, correct solution for each ethical problem, which is largely independent of person, place, or time.'²¹ Bioethics is constructed in such a way as to ignore the role of social and cultural factors, partly because since it champions an 'ideal of universal ethical principles', such variations are regarded as 'epiphenomena' and unimportant. But beyond this, bioethics is wary about the 'invocation' of social and cultural factors since they are seen to lead towards 'local meanings' and thence to moral relativism and potential disaster.²²

A strong version of this argument can be found in Ruth Macklin's work,²³ but there are elements of it in the position of those ostensibly receptive bioethicists who ask: 'How do we incorporate what we have learned [from the social sciences] into the making of good moral judgements? How do we get from the "is" of "lived experience" to the "ought" of those judgements that require us to act in some justifiable manner?'²⁴

This position seems unwilling to accept that social explanations go deeper than simply providing interesting data for bioethicists

²⁰ Hoffmaster, *op. cit.* note 14, p. 1156.

²¹ Bosk, *op. cit.* note 3, p. 62. Of course there are a number of objections to this claim, the most obvious being that there are approaches to bioethics within the 'applied ethics' model (such as Communitarianism) which reject individualistic decision-making. In addition, there are also those bioethicists outside of mainstream views who also dispute this role for the individual. As I have already suggested, I do not necessarily agree with all elements of the SSC, but merely want to present the range of positions that characterise this critique.

²² Fox, *op. cit.* note 10, p. 9.

²³ R. Macklin. 1999. *Against Relativism: Cultural Diversity and the Search for Ethical Universals in Medicine*. New York & Oxford. Oxford University Press.

²⁴ D. Callahan. The Social Sciences and the Task of Bioethics. *Daedalus* 1999; 128: 275–294, p. 288. See also: H. ten Have. 2001. Theoretical Models and Approaches to Ethics. In *Bioethics in a European Perspective*. H. ten Have H. & B. Gordijn, eds. Dordrecht. Kluwer Academic Publisher: 51–82.

to examine. The idea of a distinction between 'is' and 'ought' is assumed, while social science research suggests that at the very least such an idea needs more support (see below). The same author, Daniel Callahan, claims that: 'ethics cannot be ethics at all unless it offers some guidance in knowing how to identify an ethical problem';²⁵ failing to see that what counts as an ethical problem *in the first place*, prior to the application of ethical theory, is socially constructed. DeVries and Conrad point out that US bioethics has traditionally been silent on the topic of the ethics of healthcare funding and structure, while for many from a European perspective, inequitable access to healthcare, two tier systems, and the lack of decent health provision for over 40 million people is most definitely a topic of moral interest.²⁶ This difference suggests that 'what counts as a bioethics problem' is the result, at least in part, of social processes.

Because of this refusal to come to terms with empirical research in the way in which ethical decision making actually takes place in the clinic,²⁷ bioethics faces a difficult gap that must be bridged if it is to remain a relevant and serious discipline. How does it 'reconcile the clearly immense differences in the social and personal realities of moral life with the need to apply a universal standard to those fragments of experience that can foster not only comparison and evaluation but also action'?²⁸

This cuts deeper than simply suggesting that bioethics is empirically uninformed. A core theme is that: 'substantive moral work occurs in determining how a principle might impinge upon a particular problem, but the resources for addressing that issue are external to the principles themselves.'²⁹ The simple act of deciding how to apply a particular theory relies on ideas and concepts external to that theory, and thus beyond its consideration. Clearly

²⁵ Callahan, *op. cit.* note 24, p. 289.

²⁶ R. DeVries & P. Conrad. 1998. Why Bioethics needs Sociology. In *Bioethics and Society: Constructing the Ethical Enterprise*. R. DeVries & J. Subedi, eds. New Jersey. Prentice Hall: 233–257.

²⁷ E.g. R. Zussman. 1992. *Intensive Care: Medical Ethics and the Medical Profession*. Chicago. University of Chicago Press; R.R. Anspach. 1993. *Deciding Who Lives: Fateful Choices in the Intensive-Care Nursery*. Berkeley and London. University of California Press; R.C. Bosk. 1992. *All Gods Mistakes: Genetic Counseling in a Pediatric Hospital*. Chicago. University of Chicago Press; P. Alderson. 1990. *Choosing for Children: Parent's Consent to Surgery*. Oxford. Oxford University Press.

²⁸ A. Kleinman. Moral Experience and Ethical Reflection: Can Ethnography Reconcile Them? A Quandary for 'The New Bioethics'. *Daedalus* 1999; 128: 69–97, p. 70.

²⁹ B. Hoffmaster. Can Ethnography Save the Life of Medical Ethics? *Social Science and Medicine* 1992; 35: 1421–1431, p. 1422.

this relates to the earlier point about the gap between theory and practice; applied ethics relies on the assumption that the categories in a moral problem (e.g. 'patient', 'informed', 'non-directive', 'decent quality of life') mirror those in the ethical theory being applied. An ethical decision can then be made. But this assumes that moral decisions do not take place prior to the application of theory. As Hoffmaster points out, 'Considerable moral work gets done in deciding how a situation is to be characterized, and that moral work can determine how issues are resolved.'³⁰ For example Oonagh Corrigan's work on the nature of informed consent in clinical drugs trials shows how the decision to focus on patient autonomy and informed consent (as they are currently conceived) ignores factors which are vitally important to patients, simply because they are external to the concept of autonomy. As Corrigan notes: 'the conventional understanding of consent fails to recognise the social embeddedness of such a process . . . however noble the goal of patient autonomy, this is sometimes experienced by patients as abandonment. Informed consent is premised on an equitable doctor/patient relationship that . . . cannot always be realised.'³¹

