Moral Particularism:

Implications in Medical Ethics

Alan James Green

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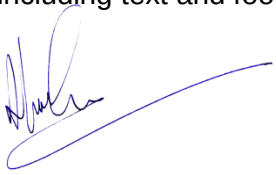
Signature of candidate  Date ……26/03/2003…

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Abstract

Particularism challenges the accepted idea of normative moral theory that morality can be reduced to a finite set of fundamental principles; it sees morality as quite capable of getting on without such principles. This thesis is concerned with asking what, if any, changes would be required in the practice of medical ethics if this is correct.

It is proposed that current guidelines for professional clinicians and medical scientists constitute a "fleshed out" normative system which provides *pro tanto* rules for ethical practice. To investigate the implications of this in a particularist world, the idea of thin and thick moral concepts is extended to cover moral principles so that generalist professional guidance is seen as constituted of thick principles. This guidance aims to provide the required confidence for the doctor-patient relationship and in particular for the trust required between doctor and patient.

Examples of the development of protocols for early phase clinical trials in cancer, and of resource allocation in a resource limited system are used to investigate the difference in decision making, and thus in the decisions themselves, between generalist and particularist professionals. In a generalist world trust is placed in the systems of trustworthiness (practice guidelines etc) and thus in the developers of such systems; in a particularist world moral decisions are made by the clinician and so trust is placed much more directly in that clinician.

The implications of this analysis are that under particularism medical ethical training (initial and continuing) would focus more on the development of moral character of the various professionals and less of following guidelines. The complexity of modern medicine implies that such guidelines would still be required, but they would no longer represent *pro tanto* duties, but rather *ceteris paribus* advice.

Contents

Acronyms and abbreviations

AChEIs	Acetylcholinesterase inhibitors (a class of drug used in Alzheimer's Disease)
AD	Alzheimer's Disease
BBC	British Broadcasting Corporation
CPD	Continuing Professional Development
CT	(X-ray or "conventional") Computed Tomography
DoH	Department of Health (UK)
G*P	This term is used to cover the general collection of good practice guidelines
GCP	Good Clinical Practice
GLP	Good Laboratory Practice
GMC	General Medical Council
GMP	Good Medical Practice
GP	General Practitioner
HCPC	Health and Care Professions Council
IR(ME)R	Ionising radiation (medical exposures) regulations
IVF	*In vitro* fertilisation
MDT	Multi-disciplinary team
MI	Molecular Imaging
MMR	Measles, Mumps and Rubella (the three diseases addressed by the "triple vaccine")
MRT	Molecular Radiotherapy
NHS	National Health Service
NICE	The National Institute for Health and Clinical Excellence
QALY	Quality Adjusted Life Year
SOP	Standard Operating Procedure
SPECT	Single Photon Emission Computed Tomography

1 Introduction

"Those are my principles, and if you don't like them… well, I have others" Groucho Marx

1.1 Introduction

This thesis is submitted in the field of Medical Ethics; in it I have tried to answer the questions, "If moral particularism is true, are there any implications for how clinical and non-clinical professionals in medicine should conduct their practice?", and, "If so, what are they?"

I will assume that the reader has a reasonable level of knowledge in ethics and will not try to mount a defence of any particular theory either of medical ethics or of either side in the particularism/generalism debate.

"Normative ethics involves arriving at moral standards that regulate right and wrong conduct", so says James Feiser in "Metaethics, Normative Ethics and Applied Ethics" (Fieser 2000 p139). Normative ethics is the study of general theories of what one ought (in a moral sense) to do. In this sense it is concerned with elucidating the general principles under which we make moral decisions. In §1.2 I will briefly discuss the three current main families of normative theories to indicate what aspects of them I will focus on in the main thesis. Theories about normative theories are the realm of meta theories[1]and it is here that particularism is found. Particularism can be seen as a claim that much of normative theory is at best redundant, "A particularist conception is one which sees little if any role for moral principles. Particularists think that moral judgement can get along perfectly well without any appeal to principles" (Dancy 2004 p1), I will

[1] I am grateful to one of my examiners for the suggestion that it is not obvious that the particularist/generalist debate is a metaethical one. "Meta-noramative-ethical" was suggested as better describing the ground on which the debate takes place. I will use the shorter "meta-normative" in this thesis.

briefly introduce this in §1.3. On what might be thought of as the opposite side of normative theory is the realm of practical ethics within which is medical ethics. Medical ethics looks at how ethically correct decisions are made in medical practice, and at how professionals within medicine can make such decisions.

1.2 Three normative theories

Much modern moral philosophy can be seen as an exploration of, and a debate about, three major theories. A full history and exploration of these is not appropriate in this thesis but some scene setting will be useful as a preamble to the main topics.

1.2.1 Deontology

Deontology (the study of duty from the Greek *deon* (duty) and *logos* (science or study)) is generally seen as dating back to the mid 18th Century and the work of Kant (specifically the Critique of Practical Reason (Kant 1788) and The Groundwork of the Metaphysics of Morals (Kant 1785a)). The on-line Stanford Encyclopaedia of Philosophy says:

> In contemporary moral philosophy, deontology is one of those kinds of normative theories regarding which choices are morally required, forbidden, or permitted. In other words, deontology falls within the domain of moral theories that guide and assess our choices of what we ought to do (deontic theories).
>
> Alexander and Moore.M 2012

The basis for Kant's moral theory is to be found in the Categorical Imperative; although Kant gives several formulations of this, I will use the first (the Formula of the Universal Law of Nature) for this introduction. This formulation states that I ought never to act except in such a way that I could also will that my maxim should become a universal law. Thus if I am contemplating making a lying promise for some personal gain, I should consider what would

happen if it became a universal law that people made lying promises, whenever they could, for personal gain. In the world so conceived there would be no possibility of a system of trust, so this is a world where no promise for personal gain is possible and at the same time a world where everyone makes lying promises for personal gain. The inherent contradiction in this world implies that it could not exist and it is thus not rational to will that making lying promises for personal gain should become a universal law. I am thus forbidden from undertaking such an act.

One of the major influences in deontology in the 20th Century was W.D. Ross whose views are set out in "The Right and the Good" (Ross 1930). Ross's major contribution was the proposition that moral obligations are (in his terms) *prima facie*, so that where obligations conflict a balance of *prima facie* rightness can be struck:

> Right acts can be distinguished from wrong acts only as being those which, of all those possible for the agent in the circumstances, have the greatest balance of *prima facie* rightness, in those respects in which they are *prima facie* right, over their *prima facie* wrongness, in those respects in which they are *prima facie* wrong.
>
> Ross *op cit* p41

I will return to Ross in §2.4. One important reason for highlighting his work here is the fact that it is a major target for Dancy when setting particularism against generalism.

Deontology is often described as "act based", in that the moral value of an act lies in the act itself.

1.2.2 Consequentialism

For consequentialists the normative properties of an act depend on its consequences. Utilitarianism is the generally cited example of classic consequentialism. Jeremy Bentham published "An Introduction to the Principles of Morals and Legislation" in 1789 in which he proposed the principle of utility:

> By the principle of utility is meant that principle which approves or disapproves of every action whatsoever, according to the tendency which it appears to have to augment or diminish the happiness of the party whose interest is in question: or, what is the same thing in other words, to promote or to oppose that happiness.
>
> Bentham 1789 p3

The theory of utility was further developed by Mill (Mill 1863) who introduced the idea that the "higher" pleasures (intellectual and moral pleasures) were superior to the "lower" (more physical) pleasures to avoid the notion that "Prejudice apart, the game of push-pin is of equal value with the arts and sciences of music and poetry" (Bentham 1811 bk3 ch1).

This promotion of happiness as the only factor in defining the right (the approved) action has led to this form of utilitarianism being cast as "hedonistic consequentialism" in more recent times where various versions of consequentialism have been proposed (see, for example, preference fulfilment consequentialism expounded by Singer (Singer 1979)).

The moral value of an act here lies in the consequences. Of special interest for the debate about particularism is the claim of consequentialists that there is one and only one rule, "maximise the good", which always indicates the correct action.

1.2.3 Virtue Ethics

The latter half of the Twentieth Century has seen the rise of virtue ethics. This rise is generally seen as starting with a paper presented in 1958 by G.E.M. Anscombe (Anscombe 1958). Anscombe refers back to Aristotle's *Nicomachean Ethics* and virtue ethics in general is sometimes seen as a reworking of Aristotelian ethics in a modern context.

> Anyone who has read Aristotle's *Ethics* and has also read modern moral philosophy must have been struck by the great contrasts between them. The concepts which are prominent among the moderns seem to be lacking, or at any rate buried or far in the

> background, in Aristotle. Most noticeably, the term "moral" itself, which we have by direct inheritance from Aristotle, just doesn't seem to fit, in its modern sense, into an account of Aristotelian ethics. Aristotle distinguishes virtues as moral and intellectual.
>
> Anscombe *op cit* p1

In virtue ethics the moral value lies in the agent, not the act or its consequences. It is often characterised by the phrase "The right action is the one which a virtuous agent would typically do in the situation".

The reference to the virtuous agent above indicates the wider aspect of virtue ethics. Being a virtuous agent is concerned with how an agent lives his or her life:

> Philosophers and theologians have recognized that being virtuous is more than having a particular habit of acting, e.g. generosity. Rather, it means having a fundamental set of related virtues that enable a person to live and act morally well. The cardinal virtues have the task of making a person sufficiently rightly ordered to perform morally right action.
>
> Keenan 1995 p714

1.3 Particularism

1.3.1 There is no need for ethical principles

Particularists deny the need for general principles in the study and practice of ethical behaviour. Much of the theory of moral particularism is due to Jonathan Dancy; he describes his "Ethics Without Principles" (Dancy 2004) as "the culmination of twenty-five years' work" (p vii). I will present the theory in more depth later in the thesis but briefly Dancy describes particularists as believing all reasons are sensitive to context, which he terms "holism in the theory of reasons". He says:

> the main aim of my particularist position is to break the stranglehold of a certain conception of how moral reasons function – the *generalist* conception under which what is a moral reason in one context is necessarily the same reason wherever it occurs. ... if [generalism] is false as a general account of such reasons, rational constraint on moral thought and action – in particular, accounts of what consistency requires in these areas – must not themselves be based on generalist assumptions.
>
> (original italics) Dancy 2000 p131

1.3.2 Particularism and generalism

There has been much debate in the ethics literature about particularism and its counter, generalism. For the purpose here I will outline these arguments in order to highlight the differences between the two camps which I believe to be relevant to medical professionals aiming to conduct their practice in an ethically correct manner.

It is not my aim to further the generalist/particularist debate or to promote one side over the other. The aim is rather to understand where the positions differ in respect of how decisions are made in a medical or clinical environment. Particularism is a relatively new proposal in ethics and medical ethics has developed in a generalist ethical environment not least because this was the understood role of normative ethics.

1.4 Medical ethics

Medical professionals going about their everyday business generally prefer to do the "right thing" or, at least not to commit ethical mistakes. They are not, however, generally desirous of studying normative ethical theory, let alone meta-normative theory. I will not be concerned in this thesis with those who do not hold to this desire, only with those (the vast majority) who do hold it but wish to follow it without being unnecessarily distracted from their proper business of aiding the sick and helping the healthy to remain so.

I will also be concerned with the perception of the patient who, through the doctor patient relationship, places his or her trust in the doctor to behave properly. There are considerable inequalities in the doctor-patient relationship; inequality of knowledge, inequality of skill and inequality of need, all influence this relationship. In order to allow the patient to have control of his or her own life, the doctor must impart sufficient knowledge for the patient to make an informed decision when alternative courses of action are possible. In the "consent based" medical system trust plays a major role; trust, then, holds a special status in this relationship.

I will aim to show that one of the main sources of guidance for medical professionals is the collection of guidelines produced by a variety of bodies such as the Department of Health, NHS Trusts, professional bodies and governmental and non-governmental agencies.

1.5 The role of guidelines

The complexity of both diagnostic tools and therapeutic interventions available to clinicians has increased with progress in medical research over the second half of the 20th Century and the start of the 21st. It is increasingly difficult for any one doctor to maintain a full overview of what can be offered to the patient in the consulting room. As well as technical complexity there is an increase in ethical complexity; it is now possible to undertake procedures unthought-of a few years ago, but technical and pharmaceutical developments often leave open the question, "just because we can, doesn't mean we should". Both the Department of Health (DoH) and professional bodies publish guidelines of which can be general (such as "Good Medical Practice" GMC 2012c) or specific (e.g. guidelines on patient's consent to treatment (DoH 2009) or guidance when it is right to use a particular drug (e.g. NICE 2002)).

The UK's General Medical Council (GMC) maintains a website which includes a section on ethical guidance, it says, "The GMC has a statutory role to provide guidance to doctors on medical ethics" (GMC 2012b). A section of this web site contains this paragraph:

> 2. Whatever the context in which medical decisions are made, you must work in partnership with your patients to ensure good care. In so doing, you must:
>
> a. listen to patients and respect their views about their health
>
> b. discuss with patients what their diagnosis, prognosis, treatment and care involve
>
> c. share with patients the information they want or need in order to make decisions
>
> d. maximise patients' opportunities, and their ability, to make decisions for themselves
>
> e. respect patients' decisions.
>
> GMC 2012a, para 2.

Other professions within medicine have similar guidance; the Health and Care Professions Council regulates a wide range of non-clinical medical professions from art therapists to radiographers, it publishes a document called "Standards of Conduct, Performance and Ethics" which "sets out the standards of conduct, performance and ethics we expect from the professionals we regulate. The standards also apply to people who are applying to become registered." (HCPC 2008). An example of the content of this is:

> You must always provide adequate information to a service user in order for them to provide informed consent. This is particularly important where any intervention may cause pain or distress. Every effort should be made to ensure that the service user understands the nature, purpose and likely effect of the intervention before it is undertaken.
>
> College of Occupational Therapists 2010 para.2.2.4

This example can be seen as refining general moral duties, such as "respect the autonomy of others", "do not cause net harm", within the realm of (in this instance) professional occupational therapists. Such codes of conduct can be seen in many professions defining the interpretation of ethical and moral principles for the specifics of the profession. As was said by the politician

Michael Portillo on an edition of the BBC Radio 4 programme The Moral Maze BBC 2012, codes of conduct depend on an underlying moral code.

Professional guidelines then often encompass a set of ethical rules of conduct for members of the profession. Guidelines are written by a variety of bodies and it is not guaranteed that they will not contain conflicting guidance. Where guidance conflicts there may be a simple way of resolving the matter (more specific guidance for dealing with Jehovah's Witnesses will overrule general rules on giving blood to unconscious patients in an emergency situation) or there may be a more difficult decision to be made (such as when NICE guidelines conflict with the best interests of an individual patient (see §5.4.3)).

Central to the arguments in this thesis is the idea that these systems are the practical and professional ethics counterpart to deontological theory at the normative ethics level. Professional guidelines within medical professions are built on one or more normative systems and relate specifically to medical practice and subsets thereof. They can contain conflicting guidance which is subject to Rossian style balancing of *prima facie* rightness. In Chapter 2 I introduce an extension of the terms "thin" and "thick" as applied to moral concepts to apply to moral principles and argue that in this context, thinness/thickness is not a binary function but a continuous one and develop the idea that professional guidance constitutes (in part) a deontological system extended ("thickened") to the degree necessary to give ethical action guidance to practicing professionals. For clarity in later chapters I will assume this argument has been made.

1.6 Generalism and particularism in practice

I will argue that in difficult situations generalists and particularists have different decision making processes; the generalist will be more inclined to seek and follow general normative guidelines whereas the particularist is not bound to believe that that the guidelines apply in all cases. Patients of generalist doctors are putting more trust in guidelines (and thus, in those who write

those guidelines) whereas patients of particularist doctors are putting more trust in the doctor him- or her-self.

In turn the doctor must have confidence that s/he is not making an ethical error when acting in a professional capacity. The same distinction is seen as above. Under a generalist system the doctor must have confidence that the guidelines will guide her or him to ethically correct decisions and actions, whereas under a particularist system the doctor must have confidence in her or his own ethical decision making ability. One important distinction between the systems is how medical professionals in training and early in their careers gain the confidence required to believe they are acting ethically.

1.7 Principlism

One of the main texts used by trainee doctors is *The Principles of Medical Ethics* by Beauchamp and Childress (Beauchamp and Childress 2001); this work is used as the basis for "Principlism" which regards the four principles discussed in Beauchamp and Childress as a complete deontological system in itself, see for example the work of Gillon (Gillon 1985;Gillon 2003).

> It is hypothesised and argued that "the four principles of medical ethics" can explain and justify, alone or in combination, all the substantive and universalisable claims of medical ethics and probably of ethics more generally. ... This approach is argued to be compatible with a wide variety of moral theories that are often themselves mutually incompatible. It affords a way forward in the context of intercultural ethics, that treads the delicate path between moral relativism and moral imperialism.
>
> Gillon 2003

In discussing Beauchamp and Childress I will generally follow this interpretation of their work (the "four principles" approach) as this is how it is often perceived within the medical

profession. I accept that this does not do justice to the views expressed in Part Three of their work:

> Often, we have more reason to trust our responses to specific cases and the characteristic responses of moral persons than a theory, principle, or rule. We also have reason to trust principles in the common morality then theories. In our model no level or type of moral reasoning – comprehensive theories, principles, rules, or case judgements – has priority or serves as the groundwork of the other levels. Moral justification proceeds from an expansive coherentist framework of "norms" that originate at all "levels". These norms can emerge from institutions, individuals, and cultures, and no norm is immune to revision.
>
> Beauchamp and Childress 2001 p408

1.8 Hypothesis

Particularism implies that normative ethics is not necessary for ethical decision making.

Particularists think that the accepted link between normative theory and ethical action is incorrect and should be abandoned.

Current guidance in medical ethics is based on normative theories.

If particularists are correct, a new understanding of the basis for medical ethics is needed.

To investigate this hypothesis it is necessary to understand what particularists mean when they say that normative ethics are not necessary for ethical decision making,

If particularism is correct, how can practical ethical decisions be reached? How is the busy clinician to know that she is not being unethical?

1.9 Roadmap

In Chapter 2 I discuss the theory of particularism with reference to the nature of moral principles and action guidance. Particularism is largely concerned with rejection of "generalism", so §2.4 discusses generalism with reference to the arguments later in the thesis.

§2.6 is concerned with extending the notion of thinness and thickness to moral principles and arguing that it is a continuous function.

Supervenience of the moral on the non moral is sometimes seen as a problem for particularism; this is discussed in §2.7.

§2.8 is a slight diversion from the main theme and is an attempt to clarify the discussion of supervenience and thickening to enable me to use these in later chapters more straightforwardly.

In §2.9 I look at some arguments against particularism and conclude in §2.10 that the question is still open.

Chapter 3 is a discussion of medical ethics in terms of the theme of this thesis.

§3.2 introduces the need for guidelines in practice.

§3.3 is a discussion of one of the central themes on medical ethics and of this thesis, namely trust.

§3.4 looks at the breakdown of trust in society and the perceived need for systems to ensure trustworthiness.

The role of codes of practice and their role in action guidance is discussed on §3.4.2 and the various types of guidance documents are introduces in §3.6.

In §3.7 I argue for the need for thickness in guidance documents.

Chapter 4 is an exploration of how action guidance would work for a naive agent.

§4.2 and §4.3 look at the relationship of naivety and experience and at the thickness of guidance required by the naive and the experienced agent.

Chapter 5 looks at the effect particularism would have, given the understanding of how medical ethics works under generalism discussed in earlier.

§5.4 introduces two real examples from my practice as a medical physicist in early phase clinical trials in patients with cancer. The ethical issues raised by these are discussed in §5.5. §5.6 then looks at how particularist and generalist scientists and clinicians (as classified by me from their arguments during discussions of trial protocols) approach these ethical issues.

§5.8 revisits the question of trust with reference to the particularist/generalist debate.

Chapter 6 looks more deeply at decision making and the question of trust in particularist and generalist medical ethical systems.

§6.3 looks at the implications of this for initial and continuing ethical training for the medical professions.

The final chapter 7 revisits the hypothesis given above and draws on the arguments made throughout the thesis to see to what extent it has been verified.

2 Particularism

"All universal moral principles are idle fancies". Marquis de Sade

2.1 Introduction

The debate between moral particularists[2] and moral generalists is a debate over the status of moral or ethical principles. Particularists can be defined by Dancy's statement in the opening of Ethics without Principles by:

> A particularist conception is one which sees little if any role for moral principles. Particularists think that moral judgement can get along perfectly well without any appeal to principles, indeed that there is no essential link between being a full moral agent and having principles.
>
> Dancy 2004 p1

Generalists, on the other hand, maintain that principles (or, at least, a principle) lie(s) at the heart of moral philosophy and the role of normative theory has been to elucidate these principles. In Principled Ethics McKeever and Ridge state:

> Modern moral philosophy is often understood as a debate between utilitarians like John Stuart Mill and deontologists like Immanuel Kant. Crucially, both sides of this modern debate are committed to the generalist idea that morality can be reduced to a fundamental principle.
>
> McKeever and Ridge 2006 p4

To engage in this debate, it is first necessary to say what is meant by "principles". I will begin this chapter with a look at what I will mean by "principles".

---

[2] I will assume the use of "particularist" and "generalist" to mean "moral particularist" and "moral generalist" throughout this thesis.

2.2 Principles

In "The Language of Morals" R. M. Hare says

> If we were to ask of a person "What are his moral principles?" the way we could be most sure of a true answer would be by studying what he *did*... The reason why actions are in a peculiar way revelatory of moral principles is that the function of moral principles is to guide conduct.
>
> Hare 1952 (original italics) p1

I will take guiding conduct in the moral sense as being equivalent to indicating a moral value for an action, or a moral valence for a feature of an action.[3] Principles provide a link between the moral value (at least as perceived by the subject of the above observation) of a feature of an action (this action is *just*, that action is *telling a lie*) and the situation in which the action takes place. This is not simply a link between narration of an action and a moral value; if P says he does not know where the thief is when, in fact, he knows the thief is hiding under his bed, then Q might say P's action was wrong. This, on its own, does not mean Q knows, and knows how to apply, a principle. It is only when Q identifies several other similar actions as wrong that we can tentatively surmise that Q understands the concept of lying and knows the principle that lying is wrong. Hare draws an analogy between learning moral principles and learning the principles of driving:

[3] McNaughton & Rawling draw a partial analogy with the chemical term "valence" "we have the following pair of principles: justice has a universally positive valance; whereas the betrayal of innocent friends has a universally negative valance." (McNaughton and Rawling 2000 p257).

> [I]n learning to drive, [we] learn, not to change gear *now*, but to change gear when the engine makes a certain kind of noise. If this were not so... an instructor would have to sit beside us for the rest of our lives in order to tell us just when, on each occasion, to change gear.
>
> *ibid* p60

Moral principles are general statements that actions of type X have a set moral value. For an agent who wishes to act morally, negative moral value is a reason to refrain from an action and positive value a reason to perform an action. Dancy says,

> moral principles ... seem all to be in the business of specifying *general* reasons. The principle that it is wrong to lie, for instance, presumably claims that mendacity ... always makes the same negative contribution [to reasons for choosing a course of action].
>
> Dancy 2004 p76

P's action of making the utterance, "I do not know where the thief is." is not, of itself, right or wrong. Q judges P's act in the light of certain facts about the situation (the facts that P knows where T is and that P knows that T is the thief); Q knows P's action is a lie and understands the principle that the feature of a statement "that it is a lie" carries negative valence: the fact that act is an example of telling a lie counts towards the act having negative moral value. In the absence of any other facts which might invoke other principles (see the discussion of *pro tanto* (*prima facie*) principles below) Q believes the act to be wrong. Using a principle then starts with examining the facts of a situation and deciding which (if any) moral principles apply.

In general terms, a situation S is defined by a set of features[4] $\mathbf{F}_S = \{F_1 \ldots F_n\}$; action guidance (of a moral sort) in a situation S is the determination of the moral value of an action X in S. A

[4] I will use "features" in a loose way to mean physical and mental facts of all sorts: it was a Tuesday; the statement was a lie; A believed D would die unless someone came to his rescue.

principle P indicates a moral value (V_P) for an action X_P given a set (possibly having only one member) of features $\mathbf{F}_P = \{F_a... F_z\}$. P indicates that action X_P has value V_P in situation S if all the facts required to invoke P are contained in $\mathbf{F}_S$ ($\mathbf{F}_P$ is a subset of $\mathbf{F}_S$ ($\mathbf{F}_P \subseteq \mathbf{F}_S$)).

2.3 Action Guidance

In the following I intend to look at whether principles can be action guiding. Before entering this argument it is necessary to say something about action guidance; I will return to this in Chapter 3. In the following discussion I will assume a high level of moral naivety so that a naive agent told the general principle "do not lie" will understand that to mean that lying is a feature which always carries a negative valence. This is equivalent to the naive driver being told that when the engine noise reaches that pitch she should change up a gear. In Chapter 4 I will look at the role of moral experience and how this relates to the generalism/particularism divide.

The general principle "do the right thing" provides action guidance iff I know from other experience what the right thing is in the current situation. To see how this could be action guiding we might consider an experienced[5] agent who can discern the right thing but has forgotten that the right thing is the thing that should be done. In order to do this the agent would be capable of attaching a label "right thing" to an action, but would not understand the meaning of "right thing" as the thing to do. In this sense it could be argued that "do the right thing" provides action guidance but in another sense it is simply a definition of what we mean when we describe something as the right thing. This principle, however, is of no use to the naive agent who cannot discern the right action, for this agent action guidance needs to go deeper into the features of the situation. It is this naive agent who is most likely to ask what s/he should do

[5] Experienced in the sense in which the action is right. An experienced financial advisor will perceive the best course of action to achieve the best financial outcome for his employer, the experienced demolition expert will perceive the best placement for the explosives to bring down a building safely, etc.

when faced with a particular situation. For the time being I will consider action guidance to be the guidance needed by a naive agent, with little or no moral experience to draw on, when deciding between possible actions.

2.4 Generalism

As McKeever and Ridge say in the quotation above, both Mill and Kant (and modern consequentialism and deontology) assume generalism.

In Utilitarianism[6] Mill asserts that

> to support [a moral theory] there ought either to be one fundamental principle or law, at the root of all morality, or if there be several, there should be a determinate order of precedence among them; and the one principle, or the rule for deciding between the various principles when they conflict, ought to be self evident.
>
> Mill 1861 p253

and later

> The creed which accepts as the foundation of morals, Utility, or the Greatest Happiness Principle, holds that actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness.
>
> Ibid p257

The Categorical Imperative devised by Immanuel Kant (Kant 1785a;Kant 1788) is an example of the basis for deontological duty:

[6] I refer to the page numbers in Warnock's collection of essays by Mill, Bentham and Austin.

> Act only on that maxim through whereby you can at the same time will that it should become a universal law
>
> Kant 1785b p262

These philosophers refer to universal or fundamental laws which they saw as analogous to the laws of natural science. The idea of such universal laws is *a priori* generalist.

So, if P is a general principle it holds that the action X_P will invariably have the value V_P when $\mathbf{F}_P$ are true; this formulation can accept that $\mathbf{F}_P$ might contain negative facts such as "the pleasure is not sadistic".