Deciding whether children of a particular age are competent to give informed consent is a categorisation that can only be made on the basis of empirical evidence. Yet it has serious implications for ethical medical treatment, and thus such empirical research is basic 'moral work.' The apparently straightforward classification of 'people as individuals' – a product of social and political forces centuries old – has a serious effect on the kinds of ethical questions that can be asked. Such a classification is part of the hidden moral work that predates the application of bioethical theories.³²

Even an apparently simple disease category like 'cystic fibrosis' is more complicated than most bioethicists seem to assume. Anne Kerr's work on the social construction of cystic fibrosis (CF) as a genetic disease³³ shows how, since the discovery of the gene involved in CF causation in the late 1980s, the definition of what counts as CF has expanded to include a form of male infertility which was previously seen as a separate and distinct

³⁰ Hoffmaster, *op. cit.* note 14, p. 1157.

³¹ O. Corrigan. Empty Ethics: The Problem with Informed Consent. *Sociology of Health and Illness* 2003; 25: 768–792.

³² Fox & Swazey, *op. cit.* note 3.

³³ A. Kerr. (Re)Constructing Genetic Disease: The Clinical Continuum between Cystic Fibrosis and Male Infertility. *Social Studies of Science* 2000; 30: 847–894.

condition. With a detailed analysis of a range of medical and scientific papers, Kerr uncovers the internal debates over this reclassification and highlights the variable and contingent ways in which researchers propose genetic explanations. Of course we need to debate the ethical principles involved in screening new-borns for CF.³⁴ But it would also be good if bioethicists addressed the ethics of changing such disease classification in the first place.

This 'incompleteness' problem is in part a product of philosophical method. One of bioethics' distinguishing methods is 'conceptual analysis.' But while such analysis can differentiate between several different meanings of the concept 'autonomy', for example, it cannot resolve substantive issues about this term. It cannot establish which one of a number of competing concepts of autonomy occurs in the clinic. Analysing concepts cannot go on to settle a dispute over which is the 'right' kind of autonomy.³⁵ One element of resolving such a dispute requires comparison with how autonomy occurs in clinical settings, how patients view their autonomy (and that of doctors and other staff) and how difficult decisions are reached. None of this can be provided by bioethics as it is conventionally conceived. The gap between bioethics and what goes on in the clinic is such that: 'taking medical ethics to be "applied" moral philosophy simply does not fit the experience of those who have spent time in clinical settings.'³⁶

One solution to this empirical impoverishment is a radical restructuring of bioethics to such an extent that: 'medical ethics would become a very different enterprise: The boundaries between social science and philosophy, between the normative and the empirical, would come close to disappearing.'³⁷ A vocal proponent of such change is the philosopher Barry Hoffmaster who endorses the adoption of ethnography as the way to 'save' bioethics. Simply put, ethnography is the classic anthropological method (though also used by sociologists) where the investigator enters into a particular setting, observes its rituals, customs and beliefs, talks to the people there, perhaps even joins in certain aspects of their daily life, but maintains a distance from those

³⁴ E.g. G. Hermerén. Neonatal Screening: Ethical Aspects. *Acta Paediatrica* 1999; Suppl. 432: 99–103.

³⁵ Hoffmaster, *op. cit.* note 29, pp. 1422–1423.

³⁶ *Ibid.* p. 1424.

³⁷ R. Zussman. The Contribution of Sociology to Medical Ethics. *Hastings Center Report* 2000; 30: 7–11, p. 10.

studied to allow reflection on the way in which the particular setting works.³⁸

Building bioethics around such a method would have a deep and wide-ranging effect on the nature of the discipline. The focus would be on the lived experience of doctors and patients, how they make ethical decisions and talk about them. It would be 'bottom up' rather than 'top down.' And it is not at all clear what role philosophical thinking would play in such a reoriented bioethics. One problem with this extreme way of combining bioethics and the social sciences is that it unproblematically presents ethnography as *the* way to incorporate social science into bioethics.³⁹ But it is not clear that as a method, ethnography is suitable for use by bioethicists, with at least one experienced ethnographer regarding it as, in certain ways, unethical.⁴⁰ Whatever the result of this debate, we should remember that there are other social science methodologies which we can use to explore bioethics. A number of studies have looked at topics in bioethics with empirical methods such as: prenatal testing using questionnaires;⁴¹ parents' consent to their children's medical treatment using interviews;⁴² the public's view on limits to human genetic research using focus groups.⁴³ A range of methods is available to explore ethical decision-making in relation to medicine and new technologies.

In addition to these methodological worries about Hoffmaster's approach, it is not clear what intellectual space there would be for the philosopher in his version of bioethics. Rather than incorporating the best aspects of bioethics and social science, Hoffmaster seems to be advocating an aggressive take-over bid, which would reduce the role of the philosopher to a worryingly unspecified level. One aim of this current paper is to outline an alternative position, which incorporates social sciences into bioethics in a more equitable manner.

³⁸ Kleinman, *op. cit.* note 28, p. 77.

³⁹ Hoffmaster, *op. cit.* notes 29 and 14; R.C. Fox & R. DeVries. 1998. Afterward. In *Bioethics and Society: Constructing the Ethical Enterprise*. R. DeVries & J. Subedi, eds. Upper Saddle River, NJ, Prentice Hall.

⁴⁰ Bosk, *op. cit.* note 3, p. 65; C.L. Bosk. 2000. Irony, Ethnography, and Informed Consent. In *Bioethics in a Social Context*. B. Hoffmaster, ed. Philadelphia. Temple University Press: 199–220; Zussman, *op. cit.* note 37. For a reply to these concerns see: B. Hoffmaster. 2000. Afterward. In Hoffmaster, *ibid.*

⁴¹ A. Kolker & B.M. Burke. 1998. *Prenatal Testing: A Sociological Perspective*. Second edition. Westport, Conn. Bergin and Garvey.

⁴² Alderson, *op. cit.* note 27.

⁴³ A. Kerr, S. Cunningham-Burley & A. Amos. The New Genetics and Health: Mobilizing Lay Expertise. *Public Understanding Of Science* 1998; 7: 41–60.

Summary

Despite these concerns, the main complaints about bioethics outlined above do, I think, hold true:

- bioethics, founded on philosophy, gives a dominant role to idealised, rational thought;
- it tends to position individuals as the sole judge in ethical decision-making, in that it relegates social and cultural aspects to the status of at best, curios, and worst irrelevancies;
- the applied ethics model assumes that social reality cleaves down neat philosophical lines, with theoretical categories matching those in social reality: i.e. that what a philosopher says is the doctor-patient relationship actually represents the relationship between doctors and their patients in all settings. Consequently, bioethics does not have the right tools to resolve substantive moral problems, external to these categories themselves.

III. THE PHILOSOPHER'S RESPONSE

This section presents three responses to the social science critique that those based within philosophical bioethics could make.

Fact vs. value

The first position rejects a significant role for the social sciences in bioethics and revolves around the age-old distinction between fact and value. Its modern incarnation can be found in Beauchamp and Childress' well-documented separation of normative ethics (what ought to be the case) from descriptive ethics (what is the case). They discuss 'descriptive ethics' in the first chapter of their classic text *Principles of Biomedical Ethics*, calling it: 'the factual investigation of moral conduct and beliefs. It uses scientific techniques to study how people reason and act.'⁴⁴ Although Beauchamp and Childress no longer class descriptive ethics as secondary to the enterprise of 'normative ethics',⁴⁵ they are clear that bioethics involves finding ethical justification for particular actions, and that descriptive ethics is not part of mainstream bioethics research.

⁴⁴ Beauchamp & Childress, *op. cit.* note 7, p. 2.

⁴⁵ This statement was made in the 1979, first edition, of *Principles of Biomedical Ethics* but was removed in subsequent editions (pointed out in Hoffmaster, *op. cit.* note 40).

The first problem with this position is that the division between ethical *justification* (the realm of bioethics) and ethical *understanding* (what social scientists look at) does not accurately represent moral decision-making. When sociologists and other social scientists study how doctors, nurses, patients (and other people beyond the medical setting) make decisions which involve an ethical dimension they find that: 'a rigorous separation of the descriptive and the normative is practically untenable.' Such a separation 'seems to be simply an artefact of the theoretical project of justification, not an intrinsic feature of moral experience.'⁴⁶

Social scientists have presented detailed research disputing the descriptive/normative division.⁴⁷ There is empirical evidence that the fact/value distinction is at best overstated, and at worst a figment of philosophical imagination. From within the applied ethics model, one might feel that the social scientists are confusing moral epistemology with social reality. But such a view has to remain a personal opinion rather than a justified intellectual point of view, since that would involve presenting evidence and the role of evidence is not admitted by this position.

The refusal to take social science seriously is all the more ironic if one considers the kinds of empirically testable statements that philosophers make about ethics. The bioethics literature contains testable, potentially disputable statements, presented as fact. A good example of this can be found in Beauchamp and Childress' discussion of 'Top-Down Models' of ethical decision making. Such a model 'holds that we reach justified moral judgements through a structure of normative precepts that cover the judgement . . . This model is simple and *conforms to the way virtually all persons learn to think morally*.'⁴⁸ The breadth of this empirical statement is matched only by the lack of evidence for such a claim. No psychological studies are cited supporting the role of theories in individual ethical development, nor are there cross-cultural reports comparing the use of theories in ethical education in other cultures. This statement is not necessarily wrong, it is just

⁴⁶ Hoffmaster, *op. cit.* note 40, p. 2.

⁴⁷ E.g. Chapter 9 of Alderson, *op. cit.* note 42; S.R. Kaufman. Construction and Practice of Medical Responsibility: Dilemmas and Narratives from Geriatrics. *Culture, Medicine and Psychiatry* 1997; 21: 1–26; M. Lock. 1998. Perfecting Society: Reproductive Technologies, Genetic Testing, and the Planned Family in Japan. In *Pragmatic Women and Body Politics*. M. Lock & P.A. Kaufert, eds. Cambridge. Cambridge University Press: 206–239.

⁴⁸ Beauchamp & Childress, *op. cit.* note 7, p. 385, emphasis added. Also on p. 14 of the fourth edition.

that on the basis of what these authors provide, we have no way of knowing whether it is right or not. Such a relaxed use of empirical claims does no good for the theories being proposed, or for applied ethics as a whole.⁴⁹ Of course, social scientists are not immune from over-stating their positions and going beyond their empirical evidence.⁵⁰ But at the core of the social sciences is a commitment to root one's ideas in social reality, which it is not necessarily the case with philosophy.