A problem which arises out of such principles is the possibility of conflict between different principles invoked by different features of a situation or by different interpretations of the application of the universal law; although Mill tries to sidestep this objection he does not give a "self evident" rule for deciding. It may be unreasonable to expect such a rule from Mill since, for him, Utility is a single principle; it is arguable that under a Utilitarian system, if the calculation of the consequences of an action is performed to a sufficient fineness there will be no conflict and thus no need of a rule, or from a different perspective, Utility is just that self-evident rule. The fact that later consequentialist systems have different single rules (for example the preference satisfaction of Singer's preference utilitarianism (Singer 1979 p94)) indicates that such rules are not universally self-evident. We might question Mill's assertion that a deciding rule must be self-evident, but if a generalist system is to provide a means of deciding which of a set of possible actions is morally best, then rules for resolving conflicts must either be further rules within the system or be self-evident, or we will be unable to resolve the conflict.[7]

[7] It is beyond the scope of this thesis to discuss the possibility of a normative system in which conflicts can be necessarily excluded *a priori*. I will simply state that I find the notion that principles can be defined in such a way that they cannot conflict, to be implausible.

Consider A intends to X, he believes that Xing is required by a general principle; he then finds that Xing necessarily involves not Ying, however Ying is required by another general principle; Xing is then both prescribed and proscribed. To flesh this out consider A has promised to return a book to B; A later discovers that B is not the rightful owner of the book, B has indeed stolen the book from C. The general principle that we should keep our promises is now dictating one action which would make it impossible to carry out the action required by the principle that we should return objects to their rightful owners.

To overcome this problem W. D. Ross introduces the concept of "*prima facie* duty" [8] which he contrasts with "duty proper" (moral obligation). An act is a *pro tanto* duty in a given situation in virtue of the situation having certain features; this duty would be a duty proper if the situation did not have certain other features which indicate a different *pro tanto* duty. To arrive at the duty proper in a situation one must weigh up the various *pro tanto* duties; these duties work in a generalist way: they are always present when the given features are present, and they always act with the same valence.

To see an example more relevant to medical ethics: Beauchamp and Childress's (Beauchamp and Childress 2001) beneficence might indicate that a doctor should prescribe a particular course of medication as the best treatment for a patient; however, if the patient wishes to try "alternative medicine" before taking a course of drugs, the principle of respect for autonomy might indicate that the prescription would not be appropriate. Rossian generalism stops short of indicating how such conflicts should be resolved; Beauchamp and Childress however are in the business of offering practical advice to working medical professionals and they introduce the process of specification to help resolve such conflicts:

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[8] Ross's use of "*prima facie*" is somewhat different from the legal use of the term; "*pro tanto*" is generally preferred currently; henceforth I will use this latter term.

> Specification is a process of reducing the indeterminateness of abstract norms and providing them with action guiding content. For example, without further specification, "do not harm" is an all-too-bare starting point for thinking through problems, such as assisted suicide and euthanasia. It will not adequately guide action when norms conflict.
>
> Beauchamp and Childress 2001 p16

The distinction between Ross and Beauchamp and Childress may not be as clear cut as the above paragraph implies, however the emphasis in Beauchamp and Childress is on practical decisions in the clinic, whereas Ross sets out to "examine the nature, relations and implications of three conceptions which appear to be fundamental in ethics – those of 'right', 'good' in general, and 'morally good'" (Ross 1930 p1). I will return to specification in § 3.6.1.

2.5 Particularism

In discussing particularism, Dancy talks of reasons:

> When I talk … about reasons for action, I mean to be talking of what I call contributory reasons. A contributory reason for action is a feature whose presence makes something of a case for acting, but in such a way that the overall case for doing that action can be improved or strengthened by the addition of a secondary feature playing a similar role.
>
> Dancy 2004 p.15

Reasons, in this sense, can count in favour of or against an action. For Dancy there can also be overall reasons, but overall reasons are not something other than the result of the contributory reasons, "To talk of what there is overall reason to do … is to talk of where the contributory reasons come down – on this side or on that." (*ibid* p16) So far these do not sound so very different from *pro tanto* duties; for Dancy however

> a feature that is a reason in one case may be no reason at all, or an opposite reason, in another.
>
> *ibid* p73

For Dancy, this defines holism in the theory of reasons.

Dancy initially distinguishes between two types of reasons, "theoretical reasons" or reasons for belief, and "practical reasons" or reasons for action.

He illustrates theoretical reasons with the example of my believing that something in front me is red. In ordinary circumstances the fact that something in front of me appears red is a reason for me to believe that the thing in front of me is red. Now suppose I have taken a drug which makes blue things appear red to me and red things appear blue. In this case the feature of the situation "the thing in front of me appears to be red" is a reason for me to suppose that it is blue. Reasons for belief then are holistic. I think this argument is reasonable: if we construct the feature "the thing in front of me appears red" to be an invariant *pro tanto* reason to believe the thing in front of me is red, then when I have knowingly taken Dancy's drug, I have an outweighing *pro tanto* reason to believe "the thing is blue" but must still have reason to hold the invariant belief "the thing is red" at the same time. Moreover my reason for my belief in these conflicting statements is based on the same feature ("to me the thing appears red"). The holistic interpretation, when I take the drug the feature "to me the thing appears red" changes its valence to be a reason to believe "the thing is blue", is more straightforward and chimes better with experience.

> If generalism is taken to be the view that all reasons are general reasons, i.e. that if a feature is a reason in one case, it is the same reason in another case, generalism is uncontentiously false of theoretical reasons.
>
> *ibid* p74

Dancy's ordinary practical reasons are reasons for action; they arise from the sets of features (**F**). For example, F_a (= that there will be a lot of people there), might be a reason for action X_b (= to go there) if F_b (= that I want to party) is true, but a reason for X_c (=to stay away from there) if F_c (=that I want to be alone) is true. So, in this ordinary practical example my action is guided by feature sets; I will be guided to (there will be overall reason to-) X_b if $\{F_a, F_b\}$ or to X_c if $\{F_a, F_c\}$.

In ordinary practical reasons a feature that is a reason in one case may be no reason at all or might be a reason to act differently in another case ("that there will be nobody much else around is sometimes a good reason for going there, and sometimes a very good reason for staying away" (*ibid* p74)). For Dancy this shows practical reasons to be holistic:

> [A]gain we should remind ourselves that nobody has ever really debated the question of whether ordinary practical reasons are holistic or not. There should be no *parti pris* on this issue; so the examples, which are legion, should be allowed to carry the day without resistance.
>
> ibid p74

Although Dancy admits this might be "too quick", it is a sufficient statement of his views thus far for this thesis. I am not concerned to establish the truth or otherwise of particularism, just to understand it well enough to see what it would mean for practical medical ethics.

According to Dancy, there are two types of reason beyond the theoretical and the practical, these are aesthetic and moral. Whilst mentioning in passing that aesthetic reasons are "largely holistic" (a feature which may be aesthetically pleasing in one situation may be anything but, in a different

situation) he says, "Luckily, I don't have to decide about that here" (*ibid* p75) and moves on to the moral.

The argument for moral reasons being holistic (in "Ethics Without Principles") centres on their not being so very different from all other reasons. No one has identified a way of distinguishing moral reasons from non-moral. Simple moral reasons (such as "causing pleasure is good") do seem to behave holistically at first sight (where the pleasure is sadistic the moral valence is seen to change) see §2.9 for discussion of this.

Holism of moral reasons does not necessarily lead to particularism; it is theoretically possible to define a holistically principled ethical system by enumerating all possible contributory principles:

> If an act causes pleasure, there is reason to do that act
>
> unless
>
> the pleasure is sadistic
>
> ...
>
> If you have promised, that is a reason to do the promised act
>
> unless
>
> your promise was given under duress
>
> you were deceived when making the promise
>
> ...

This would be very different from the sort of general principle(s) envisaged by Kant, Bentham or Mill. The point here is not that this could be a practical way of doing ethics; just that particularism does not follow necessarily from the holism of reasons.

However Dancy does say the morality we have is not grounded in any invariant principles, and that this follows from the holism of moral reasons, and further:

> It was because of this issue that I characterised particularism [...] as the claim that the possibility of moral thought and judgement (and in general, one might say, of moral distinctions) in no way depends on the provision of a suitable set of moral principles. So characterised, it seems to me that particularism does follow from holism.
>
> *ibid* p82

Particularism, then, is bound up with holism of reasons; it says that moral principles are not necessary for moral action. The holism of moral reasons says that a feature which may carry a valence and so be a reason for assigning a moral value to an action in one situation may have a different valence and so be no reason at all or an opposite reason in a different situation.

2.6 The Thin and the Thick

2.6.1 Thickness of normative concepts

One characteristic difference between generalists and particularists is that generalists seem to need to distinguish "morally relevant" features within the set of all possible features ($\mathbf{F}_{MR} \subseteq \mathbf{F}$) whereas particularists see no way of drawing the distinction between morally relevant and non-morally relevant features in a general way, outside of a particular situation; which facts are morally relevant in a situation, for a particularist, depends on the situation.[9] To investigate this further I will look more closely at the relationship between principles and features. It is useful to start by considering the distinction between thick and thin concepts and to extend this distinction to principles.

When discussing moral language Williams says:

[9] I will discuss how an agent can come to see which features may be morally relevant in Chapter6.

> [T]heorists have brought the fact-value distinction to language rather than finding it revealed there. What they have found is a lot of "thicker" or more specific notions ..., such as *treachery* and *promise* and *brutality* and *courage* which seem to express a union of fact and value. The way those notions are applied is determined by what the world is like (for instance, by how someone has behaved), and yet, at the same time, their application usually involves a certain valuation of the situation, of persons or actions. Moreover they usually (though not necessarily directly) provide reasons for action.
>
> Williams 1985 p129-130

A normative concept C is *thick* if, when C is correctly applied in a situation S, it follows as a conceptual entailment that some non-trivial facts are true of S; that is to say, the set of features which are entailed by C ($\mathbf{F}_C$) is a subset of $\mathbf{F}_S$. Taking courage as an example of a thick concept, if we say John was courageous when he saved a child from a fire, then we are committing ourselves to asserting the truth of a certain $\mathbf{F}_C$, for example F_1: entering a fire involves danger; F_2: many people would have wanted to avoid this danger; F_3: John was aware of F_1 and F_2, and so on. If we believe courage to have a positive moral valence in all circumstances then (in the absence of countering features with a negative valence) John's act has positive moral value.

A normative concept is *thin* if it is not thick. This is to say that no facts are entailed when the concept is used (or only trivial facts (e.g. that the situation is located in a possible world where the action is possible)); "good", "bad", "right" and "wrong" are often cited as thin moral concepts. If we are told of some action that it was good, we can deduce nothing more about the action. We cannot tell if it was an act of courage, of generosity, or a refusal to tell a lie.

2.6.2 Thinness of moral principles

I would like to extend this idea of thin and thick to discuss moral principles. McKeever and Ridge (McKeever and Ridge 2006 section 1.2) discuss their use of the term 'principle' in some

detail and I will take their term "action guiding standard" as a working definition in line with the discussion in §2.2. As such principles may be seen as the normative counterpart to moral concepts. The use of thinness and thickness to describe principles is analogous to the thinness and thickness of concepts.

The use of "thin principle" here is at odds with my earlier definition of principles as providing a link between the morality of an action and the feature set of the situation in which it takes place. The idea of a thin principle will be useful in the discussion below of variable thickness, I will use it as a limiting case: consider the principle "Always do that which, all things considered, is the best thing to do"; while this has the apparent form of an action guiding principle, it does not link any particular action or class of actions with any particular feature or type of feature which would allow it to guide action in any world without at the least further definition of "all things" and "best". I will use the term P_0 to indicate a thin principle. If P_0 is not thick then, from the above definition of "thick", when P_0 is correctly applied in a situation S it does not follow as a conceptual entailment that some non-trivial facts are true of S. That is to say the set of facts associated with a thin principle is empty; the empty set of facts (the null set) will be indicated as $\mathbf{F}_0$. P_0 is associated with $\mathbf{F}_0$. Since the null set is a subset of any arbitrary set we see that thin principles are invoked in any, and all, situations, in all possible worlds. Since no facts are entailed when a thin principle is applied, it follows that thin principles cannot distinguish between situations. Consider the above example of returning a book. The situation S is defined by many facts

$\mathbf{F}_S$ = {

F_1 = A borrowed the book from B,

F_2 = A promised to return the book to B,

F_3 = the book belonged to C,

F_4 = B had stolen the book from C,

… }

When considering which course action to take A considered three normative principles

P_0 = Always do that which, all things considered, is the best thing to do

P_1 = Always keep your promises

P_2 = Always return goods to their rightful owner

Each Principle has an associated set of facts, for example P_1 is invoked when the set of facts $\mathbf{F}_{P1}$ are true

$\mathbf{F}_{P1}$ ={

$F_{P1.1}$ = a promise was made,

$F_{P1.2}$ = the promise has not been fulfilled,

$F_{P1.1}$ = the promise was not made under duress,

…}

A sees that P_1 indicates a *pro tanto* duty to return the book to B ($\mathbf{F}_{P1} \subseteq \mathbf{F}_S$) and that P_2 indicates a *pro tanto* duty to return the book to C ($\mathbf{F}_{P2} \subseteq \mathbf{F}_S$); P_0 however indicates only that A should do the "best thing". If F_3 and F_4 were not true then there would be no *pro tanto* duty to return the book to C ($\neg(\mathbf{F}_{P2} \subseteq \mathbf{F}_S)$), similarly if F_1 and F_2 were not true then there would be no *pro tanto* duty to return the book to B ($\neg(\mathbf{F}_{P1} \subseteq \mathbf{F}_S)$). However no change in $\mathbf{F}_S$ would effect a change with regard to P_0; $\mathbf{F}_0$ is a subset of any arbitrary set and P_0 always indicates that A should do the "best thing"; P_0 is of no use for choosing which course of action to take in the absence of knowledge of what constitutes the "best thing"; I will look at this knowledge for naive and experienced agents in Chapter 4.

Thin principles cannot provide moral action guidance; it is the link with facts that allows thick normative concepts to guide action.[10]

Although often used simply to distinguish between concepts such as "good", "right" and "ought" (thin) and concepts such as "courage", "greed" and "lewdness" (thick), the thickness of concepts or principles need not be considered simply as a binary classification; rather, the thickness of a concept C or a principle P can be taken as a continuous function[11] of the set of facts $\mathbf{F}_P$ required by P to indicate the value V_P; thin concepts and principles stand at a low asymptotic limit of the thickness function: a concept cannot be more thin than C_0, a principle cannot be less action guiding than P_0. If B says of A, "He did the right thing", it is legitimate to ask for explanation; we want to know what A did, and in what situation; the thin principle of doing the "right" thing was uninformative, only the thicker concept he "told the truth", he "told a lie in order to protect an innocent" can help us understand what B means by "right".

2.6.3 Thickness and specification

In the field of medical ethics Beauchamp and Childress (Beauchamp and Childress 2001) discuss how to decide between competing *pro tanto* duties; they use the term "specification" to describe "a process of reducing indeterminateness of abstract norms and providing them with action-guiding content". They say

> progressive specification often must occur to handle the variety of problems that arise, gradually reducing the dilemmas and conflicts that abstract principles lack

[10] Under this analysis, it seems we might deny the term "normative" to thin principles.

[11] I am using "function" here in a way analogous to a mathematical function. It can take any value between fully thin ($\mathbf{F}_C = \mathbf{F}_0$) and arbitrarily thick ($\mathbf{F}_C \rightarrow \mathbf{F}_S$).
Such a continuous function would approach a low asymptote at 0 ("fully thin"), however features are in some sense "countable" and the continuous function model would break down at the level of a single entailment in the real world. Although it would be feasible to build the analogy with a discontinuous function (strictly an integer function); as a physicist I see this as similar to the difference between measuring radioactivity at high and very low count rates, I think this would complicate the argument unnecessarily. In a discontinuous function the low asymptote is not outside the function and fully thin concepts would not be outside the analogous "thickness" function, simply a description of the lowest possible value.

> sufficient content to resolve. Adding substance through specification is essential for decision making in clinical ... ethics.
>
> p.16

In terms of the above discussion, the process of specification can be seen as a means of thickening the thinner "abstract norms". Consider a situation S where two fairly thin principles (P_1 and P_2) conflict and recommend different actions $\{X_1, X_2\}$. The moral value (V_1) of X_1 will be indicated by the principle P_1 which depends on the set of facts $\mathbf{F}_{P1}$. Not all of, and not only, the member facts of set $\mathbf{F}_{P1}$ will necessarily be relevant to X_2 and a different Principle P_2 will be associated with the set of facts $\mathbf{F}_{P2}$ to indicate X_2's value (V_2). $\{X_1 – X_2\}$ (a subset of $\{X_1 – X_n\}$)[12] may now be seen by Rossian generalists as *pro tanto* duties in S.

In any particular situation S two fairly thin principles P_x and P_y may both be able to associate action X with a moral value (the associated sets of facts $\mathbf{F}_x$ and $\mathbf{F}_y$ which are subsets of $\mathbf{F}_S$); however they may differ in the value indicated. This can be seen in well known examples such as the conflict between beneficence, which would dictate that a doctor should give blood to an accident victim with internal injuries who will otherwise die, and respect for autonomy when that patient is a Jehovah's Witnesses who refuses blood on religious grounds. The first gives a positive value to giving blood; the second gives a negative value to the same course of action. Specification is the attempt to restrict the range of situations to which one of these concepts applies such that only one will indicate a value for a proposed course of action. For example, the above case might lead us to add "that the patient's religious beliefs are not violated" to the requirements for beneficence in order to determine the right action.

Specification (z) reduces the range of situations by adding facts to $\mathbf{F}_x$ ($\mathbf{F}_x' = \{\mathbf{F}_x, F_z\}$) and $\mathbf{S}_x'$ is a subset of $\mathbf{S}_x$. This also tends to allow more of the territory to be undefined (P' is silent on the

[12] Not all possible actions in all possible situations have moral valence.

moral value of any actions in situations defined by {**F**, $-F_z$}). For example consider the general normative principle (P) "Maximising pleasure is good", a well worn specification is (P') "Maximising non-sadistic pleasure is good", it is important to note that it would be a fallacy to draw any conclusion about sadistic pleasure from the more specified P'.[13] The specification z reduces the scope of P: **S=**{situations where pleasure is maximised}, **S'**={situations where non-sadistic pleasure is maximised}, and **S"**={situations where sadistic pleasure is maximised}; **S= S'∪ S"**; the facts of any particular situation (S_a∈**S**) then decide whether S_a∈**S'** or S_a∈**S"**.

Hard line consequentialists may say that such specification is not necessary and accept that sadistic pleasure is good. I think this is simply wrong; the pleasure a sadistic paedophile gets from torturing a child is not morally equivalent to the pleasure an organist gets from playing a Bach Toccata.[14]

Beauchamp and Childress describe specification as a "progressive" procedure; extending this to a limit beyond the discussion in Beauchamp and Childress, each S_a would have its own particular set of facts $\mathbf{F}_a$ and its own normative principle P_a which would associate the facts with the ethical valence V_a. Referring back to Hare in §2.2 we see that in this limit we have lost all generality and Hare's driving instructor is back in the car! Specification, by its nature, reduces the size of the set of situations in which a principle applies; the more specified a principle becomes, the larger the set of features required becomes and the fewer the number of situations which have the required features. The challenge for generalists is to demonstrate that there is any set facts $\mathbf{F}_G$ such that necessarily P_G is associated with V_G for all situations $\mathbf{S}_G$ where $\mathbf{F}_G$ = TRUE, and for any

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[13] I accept that generally specification is called upon when normative concepts give apparently conflicting advice based on the same set of facts about a situation, both sets will be subsets of the facts-of-the-situation set; examination of the disjunction of the subsets should reveal members of one subset (the action giving pleasure is sadistic) which can be used in the specification of the other (the pleasure given is not sadistic pleasure); however it is not necessary for specification that it be used in this way, we can ask of a normative concept "Is that always true?" which invites specification without having to choose between conflicting guidance.

[14] This seems to accept a form of moral intuition as an ultimate arbiter in moral thought experiments. By and large I am happy with this at least as far as the writing of this chapter is concerned.

particular situation S_a which is defined by facts $\mathbf{F}_a$ where $\mathbf{F}_G \subset \mathbf{F}_a$ there can be no fact F_α (where $F_\alpha \in \mathbf{F}_a$) which results in S_a having a different value from V_G. Otherwise $\mathbf{F}_G$ is an insufficient specification for P_G and a further specification $\mathbf{F'}_G = \{\mathbf{F}_G, -F_\alpha\}$ is required.

In general we think that some features of a situation are relevant to the moral value of a proposed action whereas others have no influence over that value. Generalism can be seen as an attempt to codify between the moral and the non moral domains (in the terms above moral principles provide this codification); a criticism of particularism arises from the notion that, for the particularist, there is no way in principle of deciding beforehand which features of a situation will be morally relevant when an agent in the situation chooses an action; this seems to imply that any feature of a situation might count in deciding the moral value of an action. At first sight it seems nonsensical to suppose that the agent's shoelace colour might influence the moral value of a proposed action. Holism of reasons, however, does not say that there must be a situation where shoelace colour affects moral decisions, but it does imply that the implausibility of such a consideration does not prove its impossibility. Reason such as shoelace colour may "arrive switched off" for moral relevance whilst reasons such as justice may "arrive switched on" for moral relevance. In §4.3 I will introduce default valence as a means of describing features which arrive switched on (with a positive or a negative valence).

2.7 Supervenience

It is generally accepted that moral features of a situation supervene on the non-moral. This is to say that there cannot be a difference in the moral properties of a situation without there being a difference in the non-moral properties. Given that not all the non-moral properties of the situation are required to imply the moral, it is useful to ask if supervenience has a bearing on the particularism/generalism debate.

If there are no *morally-relevant* differences between two situations supervenience implies that the right action in the first is also the right action in the second. Situation A (S_A) has a set of morally relevant features $\mathbf{F}_{MR\text{-}A}$ [15] and action X is right in situation A. If situation B has a set of morally relevant features such that $\mathbf{F}_{MR\text{-}A} = \mathbf{F}_{MR\text{-}B}$ then action X is also right in S_B. For supervenience to operate this must be a strict equality; it is not sufficient that all the features $\mathbf{F}_{MR\text{-}A}$ are present in situation B ($\mathbf{F}_{MR\text{-}A} \subseteq \mathbf{F}_B$). For the generalist there could be a feature in S_B which invokes another general rule which provides a *pro tanto* reason for X to be wrong; for the particularist there could also be a feature in S_B which causes one or more features in $\mathbf{F}_{MR\text{-}A}$ to be no reason at all or an opposite reason in S_B. For Dancy:

> It is better to think of supervenience as a syncategorematic relation between moral and non-moral properties in general, expressed in the fully general claim that if we start from a wrong action and move out to the entire non-moral nature of the world in which it is situated, and then replicate that in a new world, we are certain to have a wrong action in the replicating world. There is nothing more to supervenience than this.
>
> Dancy 2004 p87

This quotation is from the chapter entitled "Holism and its Consequences"; Dancy rejects supervenience as having nothing useful to tell us about moral decisions if we accept the holism of reasons. For the particularist, supervenience requires the entire non-moral nature of the world to be the same for there to be no possibility of a moral difference; supervenience then seems only to generate "rules" at the very end of the thickness function and cannot help with general principles. If supervenience itself is true then it is true independent of any facts in the world, and any attempt to generate a normative principle of supervenience would result in a thin principle.

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[15] Dancy would term $\mathbf{F}_{M\text{-}A}$ as the "resultance base" for the decision that Xing was right in A. For him resultance is very vulnerable to changing situations and cannot generate general principles.

2.8 Justice: a principle or a range of usage?

To examine specification further I will look the use of the concept of justice and the principle "do what is just". This is used by several writers as an example. Hooker offers promoting justice as a counter example to particularism, "how could the fact that an act would promote justice ever be anything less than a *pro tanto* moral plus?" (Hooker 2000 p9) Dancy recognises "the pull of the idea that we are not just dealing with a default, and that justice always counts in favour." (Dancy 2004 p121.).

A problem with arguments using terms such as "justice" is that the term can be applied in a number of different ways and these can have different underlying concepts and the principle "do what is just" will be associated with different feature sets. The different uses have different thicknesses, at its thinnest justice entreats us to treat equals equally (Aristotle 350 B.C. Bk V Chap. VI). The principle of supervenience says that there cannot be a moral difference without a factual difference, if two situations or two agents are equal then there is no (non-trivial) factual difference between them and justice, in this thin sense, is derivable from supervenience; thickening the concept (increasing the size of the feature set required to associate the concept with a situation, thus allowing action guidance) allows a holistic interpretation of the set of features.

If the just action is the right action, a situation (S) which involves treating two agents (p_1 and p_2) differently leads to an argument of the form:

P1	if p_1 and p_2 are equal with respect to action X in situation S, then X is a right action iff p_1 and p_2 are treated equally;	If $\mathcal{A}$ then $\mathcal{B}$
P2	Xing does not treat p_1 and p_2 equally	

P3	Xing is the right action in S	
C2	From P2 & P3	$-\mathcal{B}$
C2	$p_1$and p_2 are not equal with respect to X in S	$\therefore -\mathcal{A}$

For there to be a difference in the treatment of agents in the conduct of a right act, then, there must be a difference in the (morally relevant) features of the agents. This is a refining of the concept of the supervenience of the moral on the non-moral, which says that for there to be a moral difference there must be a difference of fact. This concept of justice is at best very thin, it is arguable that it belongs with supervenience in the realm of meta-normative rather than in the realm of normative ethics; it follows that acting with justice, in this very thin sense, is right independent of any features of any situation.

To thicken the concept, an action can be "just" or "unjust" if it concerns the distribution of some good (or some evil) between agents. Justice, in this sense, is often considered in such areas as resource allocation. Although this use is not fully thin, it might be described as "very lean"; there is a minimal descriptive element that seems more concerned with saying what type of rightness is involved, rather than indicating how to choose an action in a particular case.

The generalist, trying to choose a course of action, might think it reasonably to ask, "In what sense should the various actors be equal?" If she is deciding whether an agent's freedom should be restricted, she might reasonably think the axe murderer and the lumberjack should not be treated equally if each is requesting the return of their axe; however, if she is deciding who could be the subject of medical experimentation without consent, she might think these two are equal. The generalist can explain the difference between these cases in terms of a *pro tanto* duty to act with justice and a *pro tanto* duty to protect agents from potential harm. Alternatively the generalist can make a specification that those who might want to harm others are not equal to those who

do not in respect of actions which help or enable them to cause such harm. The holist sees the agent's being an axe murderer as counting in the first case but not in the second.

Now consider a fairly well worked set of thought experiments[16]:

Case 1

A person p^{i} is in distress in the water and will drown if no assistance is given.

Case 2

Two people are drowning close to each other.

Case 3

Two people are drowning but are so far apart that only one can be saved.