Another objection to this position comes from the roots of moral philosophy and its acknowledgement that: 'moral theory begins in and ultimately must be tested by practice. It is hard to find a philosopher for whom practice does not remain the touchstone of the adequacy of moral theory.'⁵¹ Hoffmaster cites Aristotle, Sidgwick and even Kant as moral theorists for whom practice is the proper and full test of any moral theory. Thus even moral theory, the basis for bioethics, has to be judged in terms of practice. To isolate bioethics from the nature of moral practice is to lose touch with what bioethics is for.

The linear model

The 'linear model'⁵² of bioethics accepts that social science can play a vital role in the exploration of moral dilemmas in medicine since: 'Only empirical investigations can reveal to us the major problems actually faced by health care providers and the ways in which they deal (or think they deal) with them.'⁵³ This position suggests that if bioethics is interested in the ethics of medical practice, then to ignore *how* medicine is practised makes no sense. Brody gives the example of the gap between 'do not resuscitate

⁴⁹ While I am not claiming that *all* bioethicists make such statements, or even that a majority do (since this would require empirical research beyond the range of this article), I simply note that it is disturbing that the fourth and fifth editions of one of the most widely read and critiqued books in bioethics should contain such an apparently unsubstantiated claim. I suggest that this is less to do with the failings of individual authors, and more about the institutional attitude of bioethics towards the social sciences as a whole.

⁵⁰ For a critique of this see: A. Hedgecoe. Geneticization, Medicalisation and Polemics. *Medicine, Healthcare and Philosophy: A European Journal* 1998; 1: 235–243.

⁵¹ Hoffmaster, *op. cit.* note 29, p. 1427.

⁵² This term is taken from: J.L. Nelson. Moral Teachings from Unexpected Quarters: Lessons for Bioethics from the Social Sciences and Managed Care. *Hastings Center Report* 2000; 30: 12–17.

⁵³ B.A. Brody. Quality of Scholarship in Bioethics. *Journal of Medicine and Philosophy* 1990; 15: 161–178, p. 162.

protocols' drawn up by bioethicists and the reality of such decision-making in the clinical setting; the large number of questions that doctors ask themselves that these protocols ignore, and the kinds of alternative procedures that are options that the protocols fail to mention.⁵⁴ From this point of view, failure to get the social science right is a failure to do bioethics well.⁵⁵

This makes sense if we consider bioethicists' attitude towards biological science, and the need for bioethics to 'get the science right.' A bioethicist who failed to get the science right when discussing, for example, stem cell therapy would not be taken seriously. If bioethics is about the problems of medicine and biology, then it is reasonable to expect the discussion of the science to be as accurate and as up-to-date as possible. Of course, bioethicists rely on thought-experiments and 'what if' science fiction speculation some of the time. But when writing about the ethical dilemmas involved in a particular surgical technique for example, a bioethicist's credibility depends, to some extent, on getting the details of that technique right. All the linear model asks is that bioethicists try to get the details of people's beliefs and attitudes right as well.

Encouraging as this position is (especially as leading bioethicists support it⁵⁶), it does not satisfy the core objections of the social science critique, concerning the top down, applied ethics model of bioethics. Even worse from the critics' point of view, it presents social science as a supporting, subsidiary discipline to philosophical bioethics:

It makes the social scientist a junior partner to the philosopher, someone who responds to ideas generated elsewhere but who generates few if any ideas on his or her own. The sociologist becomes a technician and little more.⁵⁷

The social scientist contributes little to theoretical discussions about the role of particular ethical theories. Although the linear model is a vast improvement on the previous position, it still fails to incorporate social science into the theoretical level, and dis-

⁵⁴ Ibid. p. 163.

⁵⁵ Examples of work carried out in this vein include: D.W. Robertson. Ethical Theory, Ethnography, and Differences between Doctors and Nurses in Approaches to Patient Care. *Journal of Medical Ethics* 1996; 22: 292–299; A. Braunack-Meyer. Casuistry as Bioethical Method: An Empirical Perspective. *Social Science and Medicine* 2001; 53: 71–81.

⁵⁶ E.g. Callahan, *op. cit.* note 24; T. Hope. Empirical Medical Ethics. *Journal of Medical Ethics* 1999; 25: 219–220.

⁵⁷ Zussman, *op. cit.* note 37, p. 10.

tance itself from the problems of simply applying ethical theory. Hence the need for a 'critical bioethics.'

Critical bioethics

The term critical bioethics is borrowed from Lisa Parker,⁵⁸ and involves critical self-reflection on the nature of bioethics and the decisions it supports. It is an alternative to both the social science critique and the two philosophical responses to it described above. It incorporates social science research but is firmly rooted in philosophical bioethics, requiring a change in perspective, and a willingness to limit the kinds of claims about ethics that can be made. The next section presents a number of features that characterise critical bioethics, and illustrates them with examples from the social science literature.