Case 4

Six people ($p^{i} – p^{vi}$) are drowning; they are in two groups p^{i}-p^{iii} and $p^{iv} – p^{vi}$.

Case 5

Six people ($p^{i} – p^{vi}$) are drowning; p^{i} is on his own and $p^{ii} – p^{vi}$ are grouped together.

Agent A has access to the only boat and the necessary skills to save one person or one group of people. Given that we don't know if any of the p^{n}s will turn into Hitler or Beethoven we can think of them all as equal. What should A do in each situation?

Case 1 seems fairly clear: a duty to rescue requires A to save p^{i}. Similarly A should save the pair in Case 2. In Case 3 A can only save one of the potential drowners, A has no reason to choose one over the other; if A is not to dither so long that both drown it seems he must choose at random whom to save and whom to abandon to her fate. Case 4 seems only different in scale from Case 3 and again random choice between the groups treats $p^{i} – p^{vi}$ equally. In Case 5 most

[16] The example here is a version of the thought experiments discussed by Taurek (Should the Numbers Count? Taurek 1977. This has led to a considerable literature over the years. I have found Lübbe (Lübbe 2008) and Hsieh (Hsieh *et al.* 2013) helpful in preparation of this thesis.

people's moral insight will lead to saving the five and abandoning the one. As he goes down for the third time, p^{i} can argue that his needs have not been given equal weight to the needs of p^{ii} – p^{vi}. With his last gasp he can accuse A of failing to act in a just manner.

p^{i}-p^{vi} are equal in all respects other than geographical position, although this difference might have arisen for any one of a number of reasons, some of which would be considered morally relevant if known to A (p^{i} was an axe murderer and p^{ii}-p^{vi} were cowering on the other side of the boat when it sank) or not (p^{i} had forgotten that they had all agreed to wear shoes with yellow laces and was returning to the cabin to change his shoes when the boat sank), this is not known to A; from his perspective all are equal and justice demands all are treated equally; in cases 3 and 4 equal treatment was achieved by a random choice of whom to save (see below). The particularist might say that in Case 5 justice simply does not count (has a valence of zero); the generalist has a few possible defences for saving the five. Firstly he might claim that p^{i} is not an equal for, for example, p^{iii} because the latter has the good fortune to be part of a group. However this looks dangerously like the sort of feature which most generalists are loath to consider as important in ethical judgement (that p^{i} happened to have put on shoes with red laces that morning). Alternatively a Rossian deontologist will see the needs of the five as outweighing the needs of the one[17] and the saving of four extra lives as outweighing the requirement for justice.

To develop this thought experiment further, consider how p^{i} – p^{vi} can be given equal treatment. If A rolls a six-sided die and sets out to save p^{i} if he throws a 1, p^{ii} if he throws a 2 and so on, he can claim to have given equal consideration to all p^{n}s. If this model of the requirement for justice is accepted, then if A set out to save p^{ii} and reaches the area in time he will be able to rescue any one in a group with p^{ii} but unable to rescue any others; given that A has assumed some sort of

[17] A consequentialist would not need to consider justice as right-making and might be exempt from this argument altogether.

duty to rescue, we see those grouped with p^{ii} as being fortunate in that they are saved alongside another member of the group. In case 4 there will be an equal chance of A's going to either group, and the outcome will be the same as before. In Case 5 however, one time in six A will rescue the one and allow the five to drown. Consideration of justice can be seen in this case to lead A to the wrong action one time in six. That is to say, if this analysis is correct, then justice will guide A to save p^{i} when he rolls a one thereby condemning the remainder to drown; saving p^{i} would seem to be the wrong action and not a *pro tanto* right action with a low weighting compared to the *pro tanto* value of saving the p^{ii}-p^{vi}. Justice here is thicker than the very thin sense in which it was used above. This thickening allows the reasons holist to question whether an act which promotes justice is always a *pro tanto* reason in favour of that act. The generalist could, of course, add a specification to the principle of justice to cover such situations. When the complexity of the situation allows rules to conflict the particularist might wonder which features count, and the generalist might look for specification of the principles; it is in complex situations where we find practical differences between particularists and generalists. In Chapter 5 I will discuss some the real decisions faced by medical professionals and try to see what differences the complexity of some of these situations exposes between the decisions of particularists and generalists.

2.9 Counterexample

Generalists opposing particularism often cite examples of supposed immutable principles as counterexamples. I will consider two in this section.

2.9.1 Causing pleasure

Hooker [Hooker 2000 p7] considers the property of producing pleasure (F_1: Xing will produce pleasure). The initial proposed principle (P) would be that any act X for which F_1 holds would, *qua* F_1, have a positive moral valance. He then says:

> However, particularists point out that, while the property of producing pleasure makes an act better in some circumstances, this property makes an act worse in some circumstances. That the act would give pleasure is not merely an overridden positive feature of the act. Rather, sadistic pleasure actually makes the act morally worse than it would be if it didn't afford sadistic pleasure.
>
> p7

Hooker says the Rossian generalist has two options. The first is to allow that P is a *pro tanto* principle, however he already seems to have ruled this out in the paragraph quoted above as F_1 is "not merely an overridden positive feature" rather it "makes the act morally worse". This seems right:

P1: Producing pleasure has a positive moral valance

P1': If Xing produces pleasure then Xing has a positive moral valance

P2: Sadistic pleasure is a type of pleasure

C1: Producing sadistic pleasure produces pleasure

C2: Producing sadistic pleasure has a positive moral valence

As I discussed in Section 1.2.1, C2 does not seem to be the sort of thing we would want to say even *pro tanto*. If the argument is sound, and the conclusion unacceptable, then we must look to the premises; I suggest the problem lies with the thinness of P1. This brings us to Hooker's second option which is to "start making distinctions". He goes on to say "the *moral* status of pleasure depends on what kind of pleasure it is" [p8; original italics]. This does not, of itself,

offer any generalist principle. Hooker gives "[n]onsadistic pleasure is always a moral plus". The modified principle (P') is thicker than P and requires a set of facts **F**'(= {F_1: Xing will produce pleasure, F_2: the pleasure is nonsadistic}). Hooker is satisfied with this slightly thicker principle, however it does not rule out the possibility of further F_α which require further distinctions or specification. Dancy comments that the pleasure people get from watching public hangings makes letting them watch morally worse; Hooker seems to accept this but subsumes this pleasure under sadistic pleasure. However there is a certain self-righteous pleasure in seeing someone "get their comeuppance", but this need not be due to "inflicting pain, suffering or humiliation" (Concise Oxford Dictionary definition of "sadism") and is not the same as sadism. To allow for this we may need a further F_α to give a larger set of facts F".

Hooker says he "cannot see how a particularist can win on this battlefield" (p7); if this is so, it is because the process of making distinctions, or of specification, constitutes a moving of the goalposts and particularists cannot catch up. However the generalist would like to find a permanent place for the goalposts and it is difficult to see how either side can win.

2.9.2 Is particularism refutable by counterexample?

Hooker begins his discussion of counterexamples with the question "Is particularism refuted by counterexamples ...?" [p7]. The statement of particularism given in § 1.3 implies that counterexamples would not, of themselves, refute particularism. The version of particularism which this statement embodies is tolerant of general principles, it simply says they are unnecessary, Dancy does state that, in his opinion, the existence of general principles other than the sort of principle arising from the logical necessity of the limit of supervenience, would be serendipity. Hooker takes counterexamples to be significant in that they weigh against the idea that, if this principle is not general, then any principle we consider may be "merely particular". Counterexamples, then, might weaken (albeit not fatally) holism; however none of the above

possible counterexamples seems sufficient. It is difficult to see how either side can win in this counter-example, counter-counter-example argument. I believe particularists can present arguments to help shore up the walls of particularism against the attacks of the generalists; however in many cases whether a feature which changes the value of an action in a situation has caused a *pro tanto* general principle to be outweighed or caused a (default) principle to no longer count is still a matter of debate.

Looking at the example of pleasure above, we see that the generalist can use specification to fine tune their principles. "Pleasure" becomes "non-sadistic pleasure". In the absence of proof that this list is closed (for particularists the holism of reasons necessitates that the list is open) this seems to be a game of constantly moving the goalposts each time a shot on goal is produced. This moving of the goalposts seems to me to be a reason for particularists to stay out of this sort of argument. If the generalist is allowed to extend $\mathbf{F}_C$ indefinitely in pursuit of a general principle there seems to be no obvious boundary. In order to ensure that there can be no fact F_α which changes the value of an action we will ultimately reach $\mathbf{F}_S$ the set of all facts when S exists. If this is a basis for a principle then is will hardly be a general one! In discussing supervenience Dancy (2004) says

> [I]f we move to another case holding fixed all the non-moral properties of the case whatever, we know in advance there can be no [differences which conspire to prevent the original wrong making properties from doing that job in the new case]. Whatever was a reason in the first case must remain a reason in the second, and nothing that was not a reason in the first case can he reason in the second.
>
> Dancy 2004 p89

In this limit, the generalist would reach a very particular principle. It would be better to characterise this end of the thickness spectrum as particular judgements made as a result of specification rather than make ever more particular general principles.

2.9.3 Is generalism refutable by counter example?

Little (Little 2000) argues that it is possible to codify the connection between moral and non-moral properties:

> Obviously, to defend particularism, it is not enough to keep offering counterexamples to proposed principles. Even if they are accepted, just what they suffice to show is precisely what is in question – those attuned to the richness of morality but loyal to the existence of principles will see counterexamples as evidence of complexity, not of irreducible complexity. (Besides there is something not a little farcical about measuring didactic success in terms of who can outlast whom – those who want to refine a principle and those who want to find exceptions.)
>
> P279

Ultimately the game of example and counter-example helps us to sketch out some differences between the particularist and generalist camps and, thereby, to understand what is being claimed by each; but it will not resolve the question of which view of morality should prevail.

2.9.4 Operative reasons

Hooker (Hooker 2000) examines Dancy's non moral examples of holistic reasons:

> [T]hat there will be nobody much else there is sometimes a good reason for going there and sometimes a very good reason for staying away.
>
> Dancy Particularists Progress in Hooker and Little p132

he asks "are there any essentially particular practical reasons?" He states that all normative (or good) reasons are either moral or self-interested; Dancy's examples are then taken to be incomplete self-interested reasons, if the reason is fleshed out:

P1 Thinking things through will increase my knowledge

P2 Time for reflection will allow me to think things through

P3 Getting away from people will allow me time for reflection

P4 There will be nobody much else there

C1 Going there will increase my knowledge

P5 "[I] have self-interested reasons to pursue pleasure or knowledge for [my]self." [p13]

C2 I should go there

Hooker says "the operative reason [is] general" [p13]; to see what he means by this it is useful to examine the propositions: P1 to P4 are all open to holistic interpretation, sometimes they will be a reason to do a thing sometimes not, sometimes I may want time for reflection sometimes I may want to party. Conclusion 1, then is also holistic, sometimes I will want to increase my knowledge, sometimes I feel I know enough. P5 then is what Hooker means by the operative reason.

> In these cases (as elsewhere) operative reasons are general. That some act would benefit you is a reason to do it.
>
> P13

What does P5 add? P5 looks to be a thin (or at least a very lean) principle. P5 is a non-moral normative principle which is true regardless of any particular feature set associated with any situation. It supports a self interested reason to go there in some situations and a self interested reason not to go there in others; the set of features required to invoke it in any situation is, in practical terms, empty. Without some thickening it will not do the work of telling you where to go. If going there will allow you to pursue knowledge and going elsewhere will allow you to pursue pleasure you have *pro tanto* reasons to go there and to go elsewhere. P5 is too thin to indicate which action to choose between the *pro tanto* reason to go there and the *pro tanto* reason to go elsewhere.

2.10 Conclusions

The debate between particularists and generalists is not resolved, and shows no signs of resolving in favour of either side in the near future. In this chapter I have introduced the main points of the debate insofar as they will be important in the discussion of how medical ethics would be affected if particularism were true. I take this to be tantamount to how medical ethics would be affected if the holism of moral reasons were true.

In this chapter I have followed the main protagonists in this debate and have taken generalism to be a form of Rossian deontology which allows for competing *pro tanto* principles or duties and have taken specification (as described by Beauchamp and Childress) to be a way for deciding the right action when there are competing candidates. I will look at the application of this idea in the next chapter. I have not included the ideas of virtue ethics in this chapter and will return to this important topic in Ch 4.

From a practical point of view one might ask for a way of deciding whether *pro tanto* reasons or holism provides a better model for morality in a world where similar situations cam produce different results; examples of such decisions are given in the following chapters, but for a preview of those arguments consider whether the fact that a victim of a road traffic accident is a Jehovah's Witness is a *pro tanto* reason not to give him blood, or if this fact changes the moral value of the fact that blood would increase his chances of survival from a positive value to not counting in this case.

In the next chapters I will ask if this distinction has any influence on the way medicine should be taught and practiced. Currently medical ethics is based on generalist ideas, I will argue that the many codes of practice, standard operating procedure, and other forma of professional advice on offer embody a set of generalist principles and develop action guidance from there. I will propose that a particularist approach would indicate that we should rely on these codes and

guides less, and aim to produce professionals with a moral approach less reliant on following the guides and more reliant on seeing and doing the right thing. I will look at how the current generalist approach works for patients and how a particularist approach would change things. As well as some case studies I will look at one of the central planks of the relationship between doctor and patient, that of trust.

The ideas contained within particularism raise real questions for generalism to answer. However while this debate continues there is still a need for ethical guidance, in the case here for professionals working within medicine.

3 Professional Ethics

Thomas More: Will, I'd trust you with my life. But not your principles. You see, we speak of being anchored to our principles. But if the weather turns nasty you up with an anchor and let it down where there's less wind, and the fishing's better. And "Look," we say, "look, I'm anchored! To my principles!" - Robert Bolt, A Man for All Seasons

3.1 Introduction

In this chapter I will look at why medicine and associated professions have professional ethics guidance and codes of practice covering ethical conduct; I will discuss what these codes are supposed to do, and look at some current guidance documents. I will look at where these documents provide guidance and where and why they fail to do so. I will argue that providing guidance in all cases in an impossible objective. I will discuss some implications of this with regard to particularism.

As a starting point for this discussion I will refer to an ethically naive clinician, by this I will mean a junior doctor, one who has had a course of lectures on Medical Ethics which was largely focussed on "Principles of Biomedical Ethics" (Beauchamp and Childress 2001) and "Philosophical Medical Ethics" (Gillon 1985), but who has little experience in clinical decision making.

3.2 Why do we need professional ethics guidelines?

In their private and professional lives people like to think they have acted in a correct manner; this can have many aspects: people wish to act within the law, in private enterprise they try to fulfil the company's mission statement and to provide a good return for the shareholders, and people in general want to behave ethically. At this level there is nothing specific about medical ethics, however the actions of medical professionals (be they giving advice, prescribing a course

of therapy, or referring to a specialist) can have a considerable effect on the lives of others; the relationship between doctor and patient is often described as "special". The doctor-patient relationship is complex, but a large element is based on trust, the doctor has knowledge and skills which she can use to help the patient; the patient trusts the doctor to apply these to the patient's benefit. I will discuss this further in § 5.8.

People also expect to have control over their own lives, for this to happen people must be able to make decisions (preferably well informed decisions) and act upon those decisions. Again, the doctor-patient relationship has special characteristics here; people are making decisions about their health and wellbeing, including life and death decisions, under the guidance of clinicians. In a paternalist context the clinician would have decided what she thought best for the patient and informed him of her decision, under our more enlightened system clinicians are expected to enable patients to make decisions. I will look at this in § 5.5.

Clinicians are faced with dilemmas in their normal practice such as how to break bad news, how to respect a patient's wishes when they think the patient will suffer as a result; just as they will turn to guidance documents about new drugs to find the best available treatment, or attend continuing professional development (CPD) seminars to understand a new technique, guidance and Codes of Practice documents assist them to maintain best ethical practice.

3.3 Trust

In discussing trust I will take it to be an interaction between people. The statement "I trust the brakes in my car" can be unpacked into several statements, such as "I believe they have been properly designed", "I believe they are properly maintained" etc, many of these statements can be further unpacked; at the end of each will be will be either some person (or people), such as a designer or a car mechanic, or some scientific principle, such as the law of friction or some equations for hydraulic pressure. The latter are verifiable statements of fact and the former are

the true objects of my trust. If this analysis is correct then saying I trust something is often a shorthand for a number of systems of trust. Trusting is an interaction which can be direct (I know the chap who services my car) or indirect (I have no idea who designed the brakes (or even what country he, she or probably they live and work in)).

The alternative that "trust" here is being used to say simply "I believe that the braking system will not fail" and that belief does not require two or more people, does not seem to look deeply enough into the situation. I am not expressing a religious belief where blind faith is required of the truster; I would like my belief that my family and I will not hurtle over the cliff as I press the brake pedal to be a rational one. That rationality is based on my belief that this is a trustworthy make of car and I have had it serviced by reliable mechanics. Ultimately trust is an interaction or a system of interactions, between trusters and trusted.

In the late twentieth century and the start of the twenty first people in the western world have been increasingly mobile, one disadvantage of this is often a lack of continuity in the health care professionals a patient will see over the course of his or her life. Even within the course of treatment for a single ailment a patient may see a series of health care professionals (specialist nurses, therapists, clinicians etc), if the treatment is prolonged some of these professionals will move on in their careers and be replaced. All of this makes it difficult for the patient and the professionals to build a system of trust as the basis for giving and accepting advice.

Meanwhile traditional trust relationships have been undermined by the high profile given to breaches of trust in the news media when individuals in a position of trust turn out to be untrustworthy.

Many of Dr Harold Shipman's patients trusted him; Durham Area Health Authority recorded that "Shipman had settled satisfactorily into his new employment, … and had been well received by both patients and professional colleagues alike" (Shipman Inquiry 2001) p 20-23). He was

convicted of killing 15 of his patients and is thought to have murdered in the order of 300 of them.

Dr Andrew Wakefield caused a lack of trust in the advice of many G.P.s when he published a high profile paper suggesting a link between the MMR "Triple Vaccine" and autism (Wakefield *et al.* 2004). The report was later discredited and most of the authors retracted, however Wakefield denied any wrongdoing; in 2010 a report by the General Medical Council found allegations against him to be proved; they noted him to be "dishonest", "irresponsible" and "misleading", and that he acted "contrary to [his] duty" (GMC 2010a).

Trust is a fulcrum around which many perceived problems of the early Twenty First Century turn. The news and information media tell us we cannot trust politicians, bankers, social workers, teachers, nurses and doctors or indeed the media professionals themselves! There are many proposed explanations for this perceived drift into a less trusting model of society, and questions as to whether the perception is correct (see for example the writings of O'Neill (O'Neill 2002b;O'Neill 2002a)). It may be that society is insufficiently homogenous in this respect for a clear picture to emerge; what does seem clear is that we believe there to be a crisis of trust. For the purpose of this thesis I am interested in looking into the mechanisms employed with the aim of engendering trust; I will not be concerned with the wider implications of the supposed crisis of trust.

From this perspective trust is not automatically due to professional people, and doctors (among others) are expected to demonstrate trustworthiness. The mechanisms for this are often codes of practice and other guidelines, such as the Department of Health's guide "Good Practice in Consent" (DoH 2001), which embody good practice in many senses, such as ethical , legal and technical. A process of audit is supposed to ensure adherence to good practice and thus trustworthiness.

3.4 Individuals in Society

The second half of the twentieth century has also seen the rise of the individual over the member-of-society. This is exemplified in U.K. politics by the premiership of Margaret Thatcher who said, "you know, there is no such thing as society. There are individual men and women, and there are families. And no government can do anything except through people, and people must look to themselves first. It's our duty to look after ourselves and then, also to look after our neighbour".[18]

A negative aspect of this emphasis on individuals is the "me first" attitude which some observers have described as arising in the final quarter of the twentieth century. For instance in 2009 the Children's Society reported that many of the problems facing children in the early Twenty First Century are due to "excessive individualism" on the part of adults saying, "Most of the obstacles children face today are linked to the belief among adults that the prime duty of the individual is to make the most of their own life, rather than contribute to the good of others"(Children's Society 2009). The Daily Telegraph newspaper reported Lord Layard, one of the authors of the final report, as saying, "You have a decline in religious belief and a decline in what you may call socialism, that kind of social solidarity which was quite strong in the first half of the 20th century." (Beckford 2009).

Early Twentieth Century medicine was characterised by a paternalistic system where "Doctor knows best" and patients did what the doctor said. As individuals have come to the fore they have expected more control over their own lives. This can set up a tension between patients and health care professionals, particularly when what is best in a medical sense (e.g. giving blood to a

[18] Prime Minister Margaret Thatcher, talking to Women's Own magazine, [Keay, Douglas, "Interview with Margaret Thatcher", Woman's Own, October 31 1987]; the transcript of this interview given by the Margaret Thatcher Foundation [http://www.margaretthatcher.org/speeches/displaydocument.asp?docid=106689] differs slightly in emphasis.

road traffic accident victim) does not chime with the patient's view of what is best for him (e.g. he is a Jehovah's Witness). Allowing patients control over their lives is the prime driving force for the emphasis on autonomy in current medical practice (see §3.4.1).

Also inherent in the rise of the individual has been a break down in the feeling of responsibility for other members of society. In a society where there is a mutual feeling of responsibility for each other there is engendered a feeling of trust, but when I believe you are out for what is best for you without regard for me, I do not have a feeling of trust towards you. It is necessary for society to function that I know how far I can trust you (whether you are my Member of Parliament, a journalist writing in my newspaper, or my General Practitioner). Codes of practice are commonly used to define a professional's responsibilities, in general, to his fellow professionals, and to his clients or patients.

> Good legislation, good regulation, good policies, good practices and consistent professionalism are a beginning; they need reinforcing with means of ensuring compliance, and demonstrating that compliance is reliably achieved. All this is easily stated, and hard to do.
>
> O'Neill 2002a p123

The start of the Twenty First Century has seen a further breakdown in trust fired largely by the exposure of previously trusted groups of professionals as being principally self serving, although surveys of the general public still rate doctors as the most trustworthy group within society.

3.4.1 Autonomy

The term "autonomy" is derived from the Greek word used to indicate city states which were self governing; in current usage it is extended to apply to individuals who have the ability to

determine their own course of action. There is little general agreement between philosophers as to what this actually means (see Dworkin 1988, ch.1).

Trivially we can see that we cannot have complete freedom of action, I cannot (meaningfully) choose to jump over the moon. Less trivially we are subject to a number of constraints placed on us by our nature or nurture, most people would find it difficult deliberately to cause significant harm to themselves; indeed those who do so may be thought to be psychologically ill and acting under the compulsion of their illness when they "self-harm". A sufferer from arachnophobia may be unable either to watch television while a large spider sits on top of the set, or to go over to the set and remove the creature. Social constraints may be more variable but they play a significant role in governing our actions: I, for instance, cannot sit comfortably reading on a tube train whilst a pregnant woman is forced to stand. Society also imposes constraints on our actions: I may choose to break a law but (assuming I am caught) I may not then be able to choose to continue my life as before.

Even when only confronted by possible courses of action, deciding on one rather than another is not necessarily acting with autonomy; few would think that the supposed author of The Dice Man (Rhinehart 1971) showed autonomous action in rolling dice to decide which course of action to follow. An alcoholic confronted with a glass of whisky may be irresistibly influenced by his addiction, and unable to make an autonomous decision as to whether to drink it. As O'Neill reminds us in "Autonomy and Trust in Bioethics" (O'Neill 2002b) "autonomy is not mere, sheer choosing".

It is useful, here, to distinguish between first-order and second-order desires. First order desires are the ordinary desires to have or to do something; second-order desires are desires about desires (the addict may desire that he did not desire to drink the whisky). It is the reflection on

second-order desires and consequent acceptance or rejection of first-order desires that is seen as important for autonomous action.

> [A]utonomy is conceived of as a second-order capacity of persons to reflect critically upon their first-order preferences, desires, wishes and so forth, and the capacity to attempt to reject or change these in the light of higher-order preferences and values. By exercising such a capacity persons define their nature, give meaning and coherence to their lives, and take responsibility for the kind of person they are.
>
> Dworkin 1988, p20

Within the field of medical ethics a working definition is generally based on that given by Beauchamp and Childress (Beauchamp and Childress 2001, ch3) In this analysis three components are required for an action to be autonomous, (1) it must be done intentionally, (2) it must be done with understanding, which is to say that the actor must have relevant knowledge of what would be involved in undertaking the action and must have had time and opportunity to reflect on that knowledge, and (3) it be done without "controlling influences".

Beauchamp and Childress take the first component to be an absolute; they state, without discussion, "acts are either intentional or nonintentional" (p59). Although it seems possible to argue with this, I will accept their contention at face value for this thesis.

The second and third components are matters of degree as can be seen from simple examples. Children achieve understanding of increasingly complex ideas as they mature, and some elderly patients may lose their capacity for complex understanding with advancing age. We may feel that these patients have sufficient understanding to qualify as autonomous (at least as far as this component of autonomy is concerned). Some decisions are simple and these patients may act with "sufficient" autonomy; some are more complex and may be beyond grasp of some patients, if forced to decide here the action would be mere sheer choosing rather than autonomous

choosing. Some highly complex situations may be difficult for any lay person to grasp fully, the problem being how to help them to sufficient understanding to achieve autonomy.

It is difficult to believe that any of us is, or would wish to be, without any significant influences; most of us are still subject to the lessons learned at our mother's knee, many Christians are happy to defer to the Decalogue, and most of us hope for the good opinion of our peers, whoever we perceive them to be.

It is not the job of the healthcare professional to force patients to make autonomous decisions (even if that were possible); it is their job to provide the tools needed for making autonomous decisions to those patients who desire them. We must understand what these tools are to see how they can be provided.

Under the paternalistic system patients were not free to choose, they were under the controlling influence of the doctor, whilst this control was (generally, at least) benign it did not allow the patient to decide the course of his or her life. This being the case, it is a simple step to see that the patient had no use for an understanding of his or her condition, or the options for treatment. Making those decisions, and thus requiring that understanding, was the role of the doctor. The patient was only required to trust the doctor and to take the medicine. It is useful to see where this model has been replaced with the autonomy-driven approach, and how far it is possible to take respect for autonomy.

Beauchamp and Childress observe that "[r]espect for the autonomous choices of persons runs as deep in common morality as any principle" (p57). Although the debate about what constitutes autonomy continues I will not pursue it in this thesis; I will take a simple view based on the Beauchamp and Childress view as sufficient for the arguments set out here. Autonomy refers to the right of agents to have control over their own lives. Autonomous individuals make decisions concerning their lives; they act according to their own beliefs, plans and life goals. This is

obviously simplistic, as noted above, not all things are possible, many actions interfere with the rights of others (no one should respect my autonomous decision to try out my new gun by shooting the first five people I meet) and autonomous desires are subject to limitations in resource limited situations. Respect for autonomy of others will often require actions rather than just the adoption of a respectful attitude.

The characteristics of autonomy thus understood require certain behaviour from others; in the context of the doctor-patient relationship a major aspect of this is the provision of information. Autonomous decisions are informed decisions; it is part of the doctor's role to ensure the patient has full knowledge of all possible courses of treatment, subject to the patient's preferences. For example a patient might preface a discussion by saying, "I don't want any surgery", in which case only non surgical interventions need be offered. How far this goes may be a matter of judgement. A doctor might not consider a course of treatment with a low probability of success to be a valid option, a patient might say he wants to consider homeopathic treatments; both of these might change the range of options offered. Similarly the doctor must ensure the patient understands the potential outcome of the various options, their probability of success and their potential to cause side effects. All of these place the doctor in a position of trust to ensure a full (but preferably non-confusing) range of options is made available to the patient.

The introduction of technology and the availability of information are two areas where medical professionals have to rely on professionals in other fields to be able to offer the best advice and treatment to patients. I have written elsewhere (Green 2009) about the chain of trust present in much modern medicine and how the special relationship extends to other professionals in the medical field; for clarity, in this thesis I will be concerned with ethics at the interface between medical professionals and patients and not with the interrelationships of the various professionals.

Complicating factors in this discussion are such as the increasing tendency for drug companies to promote their products, for example through press releases and internet sites, and in some countries direct advertisement to the public. There is also much information available to patients via the internet, patient groups and charities might have disease specific web sites, many pressure groups put information on web sites, and the problem of trust is again prominent. How to tell good information from misinformation, how to tell the painstaking researcher from the conspiracy theorist, are questions related to how the patient decides where to place his trust.

Respect for autonomy is the basis for the requirement for informed consent. Medical professionals are required to obtain informed consent before any examination or treatment of a patient. The consent part of informed consent can take many forms, a patient who rolls up his sleeve and presents his arm can be considered to have given tacit consent to having an injection. This may be acceptable for standard minor procedures but more major procedures and clinical trials will require more active written consent. In a similar way the level of knowledge which needs to be imparted is dependent on the type of procedure being proposed. For a diagnostic blood test the patient may only need to know that the doctor "wants to rule out anything more serious", before treating a minor complaint, he will then roll up his sleeve, effectively giving consent to the taking of blood, happy that he has all the information he requires. In clinical trials a doctor and a research nurse may spend an hour or more with the patient and his relatives explaining the nature of the trial, the alternatives and the possible outcomes, before giving the patient a booklet to read, and asking him to return a day later for any further discussion he may want before asking him to sign one or more consent forms.

This imparting of information (and thus the system of informed consent) is reliant on the patient trusting the medical team to give sufficient true information. In the current "information age" many patients will use the facilities of the World Wide Web ("the web") to search for information about their condition or the advice they have received. There is always a question of

which source to trust when conflicting advice is obtained. If a doctor has advised a patient with cancer that she should undergo radical surgery followed by a course of chemotherapy, but the patient has found an alternative medicine site on the web which she thinks would be a better alternative, the doctor might feel that simple respect for the patient's autonomy would conflict with his duty of beneficence if he did not try to argue her out of her autonomous refusal of conventional treatment. He might feel that her wish to take the alternative medicine route was not fully autonomous as the information it was based on was not of a sufficient quality for such an important decision. In this situation a doctor might look to the GMC or the DoH for guidance, but in the end the doctor can only aim to be seen as sufficiently trustworthy that the patient will take his advice rather than the alternative.

3.4.2 Guidance

It is often not clear to the participants what the right action is in a complex situation, or even a simple one where a clear dilemma exists. In such situations detached reflection might help gain an understanding of how to act. Such reflection might result in different approaches from those dedicated to different normative approaches; it would allow a clearer understanding of the consequences, a chance to think through conflicting *pro tanto* duties, to undertake a process of specification or to reflect on the appropriate virtues. Any or all of these might help discussion and possibly *ceteris paribus* resolution of the dilemma in a philosophy class, however such reflection is not always available, for example, to physicians and paramedics treating casualties in acute need.

Jehovah's Witnesses believe they have a religious duty to refuse blood transfusion. This is a serious and deeply held belief based on their interpretation of The Bible; in particular Acts 15: 19-21:

> 19 Wherefore *my sentence is*, that we trouble not them, which from among the Gentiles are turned to God:
>
> 20 But that we write unto them, *that they abstain* from pollutions of idols, and from fornication, and from things strangled, and *from blood*.
>
> 21 For Moses of old time hath in every city them that preach him, being read in the synagogues every sabbath day.
>
> King James Bible[19] Acts 15: 19-21 (my italics)

Some Witnesses carry statements (similar to the MedicAlert system) to inform emergency workers of their refusal of blood products.

In discussing beneficence Beauchamp and Childress state:

> Morality requires not only that we treat persons autonomously and refrain from harming them, but also that we contribute to their welfare. Such beneficial actions fall under the heading of "beneficence".
>
> Beauchamp and Childress 2001 p165

In acute situations beneficence might dictate some active intervention which involves giving blood, however if the patient is known to be a Witness respect for autonomy seems to imply respect for a preference not to be given blood. The naive Beauchamp and Childress trained medic now faces a dilemma between the principles of beneficence and respect for autonomy.

Consider a doctor treating a known Jehovah's Witness (A) in acute need of a blood transfusion. If she had time for reflection this doctor could follow a chain of specification to decide whether

[19] The official Jehovah's Witness web site (www.watchtower.org) refers readers to the "New World Translation of the Holy Scriptures", whilst the language is more modern the text is not significantly different.

she should or should not arrange for a transfusion. However, in this case of acute clinical need, she may be denied this luxury. In the absence of a mentor (I will say more on mentoring in §6.3.2), two places she can look for guidance are precedent and codes of practice.

3.4.2.1 Precedent

The value of precedent for the naive agent is to try to do something which has not been judged to have a negative moral value in the past. For the current situation S^C ($\mathbf{F^C} = \{f_1, f_2 \ldots f_n\}$) and a candidate precedent situation S^P ($\mathbf{F^P} = \{f^P_1, f^P_2, \ldots, f^P_m\}$) she needs to identify a subset of features they have in common which carry moral relevance ($\mathbf{F^M} \subset (\mathbf{F^C} \cap \mathbf{F^P})$). If this can be done then *ceteris paribus* if Xing in S^P was judged to have moral value V then Xing in S^C will also have moral value V.

For the harassed medic above precedent can be found in the case of Emma Gough (Dolan 2008). Emma Gough was a 22 year old Jehovah's witness who developed life threatening haemorrhaging after giving birth to healthy twins, she lost over four pints of blood. Her physician believed a transfusion would have saved her life, but she had given an advanced directive that she should not receive blood. After she lost consciousness her family (also Jehovah's Witnesses) continued to refuse blood transfusion for her. According to the post mortem examination the cause of death was "profound anaemia" as a result of haemorrhaging.

Although it is possible to compile a potential list of elements of $\{\mathbf{F^C} \cap \mathbf{F^P}\}$:

f_a: no treatment was available which did not involve the giving of blood,

f_b: the patient was a practising Jehovah's Witness,

f_c: the patient had expressed a wish not to have blood,

f_d: this wish had been expressed in a way consistent with Beauchamp and Childress,

f_a: the patient was competent,

f_f: the patient was female,

f_g: the patient was 22 years old,

f_h: the patient had brown eyes,

…,

and a potential list of elements not common to the cases ($\{(\mathbf{F^C - F^P}), (\mathbf{F^P - F^C})\}$)

f_z: A's family were not known to be Jehovah's Witnesses,

f_y: A's condition resulted from a road traffic accident,

f_x: A was not called Emma,

…,

it is not clear how these derived sets relate to $\mathbf{F^M}$. The statements made by those involved in the potential precedent case might elucidate what they saw as morally relevant (and thus worthy of being elements of $\mathbf{F^M}$). In the Gough case, the care team reported to the inquest that they had discussed the risks with the patient before the birth; that she had signed an advanced directive, that they had "pleaded" with the family five times to be allowed to give blood, but finally that it was a "matter of conscience".

Use of precedent, then, is an appeal to supervenience. Determining which facts are relevant for supervenience to provide precedent in particular cases may be a matter of fine moral judgement which is not available to the naive agent; I will return to supervenience in §4.3.

3.4.2.2 Codes of practice

The naive clinician might try to find a code of practice which covers the situation and dictates which actions should (or should not) be undertaken. A code of practice[20] will, typically, describe

[20] Not all codes of practice operate in this way, many have no moral import. In this thesis I am only concerned with those which do carry moral significance.

features of the situation in which it applies, e.g. "the patient is a Jehovah's Witness", and describe actions to be taken to ascertain whether other features exist (or can be brought into being), e.g. "if the patient is competent, ask them to read and sign an advance directive", it will then dictate which actions are to be taken or refrained from taking, e.g. "you should not give blood or blood products". The naive clinician can expect any action prescribed to have a positive moral[21] value and any action proscribed to have a negative moral value. The code of practice, then, is an attempt to provide a definition of $\mathbf{F^M}$, or to provide more than one set $\mathbf{F^{M1}}$, $\mathbf{F^{M2}}$, … such that if $\mathbf{F^{Mn}} \subset \mathbf{F^S}$ then the associated action X^n has moral value V^n; this is expected to be sufficient to provide action guidance.

East Kent Hospitals NHS Trust publishes "Guidelines on the Clinical Management of Jehovah's Witnesses" (East Kent Hospitals NHS Trust 2005) which discusses all aspects of clinical management of Jehovah's Witness patients. Section 4 (p5) gives "Principles for management of life threatening bleeding in an unconscious adult JW"; 4.1 states:

> If it has not already been found, any documentary evidence, for example an Advance Decision stating that the patient will not accept blood transfusion even in the event of life threatening bleeding, should be requested from relatives or associates.
>
> p5

If the required evidence is not forthcoming Section 4.4 states:

[21] Codes of practice often do not make explicit reference to moral value; their *raison d'être* often seems to be to protect the doctor and the employing authority (often the originator of the code) from potential law suits. For simplicity I am assuming that the law is in step with morality.

> If the patient's Advance Decision refusing blood transfusion cannot be properly established by the above means, the doctor may have to act in the best interests of the patient, which may involve giving blood if no alternatives are available.
>
> p5

Section 5.5 requires that the thought processes involved in decision making are written into the patient's notes. Section 7 deals with additional legal issues and 7.1 states

> A competent adult has an absolute right to refuse any aspect of medical treatment. If the patient is treated against their will the Tort of Battery is committed. A written, signed declaration of refusal of blood products is legally binding and cannot be revoked by the court or a relative even if massive blood loss occurs whilst the patient is anaesthetised.
>
> p6

This emphasises of much of the reasoning behind this document is the protection of clinicians and the NHS Trust. An appendix to this document contains a copy of the form the patient is expected to sign; it starts:

> I hereby expressly withhold my consent to and forbid the administration to me of a transfusion of allogeneic (another person's) whole blood or any of its four primary blood components, red cells, white cells, platelets and/or plasma.
>
> p9

and later says:

> My decision to refuse blood and choose non-blood management MUST BE RESPECTED EVEN IF MY LIFE OR HEALTH IS THREATENED by my refusal.
>
> I accordingly absolve the health professionals involved in my care, the hospital and every member of the medical staff concerned from all responsibility and from any liability to me, or to my estate, or to my dependents, in any way arising out of or connected with this.
>
> p9 (original caps)

The document does not allow any leeway to the doctor, patient or relatives. It defines a closed list of features:

f_a: the patient was competent,

f_b: the patient was a practising Jehovah's Witness,

f_c: the patient had signed the consent form not to have blood,

f_d: the signature was properly witnessed,

f_e: all procedure were recorded in the patient's notes,

$\mathbf{F^M}$ is now the closed set $\{f_a, \ldots, f_e\}$ and if $\mathbf{F^M} \subset \mathbf{F^S}$ then the clinician is right not to give blood or blood components and acts wrongly if she does give them (in the case where the patient is a competent adult).

The Code of Practice shown in this example is a deontological strict generalist system. It does not allow for any new or unforeseen feature, f_α which can change the moral value of giving blood when $\mathbf{F^M} \subset \mathbf{F^S}$. Not all Codes of Practice offer such a defined closed set although it is interesting to see the difference between the DoH Guidelines on Consent as published on their web site in 2001 and 2003, and the current guidance (DoH 2009;DoH 2012). The earlier documents have been taken down from the web site. The 2001 document said:

> There may be occasions when, assuming a serious question arises about the competence of the patient, the situation facing the authority may be so urgent and the consequences so desperate that it is impracticable to attempt to comply with these guidelines. The guidelines should be approached for what they are, that is guidelines. Where delay may itself cause serious damage to the patient's health or put her life at risk then formulaic compliance with these guidelines would be inappropriate.
>
> Department of Health 2001 *no longer available*

There is no such clause in the 2009 document. In general throughout this thesis I have assumed deontology to be the *pro tanto* form following Rossian lines. Particularly in some recent updates to guideline documents this approach is not expressed and the rules are given in an absolutist way. This tends to lead to an "algorithmic deontology" which may be more due to aiming for legal rather than moral defensibility.

Some Codes are designed to cover only the majority of cases or "normal" cases; it will be in the nature of such Codes that there are particular situations in which they do not apply. In the case of the consent guidelines a reference is made to beneficence:

> In the very rare event that the healthcare professional believes that to follow the [guidelines] ... in full will cause the patient serious harm, the GMC guidance states that this view, and the reasons for it, should be recorded in the patient's notes. When such concerns arise it is advisable to discuss the issue within the team caring for the patient.
>
> DoH 2009 paragraph 20

Codes of Practice can be seen as surrogates for reflection and specification, the reflection and specification having been done under more conducive conditions by clinicians and others who have a wealth of relevant experience.

3.5 What role do codes of practice play in ethical decision making?

As I said in §3.3 trust in the medical profession has been weakened by both the general lessening of trust in all figures and bodies of authority, and by a series of high profile cases where members of the medical profession have proved untrustworthy. This has led to a desire by the public that members of the professions should not only act ethically, but that they should be seen to act ethically. In this context, the creation of open, common standards of ethical behaviour is supposed to provide a yardstick against which behaviour can be judged.

From the point of view of the professional, society is becoming more diverse and medicine is becoming more complex; these factors combine to make if more likely that a doctor will meet a situation in which she is inexperienced and is unsure how to act. In this context she might look for guidelines and codes of practice to indicate which actions have been prejudged to be right.

In the rest of this chapter I will look at whether ethical guidance can answer the questions posed by the naive clinician and in the next Chapter I will look at how they interact with the expertise of more morally aware clinicians. For the purpose of this argument I will assume that a satisfactory answer can be found to the eternal question, "*Quis custodiet ipsos custodes?*", and that a suitable committee of The Great and The Good can be found to construct the guidelines.

3.5.1 Quick fix ethical acceptability

In the context of their working lives most busy medical professionals simply do not have the time to reflect on the ethical implications of every decision they make. Indeed it would be odd if they did; GPs' time is a limited resource in the health service. A GP might spend time with a patient discussing whether he should go through a course of chemotherapy, but she will not spend time reflecting on the ethical issues relating to his case. This particular case might not be

significantly different[22] from half a dozen other cases she has dealt with this week; she believes she does the right thing for her patients but has no special interest in medical ethics. If GPs spent time reflecting on ethical implications of individual cases they would either spend less time on the medical issues or see fewer patients. In this circumstance it is not surprising that in many practices GPs and associated professionals work within practice guidelines, or to Codes of Practice, which carry some acceptability, such as approval by the local primary care trust or the Department of Health, or accepted practice.[23]

In the field of clinical research a proposed procedure will be referred to an Ethics Committee whose approval is required before a research project can go ahead. This generally involves ensuring the trial protocol and Standard Operating Procedures (SOPs) contain ethically approved processes, such as obtaining written consent and ensuring patient confidentiality, and that justification has been given for potentially harmful procedures (such as administration of radioactive substances).

In routine practice and research these mechanisms are aimed at doing the things required above. Firstly, they provide the patient with an assurance of trustworthy behaviour by the medical professionals. The patient has to be given the information which he requires to make a decision, such as to make his consent or refusal of chemotherapy "informed" or to take part in the trial of a new treatment. Secondly, the professionals are assured they have behaved correctly and will have a good defence of their actions should anything go wrong.

This tends to lead toward a belief that ethically correct actions consist of following the approved procedures and ticking the right boxes. "Tick box" ethical decisions might protect the individual

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[22] I will discuss "significantly different" cases in terms of features and moral value later in this chapter and in Chs 4 and 6

[23] Here I take ethically acceptable practice to work in a way analogous to the "Bolam Criterion" which was provided by McNair J in *Bolam v Friern Hospital Management Committe*:
[A doctor] is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.

from disastrously wrong decisions (although it is possible to construct scenarios where they do lead people into just such disaster), but they will also avoid the creatively good and can leave the professional in ethical no-man's land. There will (of necessity) be no box for a new situation or for a new twist to an established scenario. At its worst then, tick box ethics simply gives up on how to act and offers no advice at all.

3.5.2 Action guidance

To approach this I will draw an analogy with the data collection in the conduct of clinical trials. In clinical trials a considerable amount of data can be collected; this data often has multiple uses, for instance, it is used in the publication of results, in "meta analysis" where data from different trials is brought together to improve the evidence base for drawing conclusions, and in determining future clinical practice, such as the drawing up of guidelines by the National Institute for Health and Clinical Excellence (NICE). In order that these activities can be carried out, there must be trust. A series of guidelines have been developed to help engender this trust. Good Laboratory Practice (GLP), Good Clinical Practice (GCP) and so forth (sometimes referred to collectively as G*P) describe the way in which data should be collected and recorded by the various professionals involved so that it can be verified and used for the benefit of patients (the ultimate trusters in this web). G*P frequently requires the use of SOPs to define data collection and analysis. As an example consider a trial in which patients are injected with a drug labelled with a small amount of radioactivity and blood samples are taken every hour to measure the clearance of the drug from the patient's circulation. "Measure the amount of radioactivity in the blood sample" is not considered a sufficient instruction to the operator and s/he is expected to follow a sequence of steps described in an SOP; this will typically define how much blood is to be measured, which machine is to be used for the measurement, what the settings on the machine must be, how and where the data is to be recorded (including recording

the settings of the machine). By analogy with the discussion of thick and thin concepts above §2.6 "measure the clearance of the drug" is a fairly thin instruction, it gives an idea of what is required but is insufficient for action guidance, within the context of a trial where knowledge of the clearance of a drug is a required outcome we can see this instruction as always true; "measure the radioactivity in a series of blood samples and calculate the clearance equation" fleshes out the requirement, it is thicker than the first attempt but still does not tell the operator what actions to take; the SOP, on the other hand, is a far thicker instruction (or instruction set), it contains a description, at a much more detailed level,[24] of the actions necessary to make the measurement. The thin instruction would be equally applicable if a fluorescent rather than a radioactive marker were used, but another thick SOP would have to be developed for the action guidance required for G*P trust.

The following statements might be considered as guidance for ethically correct behaviour:

Do what is ethically correct.
Respect autonomy.
Ensure the patient gives informed consent.
Enact the SOP:

> Take a copy of the form Trial-A01 given in the appendix.
> Discuss the implications of the trial with the patient
> Ask the patient to read Form Trial-A01 and to sign it if s/he agrees to take part in the trial.

The first is fully thin and offers no guidance. The second gives some idea that there are two people involved, one of whom might have his ability to control his own life compromised if things go wrong; it is not clear how this might happen or (more importantly) how this is to be avoided. This third increases our information about what features define the situation we are discussing; it will only help if knowledge of what constitutes "informed consent" can be taken as knowledge held in common by those who developed this guidance and the professional being

[24] It is my experience that the level of detail in SOPs has increased over the past five years. Where previously an SOP would have said "Start the counter", recent SOPs say "Press and release the central GREEN button; observe the operating light has illuminated".

guided. The last leaves very little room for misinterpretation of the requirements; it gives no transferable knowledge for acting in another clinical trial (such as one where the relevant form is in a different appendix and Trial-A01 contains a list of abbreviations used in the protocol); referring back to §2.2 Hare's driving instructor is back in the car again.

3.5.3 Normative theories

In Metaethics, Normative Ethics and Applied Ethics (Fieser 2000) Fieser defines "normative ethics":

> Normative ethics involves arriving at moral standards that regulate right and wrong conduct. We may view the field of normative ethics as a search for an ideal litmus test for morally proper behaviour.
>
> (Original US spelling) p139

> The key assumption in normative ethics is that there is only one ultimate criterion of moral conduct, whether it is a single rule or a set of principles.
>
> p139

He defines "applied ethics":

> Applied ethics is the branch of ethics that involves analyzing specific controversial moral issues.
>
> p369

Professional ethics (including medical ethics) is generally concerned with how professional people go about their business in an ethically acceptable way. Guidance documents and codes of practice are playing an increasing role in the day to day practice of medicine, many of them carry some normative content. They are not aiming to provide norms for all behaviour in all circumstances; however they are looking to guide the professional in her profession, both as a

basis for the everyday decisions, and as guidance for dealing with new situations posing new dilemmas.

I have argued that general theories are too thin to offer the precise action guidance the naive clinician requires in the clinic; she will require a way of interpreting those theories in terms of her practice. The more general the theory the more lean it can be seen to be. Leaner principles have an apparent wider sphere of application. "Give blood to patients who will come to harm if they do not receive a transfusion" seems to apply to all situations in which a patient is bleeding internally;[25] it is lean and its application is broad. However there are situations in which other principles indicate that refraining from giving blood would be the right thing to do. "Give blood to patients who will come to harm if they do not receive a transfusion and who are not Jehovah's Witnesses" is a thicker principle with a smaller set of situations in which it applies and gives more precise action guidance.

In medical practice, one of the main ways of moving from thin or very lean principles to thicker guidance is the use of guidance documents.

3.6 Guidance documents

In this section I will look at two types of guidance to ask how well they guide the naive clinician. I will consider the text which is often taken as the starting point for serious study of medical ethics, "Principles of Biomedical Ethics" (Beauchamp and Childress *op. cit.*), this is a general text covering the whole gamut of medical ethics. In contrast I will consider the DoH Guidance on Informed Consent (DoH 2009), this is a specific guidance document concerned with "obtaining valid consent for any examination, treatment or care that they propose to undertake" (p ii). The

[25] There are many other situations where this would apply, but highlighting this one will serve this argument sufficiently.

guidance is primarily aimed at legal requirements, but I will take the law as attempting to enforce morally acceptable action.

3.6.1 Four Principles Approach

Before proceeding I must refer back to the discussion of principlism I gave in §1.7 that "Principles of Biomedical Ethics" (Beauchamp and Childress (2001)) is often taken to mean a system of four interacting principles. While this does not do justice to the complexity of their work, it is how it is commonly used in practice.

Based on the work of Beauchamp and Childress the four principles approach says four principles underlie medical ethics: respect for autonomy, beneficence, non-maleficence and justice.

To continue with the example discussed above, the general theory of respect for autonomy indicates a need to find out what the patient wants and a need to ensure the patient understands the implications of the proposed treatment in terms that he can relate to his desires. The general theory of beneficence indicates that the doctor should perform the action which will do the patient good. These principles can be seen to conflict in the case of Jehovah's Witnesses in need of blood transfusions. Beauchamp and Childress describe the process of "specification" to resolve apparent conflicts in guidance; in the terms used here this is a process of building a thicker action guidance. In this situation autonomy (when properly applied) is taken to overrule beneficence.

Other conflicts arise such as the conflicts seen between justice and beneficence in the resource limited NHS. In the example of use of drugs in Alzheimer's disease beneficence might be seen to overrule justice if research which postdates the NICE advice shows the benefit of the drugs to be greater than was supposed when the advice was written.

In order to resolve conflict in these examples the lean four principles have been thickened to reduce the scope of one principle to allow the other to overrule. For generalist ethics the resolution of the conflict will always apply in relevantly similar situations.

3.6.2 Department of Health Guidance on Informed Consent

The DoH publishes a "Reference guide to consent for examination or treatment" now in its second edition (DoH 2009:

> The guide describes the process of seeking consent, the importance of establishing whether the person has capacity to give consent, what constitutes valid consent, the form that consent might take and the duration of that consent. It highlights the need to ensure that the consent is given voluntarily and that sufficient information has been imparted to allow valid consent to be made.
>
> p3.

Although much of the guide is based on legal requirements it does say that it is a general "legal and ethical principle" that consent is obtained before any procedure is commenced on a patient. The document contains information of the requirements for consent to be valid, such as sufficient information must be given, there must be no coercion; the duration of consent; and what constitutes consent, it may be verbal, non verbal or written, such that a patient may consent to having a blood pressure measurement when he holds out his arm or may be required to sign a form before surgery.

There is very little room in the document for considering the obtaining of consent to be a *pro tanto* duty rather than an absolute one. Where there is the possibility of undertaking any procedure without consent the conditions which apply are spelt out:

> During an operation it may become evident that the person could benefit from an additional procedure that was not within the scope of the original consent. If it would

> be unreasonable to delay the procedure until the person regains consciousness (for example because there is a threat to the person's life) it may be justified to perform the procedure on the grounds that it is in the person's best interests. However, the procedure should not be performed merely because it is convenient. For example, a hysterectomy should never be performed during an operation without explicit consent, unless it is necessary to do so to save life.
>
> p14

3.7 Thickness and Professional Ethics

Those seeking guidance will be doing so because they do not know how to act in a situation. It would seem that for this there must be at least two possible courses of action open to them (accepting that "doing nothing" is a course of action). The situation is defined by its features (**F** = $\{f^1, \ldots, f^n\}$) and each possible action is associated with a moral value by a feature set A^1 is V^1 if $\{f^{a1}, \ldots, f^{am}\}$ is a subset of **S**. Most simply $\mathbf{F}^{A1}$ and $\mathbf{F}^{A2}$ are both subsets of **F**. The dilemma can arise if A^1 and A^2 are the same action but V^1 and V^2 are opposite, or if A^1 and A^2 are different actions but V^1 and V^2 are the same. In order to decide which course of action is right the clinician might look for a further feature of the situation which alters one of the associations of action and value. For example if it were shown that the patient was coerced into signing an advanced directive that he not be resuscitated then the moral value of following this directive would be voided. The clinician here has found that she needed a thicker version of the guidance when she found a potentially morally relevant feature which allowed the conflict to be resolved. If the conflict remains after looking at as many features as possible, then a process of specification (as discussed by Beauchamp and Childress) will lead to thickening the guidance (§2.6) to allow one *pro tanto* action guiding principle to outweigh the other.

Many decisions in medical ethics are made in these complex situations and action guidance has to be correspondingly thick to allow for the nuances required to treat patients individually.

4 Naivety and experience in moral decision making

"It is well for the heart to be naive and the mind not to be." Anatole France

4.1 Introduction

In the discussion in Chapter 3 I have assumed throughout that the prime agent is morally naive. That is to say her sole moral reason for choosing one action over another is embodied in a set of generalist principles (a set which might have only one member for hard line consequentialists), which can be written down or conveyed to her in some other way. There are plenty of such systems of rules and calculi for their application. These can cover any breadth of interest, from general books on everyday choices to highly specific guidance documents for proper professional conduct in particular circumstances. In this chapter I will contrast this naive agent with the morally experienced agent who can make morally defensible decisions without recourse to guidance, including in unforeseen circumstances.