IV. FEATURES OF A CRITICAL BIOETHICS

Although much of the above might come across as negative, and undermining of philosophical bioethics, this would be an overly sensitive interpretation of my position. Although sceptical about many aspects of traditional bioethics, I am convinced not just that we need ethical work on new medical technologies, but also that philosophy is a crucial discipline in such work. Bioethics without a philosophical input would lack much of the rigour and the 'bite' that modern medical ethics has. As Zussman notes, an ethics that simply documents the ethical practices of a specific environment could be rather conservative, propping up, rather than challenging, unsavoury systems and practices. It would:

run the risk of losing what is probably the most important contribution of medical ethics over the last quarter century: precisely the ability to import into medicine a set of ethical standards that are not native to the occupational and organizational cultures of medicine itself.⁵⁹

Critical bioethics must be more than purely descriptive if it is to judge the decisions and choices it documents. It is possible to carry out empirical research in a medical setting, apply social scientific methodology, and maintain a critical stance with regard

⁵⁸ L.S. Parker. Breast Cancer Genetic Screening and Critical Bioethics' Gaze. *Journal of Medicine and Philosophy* 1995; 20: 313–337.

⁵⁹ Zussman, *op. cit.* note 37, p. 10.

to the world you are exploring.⁶⁰ A useful comparison can be made with the debate over what role, if any, anthropologists can or should play in the promotion of human rights. While the conventional view might be that as researchers, anthropologists must remain ‘hands off’, a convincing case can be made that anthropology has fostered and furthered human rights in a number of cases (especially those of indigenous peoples).⁶¹ Critical bioethics can be just that: critical. The importance of empirical research should not stop critical bioethicists from making normative judgements.

DeVries and Conrad point out a couple of benefits for bioethics that might come from a more open attitude towards social science. If the core goal of bioethics is to ‘*provide an independent and reasoned voice in medical decision making*’, then sociology provides a richer understanding of bioethical decisions, benefiting those wanting to reason about such a topic. In addition, the relativistic ‘debunking’ nature of sociology can help bioethics maintain its independence by highlighting the power relationships that shape the profession.⁶² Such independence is all the more vital given recent concerns over the potential co-option of bioethicists by commercial interests.⁶³

Put like this, social science seems less of a threat to traditional bioethics and more like a opportunity to improve the way ethical work is done, and expand the range of topics open to ethical scrutiny. In the remainder of this section I will present a few of the characteristics that I think will be needed for a piece of work to be called ‘critical bioethics.’

Empirically rooted

Critical bioethics is rooted in empirical research. The problems, dilemmas and controversies analysed come from looking at a

⁶⁰ E.g. Renee Fox and Judith Swazey’s work in a transplant unit where they conclude that transplant surgery has become ‘overly zealous’ and has led to ‘human suffering and . . . social, cultural and spiritual harm.’ R.C. Fox & J.P. Swazey. 1992. *Spare Parts: Organ Replacement and American Society*. Oxford. Oxford University Press: 210.

⁶¹ E. Messer. Anthropology and Human Rights. *Annual Review of Anthropology* 1993; 22: 221–249; R.A. Wilson. 1997. *Human Rights, Culture and Context: Anthropological Perspectives*. London. Pluto Press.

⁶² DeVries & Conrad, *op. cit.* note 26, p. 234, all emphasis in original.

⁶³ C. Elliott. Throwing a Bone to the Watchdog. *Hastings Center Report* 2001; 31: 9–12.

particular setting (e.g. the clinic), talking to participants and taking note of what they say. In this sense, critical bioethics is a resolutely 'bottom up' approach to ethics. This does not mean that philosophers have to become social scientists; simply that if they are interested in the ethics of a particular technology, their first port of call should be the social science literature about that technology, rather than the standard bioethics debates.

For example, in her detailed and extensive investigation into prenatal testing for Down Syndrome, Rayna Rapp⁶⁴ shows how one of the least important issues for women contemplating prenatal testing and/or abortion is the moral status of the embryo. Although a 'classic' topic of concern for bioethicists,⁶⁵ a more important factor for these women is the impact the birth of a disabled child might have on already existing people and relationships:

Under circumstances of extreme misfortune, they reasoned that the burdens of motherhood tipped against the present, diagnosed fetus in favour of their commitments to other children, adults and themselves.⁶⁶

It is not that these women do not think about the foetus, that they 'blank' it out from their thoughts, but that their reasoning about what is important is different to that presented in bioethics texts. This implies that bioethicists who wish to engage with ethical decisions as they are lived in the real world would be better employed turning their attention towards the rights and duties (or principles, or utilitarian calculations) that are involved in relationships with other people, and how these are affected by the arrival of a Down's baby, rather than the moral status of the embryo.

Of course, bioethicists could object that however powerful these women's understanding of prenatal screening is, it is simply the subjective experience of a stressful, emotional medical intervention, and that as such, it has no role to play in a rational consideration of the ethics of prenatal diagnosis. As Rapp notes, 'It is hard to break into such a hermetic and self-confident

⁶⁴ R. Rapp. 2000. *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America*. New York. Routledge.

⁶⁵ E.g. D. Beylveled. 2000. The Moral Status of the Human Embryo and Fetus. In *The Ethics of Genetics in Human Procreation*. H. Haker & D. Beylveled, eds. Aldershot. Ashgate; J. Harris. 1990. Embryos and Hedgehogs: On the Moral Status of the Fetus. In *Experiments on Embryos*. A. Dyson & J. Harris, eds. New York. Routledge.