In the real world we rarely expect adults to consult a rule book when deciding whether to utter an untrue statement whereas we do expect professionals to adhere to codes of conduct. We teach children "how to behave" and condemn adults for not behaving correctly.

At the end of the chapter I will consider the difference between the experienced particularist and the experienced generalist.

4.2 Naivety and rules

4.2.1 The morally naive agent

In Chapter 2 I have taken normative ethical theories to equate to one or more statements which would provide action guidance to the naive agent in a particular situation. From the point of

view of practical ethics this seems reasonable; in "Metaethics, Normative Ethics and Applied Ethics" James Fieser says,

> We may view the field of normative ethics as a search for an ideal litmus test for morally proper behaviour.

and

> The key assumption of normative ethics is that there is only one ultimate criterion of moral conduct, whether it is a single rule or a set of principles.
>
> Fieser 2000 p139

This view is supported by McKeever and Ridge

> [T]he history of moral philosophy is in large part a history to map the moral landscape with a set of principles. Socrates famously searched for 'true definitions' for moral predicates. … Modern moral philosophy is understood as a debate between [consequentialists[26]] like John Stuart Mill and deontologists like Immanuel Kant. Crucially, both sides of this modern debate are committed to the generalist idea that morality is best understood in terms of principles limited to moral philosophy.
>
> McKeever and Ridge 2006 p4

This view is more easily seen for deontology and consequentialism than for virtue ethics. In her book "On Virtue Ethics" (Hursthouse 1999) Hursthouse sets out to demonstrate that virtue ethics can be action guiding in a similar way to consequentialism and deontology.[27] In Chapter 1 she characterises consequentialism as "act utilitarianism" by the premises:

P.1.: An action is right iff it promotes the best consequences

P.2.: The best consequences are those in which happiness is maximised

---

[26] I have substituted "consequentialists" for "utilitarians" as the former covers a wider gamut of moral theories which judge the rightness of an act by the extent to which if furthers the goal of bringing about some predefined good (such as happiness or preference fulfilment).

[27] Not all virtue ethicists agree that virtue ethics can be codified in this way, even in principle.

She then says that "many simple" forms of deontology can be characterised using the same basic structure:

P.1.: An action is right iff it is in accordance with a correct moral rule or principle.

P.2.: A correct moral rule (principle) is one that...

here she offers a list of potential ways of completing P.2.:

... is on the following list (then a list follows – perhaps completed with an "etc");

... is laid down for us by God;

... is universalisable/a categorical imperative;

...would be the object of choice of all rational beings;

etc.

Next she offers a version of virtue ethics which fits this structure:

P.1.: An action is right iff it is what a virtuous agent would characteristically (i.e. acting in character) would do in the circumstances.

P.1a.: A virtuous agent is one who has, and exercises, certain character traits, namely the virtues.

P.2.: A virtue is a character trait that...

P.2. might be completed "simply by enumeration" or by some other means such as reference to *eudemonia*. Some versions of virtue ethics, then, can fit with the view of normative ethics I gave at the start of this section.

Normative ethics is then a search for such a principle or set of principles. If it were developed this set would tell us in all and every situation what is morally right and what is morally wrong. Whilst such a set may be unachievable in practice, the belief that such a thing is in principle possible is challenged by particularism arising out of holism as presented by Dancy, and the idea

that such principles are necessary for morally correct action is challenged by all forms of particularism.

Even if such a set were available it would not be action guiding for an amoral agent. A set of principles which arise from a normative theory will be action guiding only for an agent who wants to do the morally right thing. The moral agent is one who accepts the null principle P_0 as saying one should "do the right thing". There is considerable literature on action guidance and motivation;[28] for the purpose of this thesis I will assume that clinical and non-clinical medical professionals wish to behave in an ethically correct way (at least in their professional lives). We can assume that any clinician consulting a Code of Practice which deals with medical ethics will be seeking such guidance; for the sake of perversity we could envisage an immoral clinician seeking guidance to ensure that they do not undertake a good act, but even for such an agent seeking the code is tantamount to seeking action guidance. Normative theories (and codes based on them) need not be, in and of themselves, action guiding. Such theories can be couched in terms of such-and-such an action being "good" or "right" or (possibly more often) the reverse.

It is wrong to tell lies.

It is unethical to treat a patient without obtaining consent.

The right action is the one which maximises the good.

These statements have different degrees of thickness and can be turned into action guiding statements when combined with P_0

Tell no lies.

Do not treat a patient without obtaining consent.

Do that which, all things considered, maximises the good.

---

[28] A search of the on-line Stanford Encyclopaedia of Philosophy for "motivation" gave 490 hits (August 2012).

Returning to the naive agent, is it reasonable for her to expect action guidance from such codes?

Suppose a chemistry student in the first year of senior school is asked to perform an experiment in an acidic solution; she is given a choice of two solutions. Suppose she has never studied chemistry before and is naive in the subject of chemistry. She will look to some standard procedures for guidance on which solution she should use. She might find instructions to perform the litmus test. A drop of one solution turns the paper red and a drop of the other turns the paper blue, she can proceed to choose the former with reasonable assurance that it is the right one for the experiment. She is unaware that other solutions might be more acidic or that certain conditions can cause the litmus test to give an inappropriate colour change. The naive chemistry student is thus able to perform the experiment correctly by using written procedures to guide her action. A broad analogy can be drawn for the ethically naive doctor. Suppose she has an unconscious patient and a choice of Xing or not Xing, and she knows that some patients have reservations about Xing. She can look for local or national guidelines concerning the use of Xing. These might give her some simple tests such as "Has the patient left an advance directive concerning Xing?", "Are there any friends or relatives with evidence about the patient's attitude to Xing?" If she follows these guidelines she can be assured that the patient has received ethically correct treatment; given her initial naivety we can see the action guidance from the written procedures directed her to an ethical solution to the problem.

In this sense then, written procedures, codes of conduct, standard operating procedures etc can indicate a correct course of action or a procedure for finding such. In the terms used in the main theme for this thesis, these sources can be seen as pointing to sets of possible morally relevant features. Such features would each be associated with a moral valence, however the guidelines generally are not written to make such distinctions clear, but rather they amalgamate features and provide a moral value for final actions. In this sense the Rossian *pro tanto* duties are "pre-weighed" by the writers of the guidelines and the readers provided with the overall guidance.

There is nothing unique to morality in this; many medical codes of practise are concerned with technical or clinical decisions; the chemistry student was not looking for an ethical way to perform her experiment. A P_0 for the chemistry student could be devised such as "Always perform those experiments which will test the hypothesis under investigation".

Following the procedures will help the naive agent develop experience. The chemist will soon learn several ways to test for acidity, she will learn which features of which experiments or processes require acidic or alkaline solutions; as she become "chemically experienced" her need to consult guidelines will diminish.

4.2.2 Mother's knee morality

An analogy can be drawn between the relationship of the naive doctor to the ethically experienced practitioner and the relationship of the child to the fully formed moral agent; to make use of this analogy I will briefly look at a child learning to behave in society.[29] The child learns sets of rules from a parent or guardian, one of these sets will turn out to be moral rules, or at least the basis for moral rules as the child's understanding develops. Children learn not to lie, not to take each other's toys or sweets, to share with others etc, within a small society of family and playmates. As their understanding of the world increases their understanding of morality matures; their moral understanding moves from "mummy says you must not take Johnny's Lego" to "taking other people's property, without asking, is wrong". There are two factors involved in this generalisation. Firstly, there is the move to general rules when the child understands that it is not just Johnny's Lego he should not take without permission but that the rule applies to anyone and to all their possessions, that the feature of an object "being owned by someone else" brings a negative valence to the action "using without permission". Secondly he

[29] Here again is a potentially vast subject which I will largely ignore in the interests of staying on track for this thesis.

understands that the rule is in some sense independent of his mother; his mother may be his source for such rules in early life but this may not always be the case.

The features of this short discussion about learning moral rules that I want to focus on for this section are the generalisation of rules and the role of a moral teacher or mentor. The junior doctor is in an analogous position to that of the child. She is in a world where she has little or no experience of how to interact with others by virtue of the fact that she is in a role in relation to patients she has not previously experienced, she will need guidance about the ethics of her interactions with these patients. For example, she will have learned that a certain course of treatment would be medically best for a certain patient, but not that the patient should have a chance to understand the implications of the treatment and refuse if he so wishes.

4.2.3 "When I was a child…

> …I spake as a child, I understood as a child, I thought as a child: but when I became a man, I put away childish things.
>
> 1 Corinthians 13.11 King James Version

This quotation from the Christian Bible indicates that the learning acquired as a child needs to be re-examined and reinterpreted in the light of an adult understanding of the world.

As the child becomes a morally experienced agent the simple moral rules often seem less straightforward. The simple proscription against lying seems less clear as we interact in more complex society. Is all lying necessarily wrong? If so, what actually constitutes lying? Are the small concealments and diversions we employ to avoid making a false statement also lying? These two questions seem to work hand in hand; those for whom any form of deception is a lie seem to accept that "white lies" are necessary for society to function. Those who see lying as always wrong seem to have a tighter definition of lying and a weaker proscription against other forms of deception. "Did you enjoy the meal I spent all day preparing for you?", "Does this hat

suit me?", "Am I dying?" are all questions which, in some circumstances, will increase human misery without any commensurate increase in good, if answered truthfully. (see Jennifer Jackson "Truth, Trust and Medicine" Ch 4 "What truthfulness requires" Jackson 2004). Both the positions mentioned here take the feature "that it is a lie" to imply a negative valence to the act of stating it, one group would give this feature less weight in an overall decision as to whether to say it or not, whereas the other group would have a very high weight for the feature but their definition of "lie" would mean the feature was included in the feature sets of fewer situations.

As the medical professional moves away from training and into practice she will face similar problems with interpretation simple moral rules. She might look for guidance or she might feel she has sufficient knowledge of the relevant issues but that she needs to resolve a conflict which arises from the different sources of ethical guidance she has. Where guidance conflicts, she can consider a process such as specification. When looking for guidance the she might also consider asking a mentor whose ethics she believes to be sound or she might turn to the available guidelines for advice.

A question which will arise in this discussion is one of how prescriptive (or proscriptive) the guidelines are. More prescriptive guidelines can be seen on one hand to give more precise action guidance, but on the other to allow less scope for the professional to apply their own judgement in a situation. Prescription need not imply a high level of thickness. To say Xing is wrong may be highly prescriptive: under no circumstance should you perform an action which involves Xing. "Xing" might have a thin description such as "doing evil", or a lean one such as "killing humans" or it might have a highly detailed interpretation of undertaking a certain action ("making a statement known to be untrue" or "giving blood products without consent") in a clearly defined situation ("attempting to gain pecuniary advantage by deception" or "when the patient is believed to be a Jehovah's Witness").

Where the professional is restrained by guidelines, can she or he develop a mature ethical sense similar to the more complex understanding of the relationship between lying, concealing and a wider morality as discussed above? If not, is it desirable that they should? I think this raises again the question of what society expects of medical professionals. I will return to this question in Chapter 6.

4.3 Particularism and experience

Particularism is a meta-normative position concerning the need for, and the possibility of, generalist moral rules. Particularists argue that it is not possible to guarantee that a given set of features, which give an action a certain moral valence in one situation , simply will not count, or even indicate a different moral valence for the same action, when found within the features of a different situation. In simple clinical situations the features $\mathbf{F^b} = \{f_n$: *is an unconscious patient*, f_{n+1}: *is bleeding internally*$\}$ would imply that not giving blood would be wrong, but $\mathbf{F^b}$ would not count if the situation also had the feature f_j: *is a Jehovah's Witness*.[30]

Particularists also contend that an agent can perfectly well behave ethically without need of generalist rules. This raises a question of how a morally naive particularist decides how to act. If she has no experience of what constitutes morally good behaviour, how is she to decide on matters of morality without a generalist code? I will argue that the particularist answer to this can be found in the idea of a mentor, and propose that codes of practice (and other generalist systems) can be seen as formalised surrogate mentors.

Most of the published writing on particularism is in the theoretical realm; in this section I have tried to understand what the implications of particularism are for practical (in particular medical) ethics, in order to ask, if particularism is correct, what (if any) implications would that have for

[30] Generalists would have a different interpretation of this case but I believe it is illustrative of the particularist point of view.

the practice and teaching of medicine? In particular, in this chapter, I will be interested in the relationship between naivety and experience for moral agents.

The idea of default valence is one which will be important in developing the argument concerning how particularists can function morally in the real world. Holism of reasons is not inconsistent with default values, provided that they are defeasible. In the previous section I showed how different generalists might hold different views on the weight given to the feature "that it is a lie", here we might see the particularist accepting the, *ceteris paribus*, lying is wrong-making; she would still think that when asked by the axe murderer about the location of his intended victim, lying has a positive valence.

4.3.1 Supervenience and generalisation

> A set of properties *A* supervenes upon another set *B* just in case no two things can differ with respect to *A*-properties without also differing with respect to their *B*-properties. In slogan form, "there cannot be an *A*-difference without a *B*-difference".
>
> McGlaughin and Bennett 2010

It is widely accepted that moral properties supervene on natural properties, and I propose to take this as a given; further I will take the "natural properties" to be just those features of a situation which are discussed throughout this thesis and the "moral properties" to be just the moral valence ascribed to a proposed action as a result of the features of the situation in which the action is proposed.

The notion of supervenience is important in the development of moral experience. The naive agent may see two situations and be told that Xing is correct in one but not the other; her first question will be to ask what the difference between the situations is. She will expect that difference to be some feature set $\mathbf{F}^{d}$ which is a subset of the features defining one situation $\mathbf{F}^{1}$ and is not a subset of the features defining the other situation $\mathbf{F}^{2}$ ($\mathbf{F}^{d} \subset \mathbf{F}^{1}$, $\mathbf{F}^{d} \not\subset \mathbf{F}^{2}$). As she

gains experience she will recognise what sorts of features are included in $\mathbf{F}^{d}$. "That the patient had shoelaces of a particular colour" is often taken to be the sort of feature which is a poor candidate for inclusion in $\mathbf{F}^{d}$, whereas that the patient was a follower of a particular religion is often taken as a good candidate for inclusion. When developing moral experience an agent might start to recognise certain classes of feature which are good candidates for inclusion in $\mathbf{F}^{d}$ and certain classes of feature which are not. Crisp (in Crisp 2000 p33) talks of explanatory, motivating and grounding reasons, all of these types of reason can be features of a situation under the broad definition of feature I noted in footnote [4]. Simple explanatory features such as those which describe the interaction of two billiard balls colliding on a baize covered surface do not seem good candidates for inclusion in $\mathbf{F}^{d}$, the balls are not motivated to bounce apart at particular angles in the sense in which Crisp uses "motivating". Motivating features can be of many types, "she went to the fridge because she was thirsty", "I gave him the pill because I believed him to be in pain" include motivating features ("she was thirsty", "I believed him to be in pain"). These features can provide reasons for action ("going to the fridge", "giving him the pill"), some of these actions may have a moral value and others may not. Crisp's grounding reasons are features of the type "if someone is in pain, giving them the pill will decrease suffering". The partially experienced agent might have developed some rules of thumb for picking out the morally relevant features and might refine the initial statement of supervenience; moral properties depend on morally relevant natural properties.

This dependence provides the basic underpinning for the development of moral experience, when we need to decide how to act in a situation our decision tends to be guided by experience. That the patient is unconscious, that the patient has signs consistent with internal bleeding, that Beauchamp and Childress say "Morality requires not only that we treat persons autonomously and refrain from harming them, but also that we contribute to their welfare" (p165) may be features the junior doctor in A&E has met before and which incline her to believe the right

action is to order a blood transfusion. Whether this decision is the right one might depend on features of the situation she has not recognised as morally relevant as she has not met them before.

Whilst this dependence helps to elucidate the relationship between moral judgements in similar situations it should not be confused with supervenience. Supervenience says the moral properties of an action depend on the non-moral properties of the action. If Xing is right in situation S then Xing is right in S' if $\mathbf{F_S = F_{S'}}$. For supervenience to entail that Xing is right in S' *all* the non-moral properties of the two situations must be the same; it would be impossible to enumerate all the features of a situation. Does the dependence of moral properties on non-moral properties allow the semi-experienced agent to start formulating general principles? As I said above she might begin to formulate a distinction between morally-relevant non-moral properties and non-morally-relevant non-moral properties. This could be very onerous and would not be guaranteed to identify any common non-moral properties associated with situations where Xing is right, if Xing is the right action in several different types of situation. She might ask a moral mentor for some general rules, whilst this might help the semi-experienced agent, it raises the question of how the mentor acquired these rules. She might ask more experienced colleagues what features of a particular situation led them to a particular moral conclusion, this would be a natural extension of her training in which she will be used to asking these more senior colleagues what signs and symptoms led them to a particular diagnosis.

Continuing the example above of the junior doctor in A&E faced with an unconscious patient showing signs of internal bleeding; she is in the process of writing up the blood transfusion when a senior colleague walks in, takes one look at the patient and tells her to stop ordering the transfusion, when asked why he says, "This is the patient who is wearing red and silver shoe laces." He then explains that he saw the patient being brought in, and knowing that members of the Thor's Advocates sect identified themselves to others of the sect by the wearing of just such

shoe laces, and that they were opposed to receiving blood transfusions, he sought the patient's relatives in the waiting room. They have refused a blood transfusion.

Particularism says that we cannot know in advance which features of a situation are "morally relevant". In this highly contrived and trivial example a feature often taken to be the epitome of irrelevance had at least an indirect bearing on the moral decision.

4.3.2 Gaining experience by learning from experience

Underlying the actions of the naive doctor is $\mathbf{P_0}$. In order for her to implement this principle she must have a way of determining the best thing for her to do. Her initial training will have refined her mother's knee morality with specific reference to her chosen profession. One of the most important things for her to learn is to distinguish situations in which she needs guidance. In a situation where she has to choose between Xing and Ying (or simply not Xing) there will be situations where the morally correct action is to seek guidance. In an ideal world she would have access to a moral mentor and time to discuss the pros and cons of Xing and of Ying; she will understand the principles ($\mathbf{P_X}$ and $\mathbf{P_Y}$) which underlie the reasons pro and con the actions and how thickening one of both of these allows her to make the correct action. In practise in many situations something very akin to this will happen at case conferences or multi disciplinary team meetings where reasons (clinical and ethical) for choosing particular actions will be discussed. Such discussions will help the naive doctor towards becoming ethically experienced. However returning to § 2.2 where Hare draws analogy with learning to drive simply seeing how to behave in a number of fixed cases would be teaching her to change gear now and now, not teaching her to be able to tell when to change gear. She has several alternative sources of guidance, I will return to the General Medical Council's (GMC) published "Standards and ethics for doctors" (GMC 2012c) including Good Medical Practice (GMC 2010b in §6.3. These and other codes of

practice can provide guidance with varying levels of thickness. Discussions with colleagues and reflection on all the guidance available will be part of the doctor's development of a moral sense.

4.4 The role of experience

Particularists do not hold that moral judgements or moral actions are impossible simply that a moral agent does not need generalist principles to act morally. Particularists accept the supervenience of the moral on the non-moral but argue that this is very weak in helping make moral decisions as it is not possible to know in advance which features of a situation are morally relevant and thus, on which non-moral features the moral features supervened. If two situations were found to be sufficiently similar in morally relevant features such that if Xing in one has a positive moral valence then Xing in the other will also have a positive moral valence, we could say that the first case provided a moral precedent for divining the morally correct action in the second. Particularism does not deny the possibility of such cases; it just states that they are not generally available and that we have no reason to expect them to be so. Precedent, while being useful for suggesting a possible course of action, does not provide definitive moral judgement for generalists or particularists.

The means by which we decide if a *pro tanto* principle applies in a particular situation, or if *pro tanto* precedent does indeed apply to a particular situation, is by reflection. What we reflect upon is our moral experience. At first this may seem to fit with a system where all duties are *pro tanto* and arise from features of a situation, and where there are no absolute duties. This however does not deal with the situation in which a feature gives rise to a positive moral valence in one situation but a null or negative moral valence in another situation. When an agent reflects on a moral choice to decide on a correct course of action, she is relying upon her moral judgement, and her moral character and her experience. The quotation from McKeever and Ridge above

sets moral philosophy as a debate between consequentialists and deontologists. For the particularist neither of these camps is acceptable as ultimately both deny the holism of reasons.

Experience is important for consequentialists, deontologists and particularist agents developing a moral sense. For the consequentialist precedent will indicate how to undertake the consequentialist calculus to choose the action with the best outcome; for the Rossian deontologist[31] precedent can indicate both which features carry *pro tanto* duties (which features are associated with a moral valence) and how to balance these various *pro tanto* duties to reach an overall duty; and for particularists precedent can indicate default valences.

4.5 A three dimensional function

In the field of practical ethics (and professional ethics) agents are concerned to know how to act so that they have done the best thing, or at the least not done a wrong thing. I have looked at the problems facing a fully naive agent and at how experienced agents can reflect on their moral experience to gain insights into how to act in a given situation. I will reiterate some of what I have said in order to draw the strands of this thesis together, before discussing how this would apply in medical ethics (Chapter [cross ref]).

The moral agent can look to external sources for moral guidance. One place such guidance can be found is in codes of practice. As an example I will consider a doctor advising a course of action and seeking a patient's consent for a particular procedure, the first place she might look could be Department of Health guidelines. For consent she would find the DoH initiative "Good practice in consent", the implementation guide from this document set (DoH 2001)

[31] I have not included absolute deontologists in this account; although they might gain some insight into interpreting absolute rules (in a similar way to consequentialists) absolute rules such as the religious commandments are not learned from precedent.

states that its aim is to assist "NHS organisations to promote good practice in the way patients are asked to give their consent to treatment, care or research" (p3). In order to use this document our naive agent must have some experience; obviously experience of what is involved in the procedure which she has advised and for which she is seeking consent is a prerequisite. There are some issues which ask more of the doctor's insight and moral sense. She must be able to judge (p9) whether the patient:

> is competent to take the particular decision;
>
> had received sufficient information to take it; and
>
> is not acting under any duress.

Having found that she needs to establish these conditions, she might still not know if the patient can consent if she does not have a sufficient understanding of competence. Here she might consult Beauchamp and Childress:

> [T]he concept of competence in decision-making has close ties to the concept of autonomy. Patients or subjects are competent to make a decision if they have the capacity to understand the material information, to make a judgement about the information in the light of their values, to intend a certain outcome and to communicate freely their wishes to care givers or investigators.
>
> p71

She might seek further information or guidance on some aspects of this part of the requirements; she might also look for information on the other aspects of consent. Once she has done all this she may feel ready to act.

Suppose the patient has come to her in late autumn saying that, as an asthma sufferer, he is worried about the flu. She may judge him competent from the fact he has sought her advice and stated his need for help in relation to his underlying health problem, she might then explain that the flu vaccine only offers protection against the flu strains expected this year and say "I'll get a

vial of vaccine while you roll up your sleeve." She will take his action of rolling up his sleeve as passive consent to injection of the vaccine.

A second patient who has cancer then asks if there is anything more she can offer him; she believes he qualifies for entry onto a clinical trial of a complex new treatment. She may think his asking for more help is not of itself sufficient to indicate that he is competent to decide about entering the trial, she might discuss his disease and prognosis with him before offering him a place on the trial. There will be a patient information sheet associated with the trial which she will give him to read and she will give him time to reflect on whether he wants to undergo the treatment. If he does he will then be asked to sign a consent form and a form to say he has read and understood the patient information sheet.

The two patients are treated differently with respect to consenting to the doctor's advice. So the DoH guidelines have helped in guiding the doctor's actions but without further understanding of the difference between the two cases they were insufficient to guide the doctor's actions. More detailed (thicker) knowledge of the particular cases was required to treat each patient properly. This understanding could have come from one or more of several sources such as a senior colleague, the doctor's own experience, or the guidelines provided by the trial sponsors.

The collection of sources and advice she consults do not necessarily constitute a single coherent normative system but this is not surprising. When discussing thick and thin principles above, I have treated these principles as coherent, developing (thickening) systems; this is an idealisation of the real world processes. An agent confronted with a dilemma will search his memory of his own and others' moral decisions and compare the features of them with the features of the situation giving rise to the dilemma, this need not be a structured search; the resulting extension of the set of principles occurs *post hoc*. In the same way, the ethically naive doctor above can construct a coherent *prima facie* understanding of consent. The collection she brings together

constitutes a thick set of features which need to be present or absent in order that consent is successfully given (or denied).

In contrast an experienced clinician might see the patient for a few minutes and have a sufficient grasp of the situation and the requirements of consent that she can move straight to telling the patient what she recommends and asking if he will consent. Her experience allows her to understand the application of the principle of respect for autonomy without explicit thickening for the particular patient in the consulting room. The basic four principles generally taken to arise from Beauchamp and Childress can constitute such principles, e.g. respect for autonomy is, by itself, fairly thin. When fully understood it leads to the requirement for consent in both the above cases, but a further understanding of each case is required for ethical practice.

For the naive agent to reach ethical action she requires a very thick set of principles. She can gain no guidance from the fully thin P_0 based on the null set of features, "Always do that which, all things considered, is the best thing to do". Turning to B&C she finds she must respect the patient's autonomy which, while thicker, again offers her no real guidance as to how to act with either. The DoH guidelines now offer her some slight help telling her what sort of action she must undertake: she must seek the patient's consent and she must ensure the patient is not acting under duress, has sufficient information and is competent to consent. From here she may be able to formulate some plan of action but not distinguish between the active and passive forms of consent required by the different features presented by the two cases. The highly detailed (very thick) instructions which form part of the protocol for a clinical trial will come much closer to full instruction but only for how to take consent for a patient entering that particular trial. It is interesting to envisage an automaton programmed to enter a patient onto a clinical trial to see what a fully thick instruction set might look like. In such a set an instruction as "The patient information sheet must be given to the patient at least twenty four hours prior to the patient being asked to sign the consent form" would cause the automaton to run subroutine

to check the time is within the specified time constraint, it would contain such instructions as "unclip the patient information sheet from the back of the patient's trial folder", this would break down into a number of sub routines which in turn call lower level routines until the level of actual movement of motors or automaton muscle is controlled. This would require a program of many hundreds or thousands of instruction lines. Many programmers would be involved, each dealing with an area of specialism. This again is analogous to human learning where a baby learns to grasp an object, prior to learning to pass an object to another person. When a student enters medical school she arrives with many of the skills she will need (reading, writing, passing objects to other people …) "built in" by her previous experience and education so that these very low level functions can be taken for granted and new skills (use of a stethoscope, venipuncture, requesting consent) can be built on top. The level after which we feel that the doctor can be assumed to have sufficient instruction (a sufficiently thick description of the feature set) will depend on the level of experience she has achieved.

If we return to the naive practitioner she will require a very thick definition to be fully certain of ethical action, but even she will be assumed to have some pre-existing understanding where further thickening of the guidance will not be required. At the other end of the scale for the same practitioner, moving from thin to lean guidance (this might be the move from P_0 to B&C four principles) will not add much towards guiding her actions. When there is a relationship between two factors like this there is a temptation to construct a simple mathematical model to describe that relationship which would define a line graph with two axes (e.g. Thickness vs. Guidance). Simple models can easily be misinterpreted and the shape of such a line would be open to speculation.

Having introduced the idea of such a diagram it seems reasonable to suggest a similar one for the relationship between experience and action guidance. Consider a highly experienced moral agent, one who can see clearly the best action when presented with a situation. When presented with

the unconscious patient with clinical signs of internal bleeding she will not only know of the possible consequences of the patient being a Jehovah's Witness but will know how much time and effort should be expended to ascertain whether or not this is so. The only guidance she needs to motivate her into action is P_0, the injunction to do the right thing. If she gains more experience it will contribute little to her ability to know the right action as she is already highly experienced (for example this might imply that this relationship tends to an asymptote). To consider the other end of this relationship consider the naive agent. She will need to experience several situations before her concepts of ethical right and wrong start to coalesce into a coherent set and she can start to assess the rightness of a proposed action. For this exercise I am assuming she has no access to any guidance apart from P_0; she has no copy of B&C, no access to the DoH web site and no moral mentor. Suppose that after each patient interaction she is given the ethical value of her action, but no guidance to tell her why such a judgement was made (she is relying solely on experience and the thin P_0). Suppose she sees an unconscious patient with clinical signs of internal bleeding and prescribes a blood transfusion (she has, after all, clinical training, just no moral training); she is told this interaction had a positive value. After four or five more similar cases, all judged to have positive value, she is beginning to conclude that saving life in this way is good. After treating the next case in the same way she is told her action had a negative moral value. She might collect the hospital notes on all the patients she has treated in this way and look for features in the first set that were not present in the most recent and features of the most recent that were not present in the others. This turns out to be her first patient over sixty years old, her first America citizen and her first Jehovah's Witness patient. She might form a working hypothesis that there is no justification for allowing people to die simply because they are American or belong to a particular religious sect, so thinks the allocation of the expensive resource of blood transfusion to someone over sixty is unethical in a resource strapped health service. It might take considerably more experience before she associated an ethical dimension

with blood products and Jehovah's Witnesses. Again justification for any particular shape for a curve is beyond the scope of this thesis, but a general form of more experience being more action guiding can be seen.

In practical ethics we are concerned more with the real world. These two theoretical relationships deal with limiting cases but can form the basis for discussion of action guidance in real situations. Most professionals within the medicine will fall somewhere between these two extremes. This means that two factors combine to contribute towards action guidance. The naive clinician will attend medical ethics courses, read Gillon or Beauchamp and Childress, talk with senior staff and gain experience in workshops and in the clinic. This results in three interacting factors, the thickness of the principles she has understood, the extent of her experience and the resulting action guidance. A combination of experience and advice will be used by naive and semi-experienced agents for ethical action guidance. The junior doctor (who we may think of as a "fairly naive" agent) will not feel she can rely on her experience in any but the most straightforward of cases and will look for guidance form a source external to herself. In the case of the Jehovah's Witness who is bleeding internally, in the real world she might be alerted to a possible problem by a member of nursing or other staff to the fact of the patient's religious beliefs, while this person may not feel qualified to advise they may well feel qualified (they will often feel they have a duty) to alert the doctor to a problem which needs to be considered before the proposed action (here a blood transfusion) is undertaken. Once alerted the doctor will recognise that she is insufficiently experienced to act in this particular case and will seek guidance. This external guidance will be of different types depending on the actual circumstance. During the day in A&E there will be more experienced senior staff to ask for advice, she might even ask the more senior doctor to take over so that she can observe. In other circumstances she might prefer to consult local or national guidelines. Turning to the highly experienced practitioner, she would have no difficulty with the case of the Jehovah's Witness but

she might still look for guidance in more complex situations. Consider a patient who just failed to meet the inclusion criteria for a clinical trial but who might be helped by the trial treatment; further the patient is the father (and bread-winner) for a young family. The experienced doctor might feel she needs input from other sources in this complex situation. Any discussions will inevitably focus on the specifics of the situation and be very thick in their feature set.

4.5.1 "Find a virtuous agent and ask them"

So far I have represented normative ethics as deontological or consequentialist, recently[32] there has been a rise in writing about virtue ethics (see for example Fieser 2000 pp140-144). Virtue ethics can be introduced by the slogan "Do what the virtuous agent would characteristically do in the situation", when phrased this way virtue ethics puts the emphasis for moral behaviour on the agent, as opposed to deontology where the emphasis is on the action or consequentialism where the emphasis is on the outcome. When expressed this way virtue ethics can be seen as rejecting formal sets of deontological rules. There is a fine line to be drawn by proponents of virtue ethics to avoid an approach which asks for a definition of what a virtuous agent will do in order to avoid virtue theory condensing into a form of deontology. If it were possible to define under what circumstances the virtuous agent would lie, at what point a courageous action becomes a foolhardy one and so on, then virtue theory would become a set of rules for virtuous action. Some forms of virtue ethics are compatible with some forms of particularism but there is no general agreement on the relationship (Blum (Crisp and Slote 1997) states "'Virtue ethics' is theoretically agnostic on the particularism issue" (p205 footnote)). A second slogan is sometimes used to describe action guidance in virtue ethics, when facing a situation where she cannot decide what to do the naive agent may be urged to "find a virtuous agent and ask them".

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[32] The current resurgence of virtue theory can be seen as arising from G.E.M. Anscombe's "Modern Moral Philosophy originally published in Philosophy (33) in 1958 and reprinted in Crisp and Slote 1997)

The need to seek advice is not a feature unique to virtue ethics. All moral agents sit somewhere on the naive – experienced scale and all might find the need for advice in novel or challenging situations. This advice can come from a variety of sources (as I discuss in §6.3.2) from senior colleagues and mentors to national guidelines. Advice concerning the right course of action in a situation, as far as I am concerned in this thesis, is a statement of the moral rightness of the available actions, as such it supervenes on the features of the situation.

For the out and out generalist, I assume she has recognised a combination of features which give rise to two *pro tanto* advised actions, but has no rule for choosing one over the other; or has recognised a new feature which she believes may be a morally relevant feature but is unsure of its moral implication. For her, finding the requisite advice is tantamount to finding a new general rule, even if it only applies to two cases in her career, for the generalist doctor it will always count in the same way. When she cannot find a guideline, she will still have to decide on a course of action and will have to rely on her moral understanding to choose it.

The particularist's relationship with advice is less straight forward. Although the advice might specify a certain set of features in which it applies ("the patient in unconscious", "the patient in bleeding internally", "the patient is a Jehovah's Witness"), she has no reason to suppose that those features, or that combination of features, will always count in the same way, indeed she has no reason to suppose they apply in this particular case. If the advice comes from a senior colleague or a mentor she can discuss why she thinks the features do not count. When the advice is from a DoH guideline, the possibility for discussion is much more limited, she might seek her mentor if she believes the guidelines point in the wrong direction, but otherwise she, also, must rely on her moral understanding to choose her course of action.

In the end, both the generalist and the particularist have to rely on their moral understanding to make a judgement; as Hare says, "the problems of conduct, though sometimes less diverting

than crossword puzzles, *have to be solved*, in a way that crossword puzzles do not. We cannot wait to see the solution in the next issue" (Hare 1952 p1 (original emphasis)). The practical difference between the particularist and the generalist is when she must apply her moral understanding. It is possible, in principle, to envisage an algorithm which will take the generalist from enumerating the features of a situation through to choosing an action which could be programmed into a computer and would require no moral understanding. This might be a highly sophisticated algorithm capable of interpreting many nuances of the real world, butwould not be open ended Such an algorithm might have a structure such that, if the situation contains Features $\{F^1 – F^n\}$ then Xing is right unless F^x, F^y, or F^z is also present, in which case Ying is right. When she meets a new situation $\{ F^1 – F^n, F^\alpha\}$ the algorithm knows nothing about F^α and indicates Xing to be right. It is then for the generalist to think F^α to be the same sort of thing as F^x or F^y so that she must consider Ying. The particularist will see the choice between Xing and Ying from the outset, she may recognise the importance of F^1 or F^α and think that $\{F^1 – F^n\}$ simply do not count when they are present. She may have seen all the advice which underlies the generalist algorithm, but she will see the situation as holistic.

Returning explicitly to the generalist particularist divide, the generalist clinician takes guidelines and guidance from senior colleagues as identifying features of situations which are associated with *pro tanto* reasons for Xing. In complex clinical situations she might find one or more features indicating a positive valence for Xing, one or more other features indicating a negative valence for Xing and one or more features indicating a positive valence for Ying (which would preclude Xing). With experience she will recognise these features without needing to consult guidelines or colleagues. As she develops a moral sense she will learn to balance the competing *pro tanto* duties to arrive at a decision as to the right thing to do. For her, allowing a patient to die from internal bleeding when suitable blood was available always carries a negative valence even when outweighed by other features.

For the particularist the situation has the same features, one or more feature might carry a default valence for or against Xing or Ying which could be indicated by a guideline document or a senior colleague's opinion. She will have a holistic view of the situation, some features with default valences might be switched off in the presence of other features and some features might (e.g.) acquire a positive valence for Xing. With experience she will recognise which features count and which do not in particular situations, she might still be left with features counting for Xing and other features counting against and still have to find a way of resolving the course she should take. For her, allowing a patient to die from internal bleeding when suitable blood was available arrives with a default negative valence switched on, however this valence can be switched off by other features; features such as that the patient is a Jehovah's Witness, that the patient has made a valid advance directive and that no other treatment is available might bring a positive valence to allowing the patient to die.

I will return to this distinction in Chapter 6.

5 Particularism and Medical Ethics

"Medicine rests upon four pillars - philosophy, astronomy, alchemy, and ethics." Paracelsus

5.1 Introduction

In the first chapter of this thesis I noted that particularism is a meta-normative theory, as such it is not the kind of theory that could indicate the correct course of action in any given situation; which is to say that it is not a normative ethical theory. In the subsequent chapters I have tried to look at the very practical field of medical ethics to highlight the areas where I think the meta-normative debate between generalists and particularists has something to say about ethical medical practice. Current medical ethics is a generalist system; I have interpreted generalism quite broadly, in particular I have looked at the use of conventional generalist normative theories (deontology, consequentialism and virtue theory), at practical ethics (especially at the principalism which is seen to arise from the writings of Beauchamp and Childress), and at practical guidelines which are provided to those working in early Twenty First Century health care. There is some debate as to whether principalism could be considered a fully functional normative theory, which I discussed in Section §1.7; for the purpose of this thesis I have taken it to be normative, at least in the way in which it is normally applied. Practice guidelines published by the UK Department of Health (DoH) cannot be considered generalist normative theories, however in that they do prescribe and proscribe certain actions or types of action in defined situations likely to arise in medical practice; they are normative within their sphere of action. Within that sphere of action there is little doubt that the DoH intends them always to define the acceptable (or unacceptable) available courses of action; within their sphere they are then strong generalist principles. Many of them do not cover ethical decisions, but I have tried to include

only those which do have an ethical impact, in particular the guidelines on consent to and refusal of medical treatment.

In this chapter I will revisit the central themes of particularism and introduce some examples from my practice in clinical trials to highlight the areas where generalist and particularist medical ethics differ. I will discuss the question of trust in relation to this debate.

5.2 Counting and not Counting

In the introduction to "The Particularist's Progress" Dancy says:

> There is a common suggestion that to be a particularist is, at the outset, only to admit that circumstances can make a difference. But if this were all that particularism amounted to, it would be uncontentious.
>
> Dancy 2000 p130

He goes on to say that to be a particularist one commits oneself to "holism in the theory of reasons":

> I maintain that *all* reasons are *capable* of being altered by changes in context – that there are none whose nature as reasons is necessarily immune to changes elsewhere
>
> (original emphasis) p130

Whilst accepting in a footnote that this may be unfair to Ross he states that he is specifically concerned with opposing what he identifies as Ross's theory of *prima facie* reasons:

> What is a reason in one case is the same reason in all.
> Judgement is the attempt to determine the balance of reasons, so conceived.
>
> p131

In order to look at practical implications of this position, and to restrict it to the scope of this thesis, I have generally taken "reasons" to be reasons to undertake, or refrain from, certain

actions, specifically in this context as indicators of moral valence, and thus indicators of whether certain actions are *morally* good, neutral or bad. I have tried explicitly to duck the argument that indicators of moral valence are not in and of themselves reasons for action and have assumed that medical professionals have a preference for (in some hand-waving sense) "doing the right thing".

In his illustrative passages Dancy tends to use fairly simple statements as "reasons". "That there will be a lot of people there" is a frequent example of a feature which is sometimes a reason to go there and sometimes a reason to stay away. Such a feature becomes a reason to choose to go there or to stay away depending on other features "I want to party" or "I need to think over an important decision", whereas the set of features which describe almost any situation is which a medical practitioner has to decide how to act will be complex.

5.2.1 Thickness and Holism

I have used the term "thickness" in an extension of its use in thick and thin concepts to describe moral principles as thick or thin. In extending the concept of thickness I have argued that, rather than there being a binary division between thick and thin, there is a continuum so that one principle can be thicker than another but thinner than a third. Thickness in this sense is an indicator of how many features ($\mathbf{F}_{req}$) have to be present in a situation for a principle to come into operation and indicate the moral value of an action in the situation where $\mathbf{F}_{req}$ is a subset of the features defining the situation. A fully thin principle ($\mathbf{P}_0$) relies on no features of the situation and is true in all situations, a fully thick one would include all the features that are true of a situation ($\mathbf{F}_{req} = \mathbf{F}_S$), this would simply be a statement of the principle of supervenience; it is difficult to see how either of these limiting cases could be action guiding principles. Under this description generalist normative ethics attempts to define the subset of required features and, in

a general sense, the subset of morally relevant features. The principle of holism says that there is no general way of distinguishing morally relevant features from morally irrelevant ones.

5.2.2 Does particularism have implications at the practical level?

It is reasonable to ask if the divide between particularists and generalists is only a theoretical one or if it has practical implications for the way decisions are made in practice, especially in the case here in clinical practice. If there are practical differences, do these have implications for the way clinical guidelines are written and how medical professionals are trained?

Writing about possible practical differences between generalists and particularists Dancy says:

> [Such a difference] comes out when we consider two pretty similar cases of which we nonetheless want to make different judgements. Nobody supposes that this is impossible. The question is rather what is rationally required of the judge in such a case. The generalist might end up demanding that one make the same judgement in both cases unless one can provide a principle that distinguishes them. The particularist, by contrast, might demand only that one make the same judgement in both cases unless one can offer some reason for not doing so.
>
> Dancy 2009

To see this difference, consider two similar situations S_1 and S_2 and a set of features which enumerate the difference between them $\mathbf{F}_{\mathbf{diff}}$, whereXing is the right action in S_1 but Ying is the right action in S_2. Both generalists and particularists agree that the moral features of the situation supervene on the non-moral, and thus they can agree that the reason for a difference in right action will be found in $\mathbf{F}_{\mathbf{diff}}$:

Take two broadly similar situations, S_1 and S_2. We wish to say Xing is right in S_1 and Ying is right S_2. For both the generalist and the particularist there must be differences in the feature sets for this difference in the rightness of Xing and Ying to be present.	
Generalist Approach For the generalist those features which made Xing right in S_1 (*pro tanto* reasons to X) which are present in (broadly similar) S_2 *must* promote Xing in S_2. Any counterbalancing *pro tanto* reasons not to X did not outweigh reasons to X in S_1 so will not do so in S_2. So other features in S_2 must invoke another principle which provide *pro tanto* support for Ying, and that on-balance Ying is to be preferred.	Particularist Approach The particularist believes reasons to be holistic; she recognises that Xing is right given S_1 and Ying right given S_2. Rationally she believes this results from a difference in the features of S_1 and S_2. This difference in one or more features is the "reason" Dancy refers to for not making the same judgement in both cases.

In the form of particularism I have been discussing, the particularist would be expected to be able to indicate which feature or features of S_2 resulted in the difference in right action. The generalist would require an extra rule to say that the *pro tanto* reason to X will be outweighed by the *pro tanto* reason to Y given $\mathbf{F}_{\mathbf{diff}}$.

For the generalist the feature of a situation which indicates the Ying is right in S_2 must have a positive valence for Ying (or a negative valence for Xing) and carry sufficient weight to change the overall balance of the decision between Ying and Xing This is not to say generalists need to search the DoH website, scan B&C or some other source of generalist ethical wisdom; they do have to recognise that some other generalist rule or principle is being invoked and know how to balance these rules or principles against each other. There is considerable scope for generalists to disagree over the weight of factors which might be used to balance the various principles at play; in difficult situations different generalists might well come to different conclusions.

At the level of normative ethics, for Ying to be correct in S_2, at least one member of the set $\mathbf{F}_{\mathbf{diff}}$ must be recognised as invoking or strengthening a general rule in favour of Ying, or as negating or weakening one of the reasons why Xing is right in S_1,.

The particularist's decision seems at root reflective, given her moral experience she believes she should Y in S_2. She must see that the difference in the situations provides "some reason" for Ying rather than Xing.

If normative ethics is the search for an ideal litmus test of morally proper behaviour, then normative ethics seems at odds with the holism of reasons which is a central plank of Dancy's particularism. However supervenience holds under particularism, so if she has concluded that Xing is correct in S_1, the particularist must accept that something in $\mathbf{F}_{\mathbf{diff}}$ acts to modify the reasons for that decision such that Ying is correct in S_2.

At the level of practical generalist ethics the different features will be relevant to some aspect of the guidelines. For example, a doctor trying to follow the four principles approach to medical ethics, might recognise some fact of the patients' psychological makeup which would alter the balance between respect for autonomy and beneficence in the two cases, such that it was correct to reveal to Patient 1(the patient in S_1) the whole truth about his condition as soon as possible, while Patient 2 (the patient in S_2) would need the situation explained in a series of consultations over an extended period of time.

There may be nothing in S_1 to make a doctor think she should not follow a general proscription against lying; in S_2 however following that proscription might bring some harm to an innocent party, for example where a patient's blood type means that he cannot be the biological child of his parents, it may be that nothing would be gained by the revelation but considerable stress could be put on the whole family.

We might think of the generalist as having to run the difference between S_1 and S_2 through what might be termed a "generalist filter" (normative ethics, practical ethics or practice guidelines) before the correct course of action can be determined. The experienced agent will be able to apply such filters without recourse to external sources; she will have learned the relevant aspects

of the particular system to be applied. If asked to justify her decision her ultimate justification would be reference to the generalist system; she might say, "Lying can be justified when there is no benefit in telling the truth and such truth telling would cause harm to innocent parties." Or she might cite the relevant DoH guidelines. In this situation telling the truth has the feature "that it would cause harm", this does not change the *pro tanto* proscription of lying, but carries its own *pro tanto* valence opposing that general proscription, since truth telling is not supported by any specific benefit in the situation, not telling the truth carries the day. If the situation requires that some statement is made then lying is the right action.

For the particularist, the approach would be different; she would reflect on the particular situation and decide whether to X or to Y as a result of the features of S_1 or S_2Here "that the statement is a lie" would have a default negative valence, but this would be switched off by the feature that it would cause harm, allowing the particularist to choose the statement which would bring most benefit.

When considering a doctor acting to follow specific guidance documents a similar approach would be taken, here however the application of the documents will be far more explicit. The doctor might recognise that the patient is a Jehovah's Witness. For the generalist this will bring a strong *pro tanto* duty not to give blood which has been judged by the guideline writers to have stronger weight than the general *pro tanto* duty to do what will bring benefit to the patient. For the particularist, giving blood has the feature "it would benefit the patient" which arrives with a positive default valence, the guidelines indicate that the feature "the patient is a Jehovah's Witnesses" will switch off this default, this, of course, is also defeasible.

5.3 I see the particularist's approach as having resonance with the approach taken by virtue ethics[33] or at least by agent based virtue theory.Professional guidance

Much of the work done by clinical and non-clinical medical professionals and nursing and technical support staff is guided and sometimes dictated by professional guidance. Some of this guidance, such as the "Good practice in consent implementation guide" (DoH 2012), make explicit reference to ethical practice; the introduction to this document says "Patients have a fundamental legal and ethical right to determine what happens to their own bodies" (p9). Others, such as the IR(ME)R regulations (DoH 2000), which will be discussed in §5.4.1, make no explicit claim to guide ethical practice (apart from noting that procedures must be approved by the relevant Ethics Committee) but have ethical components; IR(ME)R guides the practitioner in the justification of an inherently harmful procedure (exposure to ionising radiation) and defines when this can be carried out in the interest of the individual patient or in the interest of society. We may thus consider these guidelines as part of the ethical framework within which the clinician is working. For the generalist, they form part of the framework of principles within which decisions about patient care are made. For the most part I will take them as providing Rossian or *pro tanto* moral reasons for undertaking or refraining from actions and associating those reasons with certain features of situations clinicians might meet in their practice. For the particularist, they are an element of the advice which she might consider when

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[33] Blum comments " 'Virtue ethics' is theoretically agnostic on the particularism issue – there could be a non-particularist form of virtue ethics – but in general virtue theorists recognize that some virtues ... have an irreducibly particularist dimension" (Blum 2000 p203 *footnote*). Stangl thinks that particularist virtue ethicists are caught in a dilemma whilst recognising "There is an obvious affinity between virtue ethics and particularism" (Stangl 2008 p665)
Whilst I believe there is a strong resonance between the views of some virtue ethicists and the position of the particularist, this thesis is not the place to pursue that discussion.

making decisions about patient care, they will indicate actions with default moral values or features of situations which have default moral valences.

5.4 Some illustrative examples

So far in this thesis I have visited many illustrative ethical questions and dilemmas, I would like to discuss two real situations which arose in my practice in early stage clinical trials of novel radiolabelled agents in cancer treatment. I will also consider some questions raised by consideration of one of the UK's main providers of guidelines. I will briefly outline the case studies in the following subsections and outline the ethical issues raised by each in §5.5. In §5.6 I will look at the generalist and the particularist practitioner and look at each of the case studies to identify whether these practitioners approach them differently, and if so, what differences this might lead to.

The particular treatments my research group is mostly concerned with are known as molecular radio therapy (MRT) and molecular imaging (MI); they consist of injecting a patient with an agent which is designed to carry radioactivity to a particular molecular target associated with cancer. In general the agent is a construct of a targeting moiety and a molecular structure which holds an atom of a radioactive nuclide. The radioactive part of the construct may emit particles (alpha or beta radiation) intended to cause damage to the tumour as therapy (MRT) or it might emit gamma radiation which can be measured from outside the patient (MI) using Single Photon Emission Computed Tomography (SPECT) for calculating how much therapeutic radionuclide can be administered to the patient or if the patient is suitable for non-radioactive treatment aimed at the same molecular target. In order to make these measurements accurately a hybrid imaging system is used; this consists of a SPECT imaging subsystem linked to an X-ray CT imaging subsystem. Every imaging session (SPECT-CT) involves an exposure to X-radiation in addition to the absorbed radiation dose the patient receives from the radioactive agent itself.

5.4.1 Unnecessary exposure to ionising radiation

In the first case we are setting up a clinical trial of an agent to assess whether patients with breast cancer who are being treated with Herceptin®[34] should continue with the treatment or whether their cancer has mutated and no longer carries the necessary molecular target (HER2 receptor). In the early (Phase I[35]) trials we would like to establish the time course of the MI agent in normal organs and cancer deposits in man. The mathematics of the standard model of kinetics of drugs dictates that we will need measurements at five time points to establish the parameters for the time course. Establishing this time course will be of benefit to the scientific community as this is the first use of this type of agent in man; our aim is that it will be of benefit to future patients as we can establish the best time delay between administration and imaging; but it will offer no advantage to the patients undergoing the trial. These patients will, however, receive the X-ray absorbed dose from the five SPECT-CT imaging time points.

In the case of this MI trial it is interesting to trace the chain of the ethical justification from the clinician who approves the actual administration to the patient to see where, and at what level, ethical justification is made. All medical exposure to ionising radiation is covered by the Ionising Radiation (Medical Exposures) Regulations Parliament 2000 (IR(ME)R), while these are a statutory instrument, they are helpful in setting out a framework of responsibilities for the medical use of ionising radiation, this framework can be of use in for investigating the ethical issues. IR(ME)R regulation 5(2) says

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[34] Herceptin® (trastuzumab) was approved for use in a certain patients (around 25% of all breast cancer patients) by the National Council for Clinical Excellence in 2002 (NICE 2002). It is a treatment (rather than a cure) which slows or stops the progression of the disease while it is being given. In 2006 The Times newspaper reported the cost as £20,000p.a., while Barrett A *et al* (Barrett *et al.* 2006) estimated the total cost of treatment at nearer £30,000p.a. given the pathology and cardiology tests required. There is thus a significant saving to be made, if patients who will no longer benefit are withdrawn from treatment.

[35] See Cancer Research UK's website for details of cancer trial phases http://cancerhelp.cancerresearchuk.org/trials/types-of-trials/phase-1-2-3-and-4-trials

> The practitioner shall be responsible for the justification of a medical exposure
>
> Regulation 5(2)

where "practitioner" is defined by

> "practitioner" means a registered health care professional who is entitled in accordance with the employer's procedures to take responsibility for an individual medical exposure
>
> Regulation 2(1) as amended 2006

IR(ME)R allows for

> the exposure of patients or other persons voluntarily participating in medical or biomedical, diagnostic or therapeutic, research programmes
>
> Regulation 3d

Under IR(ME)R no exposure can be made unless

> it has been justified by the practitioner as showing a sufficient net benefit giving appropriate weight to the matters set out in paragraph (2)
>
> Regulation 6(1)a
>
> The matters referred to in paragraph (1)(a) are—
>
> the specific objectives of the exposure and the characteristics of the individual involved;
>
> the total potential diagnostic or therapeutic benefits, including the direct health benefits to the individual and the benefits to society, of the exposure;
>
> the individual detriment that the exposure may cause; and
>
> the efficacy, benefits and risk of available alternative techniques having the same objective but involving no or less exposure to ionising radiation.
>
> Regulation 6(2)

Of particular interest in clinical trial exposure is

> In considering the weight to be given to the matters referred to in paragraph (2), the practitioner justifying an exposure pursuant to paragraph (1)(a) shall pay special attention to—
>
> ...
>
> exposures that have no direct health benefit for the individuals undergoing the exposure;
>
> ...
>
> Regulation 6(3)

The DoH also publishes a document which "provides guidance on [IR(ME)R] 2000 (the Regulations) and notes on good practice" (DoH 2005). This document says, "The process of justification must ... pay special attention to the matters set out in regulation 6(3)", and describes the practitioner as having responsibility for justifying medical exposure, further it says the

practitioner must be adequately trained to undertake this function. However it gives no extra guidance for the practitioner concerning the application of regulation 6(3). For the practitioner faced with authorising or declining a request for the exposures which will result from a patient being entered onto the trial, guidance from the DoH has run out at this point; the practitioner is left to decide how to "pay special attention" to the matters identified in Regulation 6(2) above. The practitioner can look for further guidance; in practice, in this case, to justify an individual exposure in a clinical trial the practitioner would look to see that the Local Research Ethics Committee has approved the trial; this committee will have acted on an application from the investigators. The practitioner also requires that the Administration of Radioactive Substances Advisory Committee have authorised him to approve the exposure. Part of the role of these two bodies it to assess whether the justification for the exposures offered by the investigators is reasonable.