⁶⁶ Rapp, *op. cit.* note 64, pp. 307–308.

narrative',⁶⁷ but her response is to describe the women she talked to as 'moral philosophers of the private.' And it is these women who are genuine applied philosophers, working through a moral dilemma, using values and beliefs about morality to reach a decision that they then have to put into practice. Unlike most bioethicists, these women really do get to apply their philosophy. Perhaps this will still not convince the die-hard philosophical bioethicist, but it is a position that requires more engagement than simple dismissal.⁶⁸

Theory challenging

In critical bioethics, the results of empirical research feed back to challenge, and even undermine, an analyst's cherished theoretical frameworks. While it is perfectly possible for social science research to support the principlist approach (for example), it is also quite likely that in some, if not many cases, the evidence will not fit into this particular way of structuring the social world. In this situation it is important that the analyst not retreat into philosophical evasion ('all other things being equal . . .' or 'with the irrelevant complexities cleared away . . .') but accept that in this case the principlist ideas do not hold true.

Priscilla Alderson tests various theoretical frameworks against a case she came across in her research into proxy consent and allowing adults to make medical decisions for their children.⁶⁹ She finds that no single ethical theory helps the parents and doctors in the case, since there are many different competing interests and perspectives on the medical problem in question. 'To assume that there can be one neutral answer for all similar cases is to deny individual people's interests and values.'⁷⁰ This does not mean that philosophical ethical theories (covering all levels of aempirical speculation, not just traditional meta-theoretical issues) are worthless, simply that critical bioethics tests its theories in the light of empirical experience, *and changes them as a result*. Of all people, it is Beauchamp and Childress,

⁶⁷ Ibid. p. 45.

⁶⁸ I accept that many feminist bioethicists would have no problem at all with Rapp's work, and would tie it into Carol Gilligan's 'ethics of care' (C. Gilligan. 1982. *In a Different Voice: Psychological Theory and Women's Development*. Cambridge and Oxford. Oxford University Press). As I have made clear, the focus of this paper is the dominant form of bioethics as applied ethics, rather than those traditions that have grown up in response.

⁶⁹ Alderson, *op. cit.* note 42.

⁷⁰ Ibid. p. 206.

defenders of normative bioethics, who provide the best summary of the proper relationship between theory and practice:

cases provide data for theory and are theory's testing ground as well. Case leads us to modify and refine embryonic theoretical claims, especially by pointing to inadequacies in or limitations of theories.⁷¹

Critical bioethics simply applies this testing element of practice to mature, as well as 'embryonic' theories. All ethical theories are subject to revision. This, of course, undermines elements of the universalist stance adopted by traditional philosophical bioethics, a high, perhaps unacceptable, price for the philosopher to pay to engage with critical bioethics. But it is hard to see how one can take social science seriously and at the same insist on one's ethical conclusions having an absolute and universal application, without evidence to support such a claim.

Reflexive

Reflexivity is a broad term acknowledging the inter-linked nature of subject and object. At its most simple, it 'presupposes that, while saying something about the "real world", one is simultaneously disclosing something about oneself.'⁷² In describing and representing the world, we necessarily constitute that world; how a researcher reports things impacts upon those things being reported on. For many theorists, reflexivity is not an optional 'extra' but an integral part of knowledge production. The issue is whether one then acknowledges reflexivity or tries to mask it.

In critical bioethics, reflexivity works on a number of different levels. At the most personal, it is about knowing where we come from and, as bioethicists, being self-aware. Who we are in terms of class, ethnicity, profession, religion, sexuality, education and experience of medical settings (how many times we have had surgery for example) shape our instinctive and intellectual responses to biomedical technologies. An assumption of traditional bioethics is that by thinking hard in a special way, one can abstract one's mental faculties from this context and make pure, rational ethical decisions. In critical bioethics, reflexivity is about

⁷¹ T.L. Beauchamp & J.F. Childress. 1989. *Principles of Biomedical Ethics*. Second edition. New York. Oxford University Press: 16.

⁷² D. Pels. Reflexivity: One Step Up. *Theory, Culture and Society* 2000; 17: 1–25, p. 1.

acknowledging one's personal context, but not accepting that this undermines the legitimacy of one's claims.

Reflexivity concerns not just an individual's self-awareness, but the nature of knowledge production itself. This is a particular concern for some social scientists, who feel that reflexivity undermines knowledge claims and tends towards relativism,⁷³ and some of these fears have begun to seep into bioethics. The work of Tod Chambers in particular has disturbed conventional images of the value-neutral case study, and the objectivity of bioethics writing.⁷⁴ His literary analysis of the way in which bioethicists write, what they mention, what they leave out, the rhetoric they use to construct their arguments, has led some to fear that he leads bioethics towards 'rhetorical nihilism' and 'moral relativism.'⁷⁵ How are bioethicists to write case studies if they are made 'self-conscious' about the nature of their writing?⁷⁶

Solutions to such self-consciousness can be borrowed from the sociology of scientific knowledge (SSK) which has been grappling with these issues for a while. They range: from acknowledging the importance of reflexivity but not letting it interfere with the way one works;⁷⁷ through including a running commentary on the rhetorical techniques one is using in the form of footnotes or another authorial voice; to writing up one's research in the form of a one-act play, to get round the conventions of traditional types of publication.⁷⁸

Extreme as this latter solution is, the point is that reflexivity should not stop bioethicists working. It simply roots particular claims in a specific time and a place, acknowledges the social and

⁷³ For a good review of some of the issues involved, see: S. Woolgar. 1991 edition. *Knowledge and Reflexivity: New Frontiers in the Sociology of Knowledge*. London. Sage.