5.4.2 Unnecessary Biopsy

The second case arose when we were setting up a protocol for an MRT trial. This is a Phase II trial and is expected to be effective in some patients. It would be scientifically worthwhile to look for differences between those patients in whom the treatment is effective and those in whom it is not; material obtained by biopsy would be useful in this context. Biopsy is not risk free (a study in 1995 showed complications requiring blood transfusion in 0.8% of patients and mortality in 0.3% Gilmore *et al.* 1995) and is of no benefit to the individual clinical trial subject.

This case is less bound up in regulation. The patients entered on the trial might benefit from the treatment; however the cost of putting patients through these technologically advanced trials is relatively high (the total cost per patient of a similar recent trial was £47,808[36]). This cost is

[36] "Full Economic Cost" per patient for a recent MTR clinical trial, charged by University College Hospital NHS Foundation Trust.

justified to the funding bodies by the expectation of scientific progress; this expectation is considerably enhanced when the patient agrees to undergo biopsy.

5.4.3 National Institute for Health and Clinical Excellence (NICE)

One major source of guidelines is The National Institute for Health and Clinical Excellence. NICE performs a range of functions among which are

> NICE is here to help those working in the NHS, local authorities and the wider community deliver high-quality healthcare.
>
> ...
>
> NICE's technology appraisals programme is designed to ensure that people across England and Wales have equal access to new and existing medicines that are deemed clinically and cost effective, reducing the risk of a postcode lottery of care.
>
> NICE 2012

For the purpose of this thesis I will not discuss the ethical status of NICE and its recommendations (see, for example, Harris 2005 and Claxton and Culyer 2006 for this debate) but view it as a source of guidelines.

One major aspect of NICE's work can be seen as an application of the consequentialist calculus in the framework of a resource limited health service (the UK's NHS). Essentially this asks how the country can make best use of the limited funding available to the NHS. Benefit is calculated in terms of the Quality Adjusted Life Year (QALY), in 2008 the threshold cost for acceptable treatments was £30,000 per QALY (NICE Citizens Council 2010) with some leeway for particularly severe disease recommended by NICE's Citizens Council.

NICE can then be seen as providing a generalist (consequentialist) answer to questions regarding the justice of offering particular treatments to patients with a particular disease or other condition.

NICE recommendations are sometimes ignored, either to treat patients when the recommendation is that they should not be treated or to deny treatment when NICE recommends that a patient should be treated. An example of the latter was reported by Sky News in June 2011:

> In 2004, the National Institute for Health and Clinical Excellence (Nice) said couples should be given up to three cycles of IVF on the NHS, where the woman is aged 23 to 39.
>
> ...
>
> A new report from the All Party Parliamentary Group (APPG) on Infertility shows 73% of NHS trusts are failing to implement the guidance.
>
> Sky News 2011

An example of the former is the prescribing of unlicensed medicines or the prescribing of medicines outside the terms of their license (so called "off-label" prescribing).

Variations in adherence are common, in 2004 a report by the UK's National Cancer Director noted:

> variation in usage does exist across the country and cannot be accounted for by differences in casemix and, for most drugs, is unlikely to be accounted for by cross boundary flows alone.

> clinician factors - it appears that the use of drugs is heavily dependent on individual doctors' perceived usefulness of the particular drugs and, in some cases, the choice between different drugs that exist.
>
> DoH 2004

In 2001 NICE issued the guidance document TA19 which recommended that a drugs of a particular class (acetylcholinesterase inhibitors (AChEIs)) should not be used in mild Alzheimer's disease (AD), but were recommended in moderate AD.

Many clinicians were asked by relatives and carers of patients with mild AD to prescribe these drugs and the Alzheimer's Society (www.alzheimers.org) campaigned for a change in the advice. In 2007 Wilkinson and Deas wrote of mild AD patients:

> There is an increasing body of evidence that the use of [these drugs] offers considerable respite from the more distressing aspects of the disease in this group of patients who are most in need of treatment.
>
> Wilkinson and Deas 2007

5.5 Ethical issues

The first two sections above (§5.4.1 and §5.4.2) describe situations which contain a procedure which is generally considered a harm (in the first case exposure to X-rays, in the second an invasive procedure with a risk of complication or mortality) which will not be of medical benefit to the subject. In this I am taking the risk of harm as being something which should be avoided if the principle of nonmaleficence is followed (the feature "that it could cause harm to the patient" has a negative *pro tanto* valence for the generalist or comes with a default negative valence for the particularist). Although this principle is generally expressed in terms of actual harm and can be taken as an expression of the doctrine of *primum non nocere* it seems reasonable

to extend from "do no harm" to "do not expose to risk of harm". Most patients who undergo X-ray exposure or biopsy do not suffer long term harm, but some do.

The idea of altruism is often cited when the question of participation in early phase clinical trials is discussed. In that people undertaking altruistic acts feel better about themselves, allowing patients to participate in a trial can be seen as a potential good for a patient who would not otherwise benefit from the trial, however this does not apply to all patients:

> A systematic review of published literature examining patients' motivation to participate in clinical trials concludes that self interest is a more common reason for participating than altruism.
>
> Ellis 2000

Patients in early phase clinical trials in cancer often express the hope that they will "the one", i.e. that there will be clinical benefit in their case. For many patients undergoing these trials there is measurable harm without benefit to the subject.

In the case of healthcare professionals acting against NICE guidelines there are two subgroups, In the first there is a loss of benefit to patients (not being given the recommended number of cycles of IVF), presumably for a perceived greater benefit of cost saving providing more resource for other patients (for the generalist the *pro tanto* right of infertile couples to a fair crack of the whip when it comes to IVF is balanced against the *pro tanto* rights of access to resources (in particular financial resources) for patients with other medical conditions, I will contrast this with the particularist's view in the next section). In the second the clinicians prescribing against guidelines are offering potential benefit to particular patients at the potential loss of benefit to others if the drug budget runs out (a similar clash of *pro tanto* rights to access to resources is seen here).

5.6 The Particularist and the Generalist

Is there a difference between the way a generalist would practice and the way a particularist would?

5.6.1 Similarities

Healthcare professionals work in a highly complex environment. The pharmacology and technology available to modern medicine can make the situations in which patient care decisions are made difficult to comprehend fully. As well as clinical decisions the physician may be faced with a range of diagnostic technologies, possible treatments etc all of which might have ethical implications for her decision as to what to offer or recommend to her patient. Within the context of this thesis this represents a very rich feature set and ethical considerations are one of several filters on the possible range of actions she might take. Some features will be represented in more than one filter. Magnetic Resonance Imaging (MRI) does not employ ionising radiation and may be preferable to X-ray CT in that it is not generally thought to be a potential harm to patients, so imaging technology may be a feature included in the ethical filter, it is also better at seeing soft tissue in the neighbourhood of bone but is worse at seeing bones themselves so the diagnostic question filter may also influence the choice of imaging modality.

In the very practical field of medical ethics the features which the particularist sees as relevant and those the generalist sees as relevant are likely to be very similar. It is probably that both will see the potential harm from ionising radiation as relevant but that neither will consider the colour of the patients' shoelaces to be so.

5.6.2 Differences

It is reasonable to suppose that both particularist and generalist clinicians are attempting to do the right thing for their patients; however they might be expected to have different attitudes

towards ethical frameworks and guidelines. This difference is seen in the debate between Dancy (in "Ethics Without Principles") and Hooker (in his paper "Moral Particularism: wrong and bad" in "Moral Particularism") which is pertinent to the discussion of trust §6.2. Hooker considers a situation in which particularist Patty and (Rossian) generalist Gerry have both made the same promise:

> As a particularist, Patty thinks there are no considerations which always retain their moral polarity. She thinks that a consideration (such as the fact that she promised to do something) might be a reason for keeping her side of the deal in some situation, but a reason against keeping it in another situation. So, will she think that having made a promise to you gives her *any* reason to do what she promised?
>
> Hooker 2000 p18 (original emphasis)

He answers his own question "Not necessarily". On the other hand:

> [We] know that Gerry subscribes to the general principle that promise breaking is always a moral minus ... [No general] defeating conditions obtain in the case in hand. So Gerry would hold that breaking his promise to you is a moral minus.
>
> Admittedly, Gerry does not think that breaking his promise ... would necessarily be, all things considered, wrong.
>
> p19-20

Hooker believes that we should think Gerry more likely to keep his promise; although Dancy does not dispute this assertion he says:

> Hooker writes that 'whether or not particularism is likely to lead agents to make moral mistakes, the Rossian generalist seems in the circumstances more likely to keep the promise' [p21]. But if the particularist Patty is making no mistake in not keeping her promise, that means that morality does not require her to keep it. If so, it does not require Gerry to keep it either. ... It seems then, that, Patty and Gerry will only differ

> in their behaviour in cases where it is certain that Patty will do the right thing, and not at all certain that Gerry will.
>
> Dancy 2004 p134

How is it that Dr Patty and Dr Geri[37] (here the particularist and the generalist clinicians) might reach different conclusions about what is the right thing to do? In the case given above of the choice of drugs for a patient with mild AD Dr Geri would consider the NICE guidelines to be a *pro tanto* reason for not prescribing AChEIs. Once Wilkinson and Deas had published their analysis, she might consider this to be evidence of benefit to mild AD patients (a *pro tanto* reason to prescribe) and thus weigh the NICE guidelines against beneficence to decide what treatment to recommend. In parallel with Hooker's Patty, Dr Patty might (in some circumstances) not think that the NICE guidelines give her any reason not to recommend AChEIs to a patient with mild AD. Dr Geri would always consider breaking NICE guidelines as a moral minus but might not think that it would necessarily be, all things considered, wrong. Dr Patty might think weaker evidence of effectiveness in mild AD (or no evidence at all if she believes her patients might benefit) would be sufficient to mean that NICE guidelines did not count. It does seem that Dr Geri is more likely to hold to the NICE guidelines and Dr Patty is more likely to offer AChEIs to mild AD patients.

In the case of unnecessary exposure to X-radiation in the clinical trial example, Dr Geri will always consider IR(ME)R guidance to have ethical force although this might have a low weight in her final balancing of *pro tanto* considerations; Dr Patty can simply say such exposure does not count when patients do not have sufficient life expectancy for late effects of X radiation

[37] For consistency I have made the doctors both female.

exposure to be seen.[38] Both might see the discomfort imposed on patients in late stage cancer, by subjecting them to multiple imaging sessions, to be a significant harm.

5.6.3 Is the distinction meaningful at a practical level?

The current model of ethical practice in medicine is very much a generalist one. It relies heavily on the writings of Beauchamp and Childress and the model of principalism.[39] Guidelines play a strong part in interpreting this ethical framework for application in the clinic. Guidelines come from a variety of sources ranging from departmental policy, through hospital rules to DoH and NICE guidelines.

The main concern of clinicians is the care of their patients. In this they can be forgiven for not wishing to spend a large portion of their professional time worrying about the ethical aspects of their clinical decisions. Whilst they wish to act within acceptable ethical boundaries, they are happy to have those boundaries set by people or bodies whose concern is the ethical implications of medical practice. In many cases then, "because a moral authority endorses Xing" is a reason for Xing. This reason works for both generalist (as a *pro tanto* reason) and particularist (as a default reason) agents. In their day to day practice both generalist and particularist clinicians could use this as a rule of thumb for staying within the boundary of acceptable practice. The ethically interesting cases occur when this reason fails. This moral authority rule of thumb might fail for one (or more) of several possible causes. For example, a new treatment option might raise ethical issues while it is not sufficiently mature to be subject to the guidelines. Alternatively

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[38] This ignores the legal duty on both physicians imposed by the IR(ME)R Statutory Instrument.
[39] I use "model" and "framework" here as I do not think that principalism is in and of itself a normative ethical theory; rather it should be seen as a template provided by some moral authority in his study to guide the medic in her clinic.

guidelines might offer conflicting advice. It is at such a point where we might expect differences between particularists and generalists emerge. I will examine the examples laid out above in the light of this analysis.

5.6.4 Unnecessary exposure to ionising radiation

The generalist approach to this can be seen as grounded on Kant and the Humanity Formula of the Categorical Imperative (Johnson 2010),

> So act as to treat humanity, whether in thine own person or in that of any other, in every case as an end withal, never as means only.
>
> Kant 1785a

The generalist following Ross's line will consider this as a strong *pro tanto* reason for not proceeding and will consider balancing reasons.

In general the investigators in the clinical trial will not be the IR(ME)R practitioner but the legal responsibilities laid down here for the practitioner will help the generalist agent in weighing the *pro tanto* duties when developing an ethically acceptable protocol for this trial. The legal concept of the practitioner is not relevant here but the moral agent is indeed trying to justify the exposure on the grounds that the net benefits to society are sufficient to justify exposures that have no direct health benefit for the individuals undergoing the exposure.

One potential source of guidance for the generalist will be the IR(ME)R guidelines. Initially IR(ME)R seems to lay out something like a Rossian process. He has *pro tanto* reasons for rejecting the proposal (that there is no benefit to the patient in undergoing the CT exposures, that all X-ray exposure increases the patient's risk of developing new cancers[40]) and *pro tanto* reasons for approving the proposal (these are generally thought of in terms of the benefit to

[40] The actual risk from low level X-radiation exposure is still a matter of debate, but the regulatory framework assumes that all exposure accumulates risk over a patient's lifetime.

medical research which are ultimately regarded as a good for society). However IR(ME)R seems to run out at this point, leaving the practitioner to pay special attention to the exposure in this case as it has no benefit for the subject but not indicating how she should do so.

When considering clinical trials and other experimental medicine Beauchamp and Childress look to the Declaration of Geneva:

> The Declaration of Geneva of the World Medical Association affirms that "the health of my patient will be my first consideration", and the Physician's Oath of this same association demands that "Concern for the interests of the subject [of research] must always prevail over the interests of science and society".
>
> Beauchamp and Childress 2001 p319

At first sight this seems more Kant than Ross, but B&C draw a distinction between two roles for the physician: the physician acting as clinician and the physician acting as investigator. The Declaration of Geneva gives a clear statement of the clinician's duty, but this becomes a *pro tanto* duty for the physician who also has *pro tanto* duties as investigator:

> As an investigator, the physician acts to generate scientific knowledge to benefit individual patients in the future. ...
>
> Research involving human subjects is socially important but morally perilous. ... Ethically justified research must satisfy several conditions, including (1) a reasonable prospect that the research will generate the knowledge that is sought, (2) the necessity of using human subjects, (3) a favourable balance of potential benefits over risks to the subjects, and (4) fair selection of subjects.
>
> B&C p319-320

This does provide a clearer statement of how the various features of the situation bring *pro tanto* duties to bear on the overall final decision; most of these can be dealt with in a reasonably concise way:

(1) The research question is well formulated: "Can we distinguish HER2 +ve tumour masses from HER2 –ve masses by external imaging using this agent?" The relevant technology is understood and interpretation of the results is not expected to be different from interpretation of results in similar established procedures.

(2) By the time we are ready to open the study for patients[41] the agent will have been shown to be effective in animal models of human breast cancer and no further non-human testing will answer the research question.

(3) See below.

(4) Patients from the group of patients expected to benefit from the research in the future will be invited to participate.

Item 3 looks at the conflicting *pro tanto* duties. A simple cost-benefit analysis of potential benefit to many "individual patients in the future" versus the potential harm for the individual trial subjects does not give the weight to the duty of care for the subject that B&C, citing the Declaration of Geneva, require. In balancing these risks the IR(ME)R framework ensures that the risk to the subject is minimised (the lowest radiation absorbed dose consistent with achieving the required data), and the protocol design is aimed at ensuring the most future patients benefit (the requirement for five imaging time points to make the best model of the uptake and clearance of the agent will ensure optimal imaging for future patients). The generalist may next look to the past to see what protocols have been judged ethically acceptable. Simply by the nature of clinical research this study differs from previous studies in significant ways, there is then always some difference in the nonmoral features of the situations and there need be no

[41] The length of time taken to negotiate the regulations in order to open a clinical trial mean that the protocol is often developed in parallel to much of the pre-clinical work and amended as necessary, rather than waiting for the pre-clinical results to be ready before starting setting up the trial.

algorithmic precedent set. A less strict study of precedent might help find elements of protocols which have been judged acceptable and elements which have not in past studies.

In concluding their section on clinical trials[42] B&C do not provide any fixed rule for determining how one can balance individual risk with collective benefit:

> Our obligations to future patients are so strong that we should permit, encourage and support research that can generate knowledge, but do so without violating the rights and interests of current patients.
>
> B&C p327

In the end, it seems that the generalist can run out of guidelines, rules and principles and she must weigh the *pro tanto* duties in the light of her moral experience.

The particularist will see the same set of features defining the situation and is also subject to IR(ME)R regulations, however she may not see the same features as relevant, as the generalist does. In the case under discussion the particularist looks at the question of the unnecessary X-ray doses and argues that the reason for controlling X-ray doses at this level is the possibility of later developing cancers (that an exposure to X-rays would have no benefit for the patient would be a default reason not to make the exposure), this is an early phase trial so that the patients invited to take part in the trial are late stage breast cancer patients whose life expectancy is less than five years, new cancers resulting from the X-ray absorbed doses would not show up on this time scale. The default reason becomes no reason at all in this case and the question of X-ray exposure is not relevant and need not be considered when justifying this trial.

The particularist is looking to her own judgement to decide which features of the situation are relevant to the ethical acceptability of the trial. In this she is using the holism of reasons ("A

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[42] Much of B&C's section on clinical trials is concerned with randomised trials undertaken from a position of equipoise, which is not the case here.

feature that is a reason in one case may be no reason at all ... in another") to see that the feature "the procedure gives rise to an exposure to X-radiation" may be a reason to ensure there is net benefit to the individual patient in most cases where the procedure is considered, but it is not a reason in this case. The generalist might consider unnecessary radiation exposure always to be a consideration albeit one with a low weight, or she might increase the specification of the rule "avoid unnecessary radiation exposure" to "avoid unnecessary radiation exposure in patients who have a reasonable expectation of living long enough for the effects of that exposure to be seen", the specification is the development of a rule for balancing the *pro tanto* duties, giving a low weight to the feature "the exposure will not benefit the patient" when the feature "the patient's life expectancy is too short for any disbenefit to manifest" is also present).

5.6.5 Conflict in biopsy case

In this case a strict absolutist deontologist line would rule out the biopsy option for the trial; the biopsy offers no benefit to the patient and undertaking it is treating the patient as a means to an end (the acquisition of scientific data). The Rossian generalist following the four principles must weigh autonomy, nonmaleficence and benefit to society.

Nonmaleficence and benefit to society are both fairly clear features and are an obvious source for ethical conflict here. If all patients have a biopsy then there will be a significant amount of material available to provide scientific data for the benefit of society, however all those patients will have been put at risk without benefit to themselves. As stated in §5.5, I am taking the harm due to a biopsy to be the risk of complication not the simple harm of cutting the skin etc inherent to a minor surgical procedure.

The patient's autonomy must be protected by ensuring they are fully informed as part of the consent procedure. In clinical trials patients are generally given an information sheet where the risks and benefits are clearly set out, usually they are invited to discuss anything they do not

understand before deciding whether to participate. Some patients have a desire to participate in trials on an altruistic basis while some want to participate under the belief that they might benefit from the treatment. The former group are simpler for the generalist to deal with, as long as they understand the level of risk and thus their decision is fully autonomous, thus autonomy will carry considerable weight in the decision. The latter case is more problematic, this is a Phase II trial so some patients are expected to benefit, and it is at the level where some patients benefit that biopsy material is particularly useful. However those patients who benefit will do so whether or not they undergo biopsy. So the line of reasoning It was agreed that the consent documents should not open the way for patients to think "taking part in the trial involves having a biopsy, I might benefit from the trial, therefore I might benefit if I accept the biopsy" as the relies on the premise that the biopsy is a necessary part of the trial.

The feature set being examined by the research group contained a wide variety of elements including:

F_1: Subjects have a limited life expectancy without treatment.

F_2: No conventional treatment is available.

F_3: This is a Phase II trial so some patients are expected to benefit.

F_4: We cannot predict which patients would benefit.

F_5: Biopsy would help decide which future patients would benefit.

F_6: Biopsy offers no benefit to the subjects.

F_7: Biopsy exposes subjects to risk.

$F_{1\text{-}4}$ provides *pro tanto* reasons to offer a patient a place on the trial; F_5 a *pro tanto* reason to ask them to undergo a biopsy; and $F_{6\text{-}7}$ a *pro tanto* reason not to ask them to undergo a biopsy. In this case the particularist cannot argue that the risk to the patient does not count (as she could in the

X-ray exposure case) as the risk is more immediate and the patient's life expectancy could be enhanced by the treatment.

One proposed option was that acceptance onto the trial should be conditional on consent to biopsy. The reasoning put forward was that these patients had a chance of benefit not available to those not on the trial, the trial would be expensive to run so the best use of money was to maximise scientific benefit:

F_8: Phase II trials are expensive.

Those who proposed this were appealing to justice to provide a *pro tanto* reason to ask all patients to undergo a biopsy.

An argument was proposed that the trial protocol be written in such a way that a decision whether or not to ask a patient to undergo biopsy should be made when the decision whether or not to invite the patient to participate in the trial was made (usually at the Multidisciplinary Team[43] (MDT) meeting). The MDT would decide on an individual patient basis from a sufficiently detached standpoint. This accepts that deciding for an abstract patient is not possible and the feature set is still too thin; the decision requires a thicker feature set, which must include patient specific features, for the correct action to be identified.

A faction I class as generalist were in favour of defining a list of reasons for deciding which patients should be in the biopsy group and which not. Features such as, "The patient lives a long way away", "The patient is close to feeling he has had enough discomfort" and, "The patient has a young family" were proposed for inclusion in this list. A faction I class as particularist were

[43] Current best practice in cancer care is based on the Multi Disciplinary Team concept; see for example the Cancer Care Network handbook "The Characteristics of an Effective Multidisciplinary Team (MDT)" (ncat.nhs.uk/sites/default/files/NCATMDTCharacteristics.pdf)

opposed to defining such a list; for them the MDT should choose patients to be offered a place on the trial, but the decision concerning biopsy would be made by the individual doctor when interviewing the patient prior to offering them a place on the trial. They argued that it would not be possible to define such a list as we could not know in advance which features would be important.

5.6.6 The difference between the generalist position and the particularist here is in whether the features which distinguish those who should be invited to undergo biopsy can be defined "up front" and built into the protocol; the particularist will reject this attempt as being against the holism of reasons.NICE

The guidelines produced by NICE can be seen as resulting from a consequentialist analysis and thus as a guide to the just action when deciding which (if any) drugs or treatment should be prescribed for patients suffering from certain conditions in certain situations.[44] Accepting that NICE's remit is to see the big picture, I will take it that their recommendations define the just action and thus will always have a positive moral valence for the generalist clinician. Nonetheless variations in adherence are common as was noted in §5.4.3.

Both generalist and particularist clinicians can use the literature and the reports which are pooled to provide the evidence for "meta-analysis", such as the paper by Wilkinson and Deas cited above, in their feature set when deciding whether to break the NICE guidelines. For the

[44] There are many who would argue with this statement, but for the purpose of this thesis I will take it to be a reasonable statement of the aim of NICE.

generalist this paper provides strong evidence of benefit to mild AD sufferers and they can weigh the beneficence of prescribing these drugs against the justice of not doing so. The generalist has to wait for sufficiently strong evidence to be available (here a peer reviewed meta-analysis of several small studies) for beneficence to acquire the weight needed to overcome the pull of the NICE advice. The particularist clinician is able to act earlier on her moral insight, or on the weak evidence of one of the papers pooled by Wilkinson and Deas, that her mild AD patient will benefit from her not following NICE guidance. This case seems most similar to the scenario discussed in §5.6.2 and we see the generalist clinician as more predictable in following NICE guidelines but the particularist less likely (in an extension of Dancy's view) to make a moral mistake.[45]

5.7 Becoming an experienced agent

In Chapter 4 I looked at the relationships between naivety and experience, and the thinness and thickness of principles, and how these interact in action guidance.

In discussing the role of experience I have tried to avoid the question of whether experience can guide the particularist at the most basic level of morality. Does the particularist learn from experience that killing innocent people is wrong by default, or that *ceteris paribus,* the feature "it will bring pleasure" will have a positive moral valence? (See also §6.3.2.1.) I am more concerned to see how experience allows moral agents to understand how the features of complex (thick) situations interact to give moral values to possible courses of action; I have referred to this loosely as developing moral insight.

When guidance from what I called "algorithmic deontology" (§3.4) runs out the generalist clinician still needs to act and must make up her mind what to do; in this situation there is little

[45] In 2007 NICE issued revised guidelines (TA111) with a further revision in 2011 (TA217). The drugs discussed in the text are now recommended as options for managing mild as well as moderate AD.

difference between the particularist and the generalist. Hard line generalists might argue that in principle the principles do not run out, in practice it seems that they do; for instance IR(MR)R guidance (as discussed in §5.4.1) says the physician must be adequately trained to make the decision.

A difference might arise between particularist and generalist if the particularist is used to making decisions whereas the generalist is used to principle based guidance. The particularist is better equipped to deal with practical guidance running out. The generalist, on the other hand will be more experienced at finding and interpreting what guidance there is.

5.8 Trust

I will conclude this chapter by returning briefly to the topic of trust, preparatory to a longer discussion in the next chapter.

In seeking advice and treatment from a doctor the patient is inherently placing his trust in the professionals in the healthcare system. The doctor-patient relationship is based on this trust; the doctor (explicitly or implicitly) agrees to being trustworthy.

> Elaborate measures to ensure that people keep agreements and do not betray trust must, in the end, be backed by - trust. At some point we just have to trust. There is, I think, no *complete* answer to the old question: 'who will guard the guardians?'. On the contrary, trust is needed precisely because all guarantees are incomplete. Guarantees are useless unless they lead to a trusted source, and a regress of guarantees is no better for being longer unless it ends in a trusted source.
>
> O'Neill 2002a p6 (original italics)

This quotation from O'Neill serves to remind us that trust can lead to a source; the person sitting opposite the patient in the consulting room is not necessarily the one ultimately being trusted. Many forms of trust might be involved: trust in the research scientists who develop

drugs and publish the results of clinical trials, trust in the skills of the laboratory technicians who perform the various diagnostic procedures. Here I am concerned with trust in the ethical decision makers.

5.8.1 Trust the writers of guidelines

Under a fully generalist scheme it is not clear who the public would be trusting. A trusts his doctor to prescribe the best treatment for his condition. If the doctor follows NICE guidelines, there is a chain of trust from A, via the doctor, to the NICE committee who considered the use of the relevant drugs:

> Every piece of NICE guidance and every NICE quality standard is developed by an independent committee of experts including clinicians, patients, carers and health economists.
>
> All of our guidance is considered and approved by the NICE Guidance Executive, a committee made up of NICE executive directors, guidance centre directors and the communications director, prior to publication.
>
> Our Citizens Council, comprising 30 members of the public, provides NICE with advice that reflects the public's perspective on what are often challenging social and moral issues raised by NICE guidance.
>
> NICE 2012

The doctor might have seen reports of compelling evidence that weighs against the NICE guidelines and may follow a process of specification which could result in her not following those guidelines.