⁷⁴ T. Chambers. From the Ethicist's Point of View: The Literary Nature of Ethical Inquiry. *Hastings Center Report* 1996; 26: 25–33; 1999. *The Fiction of Bioethics: Cases As Literary Texts*. New York. Routledge; Centering Bioethics. *Hastings Center Report* 2000; 30: 22–29; The Fiction of Bioethics: A Précis. *American Journal Of Bioethics* 2001; 1: 40–43.

⁷⁵ A. Frank. Rhetoric, Moral Relativism and Power. *American Journal Of Bioethics* 2001; 1: 51–52.

⁷⁶ C. Elliott. What We Talk about when We Talk about Right and Wrong. *American Journal Of Bioethics* 2001; 1: 52–53.

⁷⁷ For example, see: G. Myers. 1990. *Writing Biology: Texts in the Social Construction of Scientific Knowledge*. Madison, Wisconsin. University of Wisconsin Press.

⁷⁸ M. Mulkay. 1985. *The Word and the World*. London. Allen and Unwin; M. Ashmore. 1989. *The Reflexive Thesis: Wrihting Sociology of Scientific Knowledge*. Chicago. University of Chicago Press.

cultural influences that make us who we are, but does not mean that we cannot say anything meaningful about other people's lives or about their choices. It makes us think about how bioethics came to occupy the position it does in medical settings and education, and raises issues of power and authority that we would perhaps, rather not think about.⁷⁹

Politely sceptical

DeVries and Conrad allude to the 'debunking' nature of sociology, and this is another useful tool up the critical bioethicist's sleeve: polite, informed scepticism about the claims of not just other bioethicists but, perhaps more importantly, the claims of the doctors, patients and scientists who provide the empirical element. 'Polite' means one does not necessarily dispute matters with these people; but the sceptical element means accepting that the truth is often more complex than people claim.

A good example of this is the kind of scepticism brought to scientific claims by constructivist sociologists of science. Consider the recent debate in a special issue of *Bioethics* over the use of placebo trials in developing countries to test a cheap alternative to the '076' protocol, which is standard in western countries and which cuts the transmission of HIV from mother to foetus from 25% to 8%. Unfortunately, the 076 regimen costs over US\$800, hence the search for an alternative that uses less AZT, is cheaper and thus maybe viable for developing countries. The debate in the special issue is led by a paper from David Resnik,⁸⁰ followed by a number of responses from different authors⁸¹ and a final reply from Resnik. The research that would be of use in this debate is work carried out by Steve Epstein,⁸² which could have

⁷⁹ Of course there are bioethicists who reflect upon their own role and the nature of bioethics as a whole. Carl Elliott (1999. *A Philosophical Disease: Bioethics, Culture and Identity*. New York. Routledge) is a good example, as are many of Daniel Callahan's pieces which focus on the nature of bioethics and how it has changed over the years: Doing Good and Doing Well. *Hastings Center Report* 2000; 31: 19–21; Religion and the Secularization of Bioethics. *Hastings Center Report* 1990; 20: S2–S4.

⁸⁰ D.B. Resnik. The Ethics of HIV Research in Developing Nations. *Bioethics* 1998; 12: 286–306.

⁸¹ E.g. R.K. Lie. Ethics of Placebo-Controlled Trials in Developing Countries. *Bioethics* 1998; 12: 307–311; U. Schüklenk. Unethical Perinatal HIV Transmission Trials Establish Bad Precedent. *Bioethics* 1998; 12: 312–319.

⁸² S. Epstein. 1996. *Impure Science: AIDS, Activism and the Politics of Knowledge*. Berkeley. University of California Press.

added to discussions of 'clinical equipoise'⁸³ or the attitude of people enrolled in these trials, and their access to medical treatment⁸⁴ or any number of other points.

I am not claiming that all Steven Epstein's results directly map onto debates over clinical trials in the developing world; his conclusions are specific to the time, place and socio-economic groupings that he studies (mainly homosexual AIDS activists in the US in the 1980s and early 1990s). But what we can take from his work is that: 'The notion that a "definitive" clinical trial can settle the question of drug efficacy . . . misses this fundamental point: a study's "definitiveness" is not given but is a negotiated outcome and one that may be actively resisted by some parties to the controversy.'⁸⁵ This sceptical approach to scientists' claims allows bioethicists to 'unpack' ethically controversial topics like clinical trials, and analyse the interests that underpin some of the claims made about the objectivity and reliability of scientific results. The debate in *Bioethics* largely assumed that scientific claims about the 'reality' of such clinical trials (with or without placebo) could only be challenged on ethical, rather than epistemological, grounds. By adopting the perspective of the sociology of science, new issues open up for ethical consideration: how scientific opinion about the validity of clinical trials varies; the influence of different organisations (activists, patients, regulators, funders, universities, companies) on the nature of different trials; and the nature of regulations for clinical trials.

V. CONCLUSION: TAKING SOCIAL SCIENCE SERIOUSLY

Why should bioethics take social science seriously? After all, bioethics has done rather well over the past ten years. The rise of new technologies has given professional bioethicists a voice in the media and as consultants to industry. The 5–7% of the Human Genome Project's funds dedicated to social and ethical research resulted in significant money being directed towards bioethics programmes, bioethics courses are expanding in number and the media profile of some members of the profession is impressively high. Even the fact that we can describe bioethics as a 'profession' at all indicates some degree of respectability.⁸⁶

⁸³ Resnik, *op. cit.* note 80, p. 290; *ibid.* p. 251.

⁸⁴ C. Del Río. Is Ethical Research Feasible in Developed and Developing Countries. *Bioethics* 1998; 12: 328–330.

⁸⁵ Epstein, *op. cit.* note 82, p. 334.

⁸⁶ K.Y. Kreeger. Burgeoning Crop of Bioethics Programs and Courses Reflects the Deepening of Scientist's Moral Concerns. *The Scientist* 1994; 8: 1.

Yet encouraging as this must be for philosophers, it is not clear that bioethics has had much impact on decision-making about these new technologies, or on the world of policy as a whole. A number of policy makers at a number of different levels have, over the past few years, complained about the lack of empirical evidence relating to topics such as human genetics and surrogacy.⁸⁷ For these people, the problem is not a lack of speculation about the possible long-term societal effects of surrogacy arrangements, but the need to find out how surrogacy affects people's lives here and now.

For bioethics, the danger is of being sidelined. Of course, at the moment, bioethicists far outnumber social scientists on government advisory committees. Yet this may be more a result of historical contingency than a mark of philosophy's strength. The kinds of answers required by policy-makers are the kinds of things that social scientists are better at providing. Unless bioethicists can engage with these answers in a meaningful way, they run the risk of being cut out of the policy-making loop, and being isolated from the kinds of decisions that bioethics has always aspired to influence.⁸⁸

For some social scientists, the isolation of bioethics from the policy-making process might come as suitable come-uppance for the perceived high-jack (from the social sciences) and subsequent dominance of questions of value and ethics in medicine.⁸⁹ But the policy arena with bioethics removed would be sadly impoverished, lacking the benefits that philosophical analysis can bring to such discussions. At the same time, critical bioethics requires philoso-

⁸⁷ House of Commons Science and Technology Committee. 1995. *Third Report: Human Genetics: The Science and its Consequences*. London. HMSO; O. O'Neill. What would the HGAC have liked to Know about Genetics Research? Presentation at 'The Wellcome Trust Society and Genetics: Research Training Course', 11–14 September, 1999. Hinxton Hall, Cambridge; M. Brazier, A. Campbell & S. Golombok. 1998. *Surrogacy: Review for Health Ministers for Current Arrangements for Payments and Regulation*. London. Department of Health; T. Wilkie. Navigating the Moral Maze: The Biomedical Ethics Programme. *Wellcome News* 1998; 14: 8–9.

⁸⁸ R.W. Momeyer. Philosophy and the Public Policy Process: Inside, Outside, or Nowhere at all? *Journal of Medicine and Philosophy* 1990; 15: 391–409; D. Stermerding & J. Jelsma. Compensatory Ethics for the Human Genome Project. *Science as Culture* 1996; 5: 335–351; S. Lehrman. What ever Happened to ELISI? *Geneletter* 2000; 1: <http://www.geneletter.com/08-01-00/features/elsi.html>.

⁸⁹ Charles Bosk points out: 'the contribution of sociologists to topics bioethical is as remarkable as it is unappreciated . . . the sociological involvement with these issues predates bioethics as either an organized domain of inquiry or an emergent professional occupation' (Bosk, *op. cit.* note 40, p. 398).

phers to accept that there are some questions that they cannot answer, and that trying to answer them through adopting certain philosophical methods may be counter productive.⁹⁰

This list of features for a critical bioethics is tentative and others may want to add or subtract elements. What I have proposed is not a methodology, but more a way to help bioethicists develop a 'sociological imagination.'⁹¹ Of course the demands of critical bioethics may conflict with traditional philosophical research, but it is worth noting that bioethicists seem quite capable of carrying out empirical social science research, without losing their sense of disciplinary identity, while accepting that the way things are can tell us something about the way things ought to be.⁹²

Yet until such work is attempted, we will not know whether a critical bioethics is possible. It seems a very modest proposal that traditional bioethics engage with the social sciences through adopting these basic features.

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⁹⁰ For example, thought-experiments or analyses which rely on ideas like 'it is conceivable that' as the basis for action can be applied to questions best answered by empirical research. But the end result of such philosophical work does not answer these questions in any helpful way.

⁹¹ Both DeVries & Conrad, *op. cit.* note 26, and Charles Bosk, *op. cit.* note 40 adopt C. Wright Mills' famous phrase: C.W. Mills. 1959. *The Sociological Imagination*. New York. Oxford University Press.

⁹² E.g. S. Hølm. 1997. *Ethical Problems in Clinical Practice*. Manchester and New York. Manchester University Press; or the work of Laura Siminoff and colleagues: J.G. Adams, R. Arnold, L. Siminoff & A.B. Wolfson. Ethical Conflicts in the Prehospital Setting. *Annals of Emergency Medicine* 1992; 21: 1259–1265; S.K. Hoge, C. Lidz, E. Mulvey, L. Roth, N. Bennett, L. Siminoff, R. Arnold & J. Monahan. Patient, Family, and Staff Perceptions of Coercion in Mental-Hospital Admission – An Exploratory-Study. *Behavioral Sciences & the Law* 1993; 11: 281–293; L.A. Siminoff, R.M. Arnold & J. Hewlett. The Process of Organ Donation and its Effect on Consent. *Clinical Transplantation* 2001; 15: 39–47. I am not claiming that what these authors are doing is 'critical bioethics' or that they would agree with the whole of this paper, simply that their work supports the idea that a critical bioethics is methodologically possible.