5.8.2 Trust doctors

The system of trust is shorter and clearer under particularism. A again trusts his doctor, but here the doctor considers the features of the situation, these will include the NICE guidelines, any

evidence to the contrary and the individual patient's needs. She will make a decision about what course to recommend. The particularist doctor does not rely on an adequate supply of principles to behave ethically.

5.9 Conclusions

In many cases both doctors will reach the same conclusion and make the same recommendation. However we are here concerned to identify the differences between particularism and generalism in medicine.

What then will be the differences between a generalist and a particularist approach?

By extension of Hooker's analysis, the generalist is more likely to follow guidelines; he is not necessarily bound by these guidelines but he will always regard them as being reasons in favour of choosing the recommended course of action. These guidelines can come from a variety of sources (such as medical ethics text books (I have considered the "four principles" interpretation of Beauchamp and Childress as the primary example of these in this chapter), national and local guidelines and professional web sites).

By extension from Dancy, the particularist does not need a supply of guidelines and will regard them holistically in that they might not count in any particular situation. Dancy's position is that the generalist might be expected to behave more consistently but that the particularist will be more likely to behave ethically correctly.

In the next chapter I will look at the differences between these positions with regard to the trust a patient requires in the medical profession.

6 Generalism and Particularism in Practice

"I never trust people's assertions, I always judge of them by their actions." Ann Radcliffe

6.1 Introduction

In much of this chapter I will use trust as an ethical feature of interest for the discussion of the differences between the particularist and the generalist practitioner. In "Moral Particularism: Bad and Wrong" (Hooker 2000 p1-22) Hooker questions how much one can trust a particularist. If being a particularist makes an agent's trustworthiness questionable then this is a significant problem for particularist doctors.

Trust is central in the doctor patient relationship (and, by extension, the relationship of the patient to other professions in modern medicine). There is much talk in current medical practice of the autonomy of the patient backed by informed consent; for a patient to be able to give *informed* consent he must have access to relevant information. Although many sources of information are available in modern society a primary source for patients is their doctor. For instance, a patient can look up alternative forms of treatment on the internet but this will often be based on the diagnosis given to him by his doctor. For patients to give consent they must have trust in the information underlying that consent. Based on my argument (§3.3) that finally trust is an interaction between people, the patient must be able to trust that the doctor has provided sufficient true relevant information for him to make the required decisions.

Again, if a patient consents to any procedure, be it allowing the doctor to listen to his heart with a stethoscope, give him an injection or perform open heart surgery, he is trusting the doctor to have the relevant skills to undertake the procedure competently and with as little risk to the patient as is reasonably practicable.

I will propose that to trust the particularist[46] is to place trust directly in the individual practitioner whereas to trust the generalist is to place trust in the system of guidelines and standard procedures (and thus in the committees of the great and the good who develop and publish those documents). I will then propose that if particularism is correct, then this will have implications for how healthcare professionals are taught medical ethics.

6.2 Trust

At the time of writing there is much discussion of trust in Britain. Politicians, bankers and journalists are all subjects of reports of wrong-doing of one sort or another, following several high profile cases. In 2011 only 17% of those surveyed said they would trust government ministers to tell the truth; at 88% doctors have retained their status as the most trusted professionals in the UK (Ipsos Mori 2011). I will look at the examples introduced in §5.4 to see how a patient's trust is affected by the different approaches of the particularist and the generalist

6.2.1 Risks in Clinical Trials

The clinical trials discussed in §5.4.1 and 5.4.2 are performed on patients suffering from the relevant type of cancer, in early phase trials these patients will have undergone normal "standard of care" treatments before being referred for assessment for suitability for participation in the trial. Many of these patients, then, are especially vulnerable, many will be desperate for the medical profession to find something else to offer them when standard treatments have failed.

Patients and their relatives trust professionals to keep risks at acceptable levels, in the development of new cancer treatments this is done by a system of pre-clinical ("bench-top" and animal) experiments which allow a reasonable estimation of potential effectiveness and potential

[46] The generalist and the particularist are here the idealised generalist who always follows the guidelines, and particularist who always sees the guidelines from the holistic viewpoint.

adverse events. Moving into the clinical phase of trials, Phase I trials involve starting with a dose of the proposed therapeutic agent which is below the level expected to show therapeutic advantage or adverse effect. Phase I trials are generally dose escalation trials where the administered dose is increased until a predefined level of severe adverse events, or a predefined effectiveness, is seen; safe levels for administration and identification of side effects are usually the primary goal of Phase I trials. Phase II trials follow successful Phase I trials and their primary goal is to look for statistically sound evidence of effectiveness.

The trial described in §5.4.2 is a Phase I trial. In this case, at this stage of development of the targeting agent, the aim is to use it for diagnostic imaging, so that the expected outcome is either a level where adverse events are seen or a level where there is sufficient differential uptake of the agent that diagnostic quality images can be obtained.

The research group finally had to choose between two proposed protocols for the trial. Both involved the same dose escalation regime. The first protocol had one imaging time point set at the time expected to be most likely to give diagnostic quality images based on the results of the pre-clinical studies. The second protocol involved five imaging time points to allow for kinetic modelling of the time course of the agent in tumour and normal tissues.

The argument in favour of a single imaging time point is based on putting the patient to as little discomfort as possible and giving them as low as possible a radiation absorbed dose, whilst still getting the minimum information required from the trial: can we achieve acceptable image quality without significant side effects?

The principal argument in favour of the complex trial is that this will be the first systemic use in man of a protein of this type and much valuable scientific information for future uses of such proteins can be gained from the measurements at multiple time points. Justification for the more complex trial was split between two camps. On one hand were those who were concerned to

ensure that sufficient "net benefit" (see discussion of IR(ME)R) §5.4.1) could be seen by the practitioner (the physician who would finally approve the administration of the trial agent to the individual patients) for him or her to agree with the justification for the exposure. The fact that these patients were taking part in a Phase I clinical trial in cancer, and their life expectancy was less than a year, was seen to reduce the weight given to increased radiation exposure, as late effects would not be seen on that time scale. Although no diagnostic or therapeutic benefit to the trial subjects could be expected, the net benefit to society from having data on a new class of proteins for *in vivo* use in man were thought to be considerable, giving a strong positive weight to giving the exposure. IR(ME)R paragraph 6(2)d gave rise to the option for SPECT imaging without CT. This is an older technique which gives qualitative images with considerably poorer quantitative accuracy, but does not involve the extra X-radiation exposure of SPECT/CT. On the other hand a group of those present saw scientific merit in the complex trial but thought the radiation exposure to the patients simply had no bearing due to their clinical condition. Both groups felt the increased time on the imaging couch was relevant and that this should form part of the discussion when patients were invited to join the trial (including a visit to the imaging suite and a chance to test the couch before consenting to the trial).

In the discussion of justification for the complex trial, the first group are taking a largely generalist stance and using a set of guidelines to identify and weigh the relevant features from the feature set which defines this trial. The second group's assertion that increased exposure had no bearing is (in the terms of earlier chapters) a statement that in these patients radiation absorbed dose at these levels does not count in the decision. This group are taking a largely

particularist stance. Although those identified as generalist and those as particularist reached this position by different routes, in the end all agreed to the complex protocol.[47]

A patient considering a place on this trial is trusting that she will not be placed at undue risk by taking part. Under the generalist analysis, this trust is ultimately placed in the developers of the IR(ME)R regulations. These were brought into force in 2000 to implement the European Directive 97/43/Euratom (The Medical Exposures Directive) (EEC 1997) and are overseen by the Care Quality Commission ("the independent regulator of health and adult social care services in England" The Care Quality Commission 2012). All of this represents a large bureaucratic framework but it is difficult to find who actually has the expertise to write guidelines for justifying radiation exposure. In general the patient relies on a committee of "the great and the good" to have developed the guidelines and the local research team to have applied them in her best interests.

Under the particularist analysis, the patient is trusting the collective opinion of the research team.

Looking at the second example case, three questions were raised concerning biopsy. Firstly should every patient be asked to undergo a biopsy when entering the trial? Secondly, if not, how should the biopsy group be chosen? Thirdly, should entry onto the trial for those asked to undergo a biopsy be conditional on agreeing to the biopsy?

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[47] The participants in the discussions described were a mixture of medical doctors, research nurses, research scientists and clinical trial administrators. To the best of my knowledge none of participants (apart from me) has studied the particularist/generalist debate. I have characterised them as particularists and generalists based on the opinions they expressed in the debates. This is similar to the proposal expressed in the quotation from Hare in §2.2 of understanding a man's moral principles from what he does. I have taken the arguments put forward by the participants at face value and have assumed that by saying "A bit of extra X-ray dose really doesn't matter here" the doctor in question is making a particularist statement that this feature does not count, rather than a generalist statement that it is a low risk and should have a low weight in the decision.
These are by no means exhaustive descriptions of possible generalist or particularist positions in the situations and are more akin to the Patty/Gerry characterisations in the Hooker-Dancy debate on promise keeping. I believe they can serve to allow me to discuss the issue of trust for the patient entering the trials.

The first question seemed to provoke more debate between different generalist factions than between generalists and particularists. This debate centred on the cost of the trial. This trial is funded by donations from several small charities and the cost:benefit ratio was taken to have two aspects, one concerned with the benefit in the trial at hand and one concerned with the benefit to scientific progress. The cost per patient without biopsy was significantly less than the cost with, so more patients could be recruited for the same pool of money, thus increasing the statistical strength of the trial while sacrificing wider scientific knowledge. It was agreed that this knowledge would be valuable but that sufficient knowledge could be gained by biopsying around 30% of patients recruited onto the trial. Those of a more particularist disposition simply said it would not matter if the protocol stipulated all patients should undergo biopsy as clinical decisions in individual cases would overrule the protocol and it would be counterproductive to then exclude other data from non-biopsied patients from the main trial analysis.

The second question divided more between those I characterise as generalists and those I characterise as particularist. The generalists were in favour of writing a list of criteria for deciding which patients should be asked to undergo biopsy, these criteria would be used at the MDT meeting when deciding whether to invite a patient to participate in the trial and, if so, whether to ask them to undergo biopsy. The particularists argued for looser wording in the protocol to allow the MDT greater freedom of action, particularly in not asking a patient to undergo biopsy where it was felt it would be against the patient's interest for unforeseen reasons as many patients feel pressured to agree to such optional procedures. Further the particularists wanted to include a clause in the protocol to allow the clinician undertaking the first trial consultation with the patient to overrule the MDT decision if s/he thought it appropriate to do so. The examples given by the particularist group were concerned with patient specific features such as a patient not being asked to undergo biopsy who has spoken with another patient on the trial and is really keen to volunteer for this aspect of the trial; or a patient due to be asked to undergo biopsy who

turns out to be the sole carer for pre-school children; it was argued that an exhaustive list of such factors was not possible.

The third question was quickly decided as all thought it would be unjust to exclude patients on the grounds that they would not consent to biopsy, especially when some patients entered the trial without being asked to undergo biopsy. This being a Phase II trial some patients are expected to benefit from participation.

The difference between the two groups can be characterised as how close to the patient the decision would be made. Under the generalist approach the research group would develop a system based on generalist rules to decide whether or not the patient should be included in the biopsy group; these rules will guide the MDT and thus the doctor discussing the trial with her. The particularist approach is to allow the decision to be made much closer to the patient. The doctor interviewing the patient has to form an opinion based on her understanding of the patient's situation and desires.

6.2.2 Adherence to NICE Guidelines

Nice guidelines can be overridden by generalists who see some other feature in a situation as outweighing the guidelines or by a particularist who thinks that the guidelines operate holistically and in some circumstances do not count as a reason for suggesting or for refraining from suggesting some course of treatment.

When NICE guidelines are followed, the patient is relying on those who wrote the guidelines. NICE maintains an open and transparent way of working: the evidence and those who assess it, are easily findable on their web site (http://www.nice.org.uk). The patient might reasonably ask what NICE is guiding her doctor to do.

> NICE's technology appraisals programme is designed to ensure that people across England and Wales have equal access to new and existing medicines that are deemed clinically and cost effective, reducing the risk of a postcode lottery of care.
>
> NICE 2012

In the IVF case there is conflict between NICE guidelines and local NHS Trust policies. Both particularist and generalist are able to consider the best interests of the individual patient. There seems to be little practical difference between the generalist seeing NICE guidelines and the NHS Trust policy as providing different *pro tanto* guidance, and deciding that the patient's interests (represented be consideration of beneficence) come down on this side or that, and the particularist seeing these three features holistically and making the same decision.

With the generalist clinicians the patient's trust is placed on various people in a structured way. The first node is the clinician who has to decide whether or not to offer a third course of treatment; to do this she is choosing between *pro tanto* guidance to undertake one of two different courses of action. These always count in the generalist scheme, so the patient relies on the guideline writers not only to have written the guidelines but to have presented them so that the clinician discussing options with the patient can weigh them against other *pro tanto* guidance.

The particularist clinician will see the features of the situation holistically and the patient here is trusting the doctor in a much more straightforward way.

As I said in §5.6.6 the mild AD case seems more likely to produce different actions from the two doctors. I think the difference can be illustrated by consideration of when each clinician decides to breach NICE guidelines and prescribe AChEIs. When presented with a mild AD patient the generalist is unlikely to think the *pro tanto* guidance from NICE can be outweighed without strong evidence, such as that provided by the meta-analysis paper (Wilkinson and Deas 2007). The particularist might decide much weaker evidence is sufficient. In the promise breaking example used by Hooker and Dancy, Hooker asks, "If Patty would really live by such beliefs,

how much could you trust her?" (Hooker 2000 p18). For Dancy Patty would only differ from Gerry "in cases where it is certain [she] will do the right thing" (Dancy 2004 p134), so, in this case it is reasonable to ask what the patient is trusting the doctor to do. A patient (or more likely in AD, a relative) might want the doctor always to prescribe AChEIs, but neither clinician can be relied on to do this. In parallel with the Hooker-Dancy exchange, the generalist can be trusted to be more likely to follow the NICE guidelines whereas the particularist is more likely to breach these in favour of the needs of the individual patient. On selfish grounds the patient with AD (or their relative) might prefer the particularist, while the next patient in the waiting room who is waiting for a hip replacement in a cash-strapped NHS might prefer the doctor who is less likely to spend money against NICE advice.

6.2.3 Trust in GP

The Hooker-Dancy exchange raises the question of what we trust doctors to do. The opinion poll referred to in §6.2 asked the interviewees "would you tell me if you generally trust them to tell the truth, or not?", this is not the same as trusting the doctor to act in my best interest when NICE indicate that the morally correct action would be against my self interest.

If the above analysis is correct the patient can expect the generalist doctor to be more likely to adhere to guidelines, which is to say she would see the guidelines always as a reason; the patient would expect the particularist doctor to be more likely to see all features of the situation holistically such that some features might mean the guidelines are no reason.

For the self interested patient in the case of AD it seems that he is more likely to receive the drugs which might help his condition from the particularist doctor. However in the IVF case the self interested patient who would like the maximum number of treatments might be more likely to receive them from the generalist doctor following NICE guidelines than from a particularist

who thinks that the guidelines are no reason after two treatments when there are other calls on available resources.

Less self interested patients want to trust their doctors not only to tell the truth but to do the right thing. It is in the interpretation of "the right thing" that a difference between generalists and particularists becomes apparent. The right thing for the generalist is that which follows the guidelines as closely as possible or which sees the different guidelines as presenting *pro tanto* duties to be weighed when recommending a course of action (or a choice of courses of action) to the patient. The particularist will see these recommendations by the guidelines as based on some features of the situation and may draw the same conclusion as the generalist, but she will view the situation holistically and might see the guidelines as default reasons but in a particular situation she may see them as no reason to recommend a course of action depending on other features.

For the patient to trust the generalist doctor he must trust the chain by which the guidelines are reached. In a particularist world the patient trusts the doctor more directly. He trusts her to see the situation holistically, to understand which features count and which do not. For Hooker the generalist is more consistent but Dancy says the particularist will only differ from the generalist where the generalist would make a moral mistake by following the guidelines. For the patient to trust the particularist doctor he must believe the doctor's understanding of the ethical features is well developed and correct.

6.3 Ethical Development

Medical training includes one or more courses on "Medical Ethics". Nursing degrees generally include an introduction to ethics.[48] Although there is, in general, no explicit training in professional ethics for non-medical clinical scientists,[49] the body which issues certificates of proficiency which allow them to practice includes in its required attainments, "Understanding of the legal and ethical requirements of the modality, and the ethical aspects of scientific research".

6.3.1 Generalist nature

Medical ethics is often taught around the "four principles approach" attributed to Beauchamp and Childress but more explicitly stated by Gillon who

> [hypothesises and argues] that "the four principles of medical ethics" can explain and justify, alone or in combination, all the substantive and universalisable claims of medical ethics and probably of ethics more generally.
>
> Gillon 2003 p307.

The four principles are often described as being like four part harmony, so that each "voice" will dominate in different circumstances, and indeed sometimes producing disharmony when the principles conflict. Gillon prefers a more complex analogy:

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[48] For example the description of the Nursing Degree on Southampton University's web site says "You will be introduced to the key sciences in nursing ..., as well as topics such as assessment, care planning, communication, law and ethics.

[49] I apologise for the confusing terminology; holders of medical degrees are sometimes referred to as "clinicians", "clinically trained" or "medically trained", so that biochemists, pharmacists, physicists etc working within health care are sometimes referred to as "clinical scientists" and sometimes as "non-clinical scientists".

> But I think the four principles should also be thought of as the four moral nucleotides that constitute moral DNA-capable, alone or in combination, of explaining and justifying all the substantive and universalisable moral norms of health care ethics and I suspect of ethics generally!
>
> (original punctuation) Gillon 2003 p308

However, whatever the analogy, the way the approach is presented is as a generalist system, where the problem is to interpret the rules in line with the situation to achieve ethical guidance. As I have discussed, one way in which this interpretation can be achieved is through training in the use and interpretation of guidelines.

6.3.1.1 Guidelines

The GMC publishes guidelines for Good Medical Practice (GMP) and has an interactive web site (GMC 2012c). This web site offers doctors a range of scenarios (20 in total in December 2012, but more are added as they are developed).

One scenario from module 1 concerns a patient who is a student ("Katy") who has taken illegal drugs and is now unable to sleep due to anxiety attacks; the patient asks for diazepam (a tranquiliser) to help her sleep. The web site the offers a set of three possible courses of action, clicking on one of these will navigate to the GMC's opinion of that response, e.g. for "refuse to provide treatment for Katy unless she agrees to settle down and not take any more illegal drugs" the web site says "This would not be in line with GMC guidance" and provides an explanation for why not. The other two possible answers are within GMC guidelines, although one is preferred over the other. A set of references to GMC guideline documents and explanations is given to explain the reason why the answers are classed as they are. This is a three part scenario with Katy returning for further consultation.

Overall this part of the GMC web site contains a training in following GMP guidelines; explanations of why a particular choice of action is advised (or not) are given in terms of GMC guidelines. This is a fully generalist approach to ethical practice.

The GCP guidelines contain fairly lean guidance in the doctor patient relationship such as: "Make the care of your patient your first concern", and "You must make sure that your conduct at all times justifies your patients' trust in you and the public's trust in the profession".

6.3.1.2 Looking Deeper

Some professionals within medicine wish to have a deeper understanding of medical ethics, often they will take a course leading to a diploma or a higher degree; one example of the latter is the MA in Medical Ethics and Law at Keele University. Keele gives an outline of the course content on the university web site, as well as modules dealing with specific medically related ethical issues (e.g autonomy and paternalism). The course has an introduction to ethical theory:

> Introduction to Moral and Legal Concepts:
>
> This module provides an introduction to the concepts and theories used on the course. It explores the distinction between consequentialist and deontological theories of ethics, the relationship between law and morality and the nature of moral and legal rights, as well as providing an introduction to some basic legal concepts, the structure of the English legal system, and the Human Rights Act.
>
> Keele University 2012

This then takes a generalist approach to ethics.

6.3.2 Ethical behaviour in particularist world

If particularism were to be accepted as the underlying model for ethical decision making, doctors would be placed in a more central role of guardian of the ethical value of their own decisions. This is a key practical difference between generalists and particularists which is brought out in

the Patty/Gerry debate. Gerry, being the generalist, is more likely to keep the promise because he subscribes to the general rule "promise keeping is morally good" and he wants to do what is morally good. Patty, being the particularist, sees the situation holistically, she had intended to keep the promise when she made it,[50] but she must make her mind up whether to keep it in this particular case. Patty views the situation holistically and decides what moral value to give to keeping her promise.

[As in Footnote 37 I will then change Gerry's gender and call her "Geri".]

The patient who has Geri as a doctor will be able to trust her to be likely to follow national and local guidelines, to respect his autonomy and to act with beneficence, nonmaleficence and justice.

Patty's patients, however, have (by extending Hooker's argument) no reason to trust her to act in any preordained way. Patty is not, however, some scatterbrain acting on whatever whim catches her attention; she is a professional doctor wanting to act in the best interests of her patients. In many cases she and Geri will act in the same way. To paraphrase Dancy, if Patty is making no mistake in not following NICE's recommendations then morality does not require her to follow them. He goes on to say that Patty and Geri will only differ in cases where it is certain that Patty will do the right thing, and it is not at all so certain that Geri will (as discussed in §5.6.2). This seems a little harsh on Geri if we accept that there can be degrees of good in complex situations. However my concern in this section is to see how Patty can learn to make morally correct decisions. She wants to make correct decisions, although the Bolam criterion is no longer regarded as a final arbiter, I will take it as a sufficient arbiter of which decisions are morally

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[50] There is an obvious difficulty in this statement in that Patty's promise is a more complicated statement than Gerry's. Gerry is saying Xing will have a positive moral valence in the future *qua* having been promised; Patty must know that she regards the promise as breakable and is saying something such as "It seems to me now that the situation in the future will be that the morally correct thing will be to X"; always assuming that she sees moral value in telling the truth when making the statement.

correct for the purpose here; so she might summarise her position by saying she wishes to act "in accordance with a practice accepted as proper by a responsible body of medical [practitioners] skilled in that particular art". This seems close to the idea that the right thing, according to virtue ethics, is that thing which a virtuous agent would typically do in the situation. As I have said (§4.5.1), this thesis is not the place to try to show if a form of virtue ethics could be normative counterpart of the meta-normative theory of particularism, only that the two can be seen to have instructive parallels. Investigation of these parallels will be helpful in seeing how medical ethical training would change for the particularist world.

6.3.2.1 Learning to act ethically

> Virtue ethics is more developed than any other potential normative particularist theory so I will start with learning to act virtuously:[W]hy should a proponent of virtue ethics deny the significance of such mother's-knee rules as "Don't lie", "Keep promises", "Help others"? Although it is a mistake (I have claimed) to define a virtuous agent simply as one disposed to act in accordance with deontologist's rules, it is a very understandable mistake, given the very obvious connection between, for example, the exercise of the virtue of honesty and refraining from lying. Virtue ethicists want to emphasize the fact that, if children are taught to be honest, they must be taught to love and prize the truth, and that *merely* teaching them not to lie will not achieve this end. But they need not deny that, to achieve this end, teaching them not to lie is useful, or even indispensible.
>
> (original emphasis) Hursthouse 1999 p39

In this passage Hursthouse distinguishes between learning rules for proper behaviour and learning to be someone who behaves properly. This chimes with particularism because particularists argue that a final closed set of moral rules is not possible and such a set is not required for moral action, so learning to behave morally is more than merely than learning a set of rules.

The development of a moral character is a process which starts at the mother's knee but continues throughout life. In the particularist world agents must distinguish between situations where a rule ("Do not lie", "Give blood to a patient who will otherwise die") counts and one where it does not ("A stole the book from B", "The patient is a Jehovah's witness"). This distinguishing between situations is itself holistic and other features of the situation might further change the moral value of the proposed action (returning the book, setting up a blood transfusion). An increasing supply of ever thicker rules will not provide a definitive moral decision algorithm.

Teaching medical ethics to trainee professionals would be less about learning to apply the four principles and more about understanding the interaction between features of situations. The aim would be to equip those potential professionals with the moral grounding so that they could make decisions, rather than search for further guidance, in complex situations. In the current GMC Good Medical Practice in Action interactive web site (see above) the student can see several scenarios and choose one of three potential actions; if she chooses "wrongly" she is told (e.g.) "This would not be in line with GMC guidance. Doctors must not [X]". Although there might be more room for discussion in a classroom situation, this approach is one of learning the rules rather than learning to be a doctor who behaves properly. In the particularist world, there must be room for more explanation of why most of the profession think that Xing would be wrong.

Dancy's statement that particularist morality is in perfectly good shape is not to say that any action I decide to undertake is right because I have decided to undertake it. The student's deciding to X in the above scenario does not make Xing right, but simply telling the student she is wrong does not give her sufficient moral understanding to choose an action properly in similar situations. It is reasonable to suppose that those wishing to enter medicine or a related field already have some mother's knee understanding of morality; particularist medical ethics would

require a process of understanding the doctor-patient relationship by building on that framework.

6.3.2.2 Continuing professional ethical development

When moving into practice the doctor will inevitably start to meet more difficult situations than those envisaged in her training. Particularism indicates that there can be no look up table detailing which acts have positive moral value and which negative. Continuing training would require provision of advice and review of decisions.

When seeking advice the doctor might again look to virtue ethics and find that the right action is to do what a virtuous agent would typically do in the situation and if we do not know what a virtuous agent would typically do as Hursthouse suggests by finding a virtuous agent and asking him. At first sight this does not seem particularly helpful, but in the context of a newly qualified doctor entering into practice such an agent could be provided by supplying a mentor who is more senior in the practice. In a particularist NHS mentors might be appointed to cover several General Practices.

Returning to the question of who the patient is relying on to ensure the morality of their doctor, we see that the doctor is making her own decisions but is doing so under the influence of the teachers and her mentor. Such a mentor would have the dual role of guiding the doctor and reassuring the patient that there is some oversight of his care.

6.3.2.3 Guidelines in particularist medical ethics

Doctors need to be able to carry out their work without needing to have an academic interest in moral philosophy. In the generalist world systems to offer action guidance carry, embedded within them, thick ethical principles giving *pro tanto* duties for practicing professionals. One of the duties is the duty to keep their ethical training, part of the current standard of practice, up to

date. In the particularist world the concept of *pro tanto* duty does not play a role in ethical decision making. However it would be too demanding that doctors consider every aspect of every case before recommending a course of treatment. A patient with an infected finger requires antibiotics, if there are no medical reasons for not prescribing them it would be odd to think that the doctor should spend time and effort considering whether it is ethical to prescribe them. Whilst there may be many features involved in the ethical valence of the decision ({"that the patient is in pain", "that antibiotics will combat the cause of the pain"...}) it might not take the particularist doctor long to decide that these features do, in fact, act in this case in the same way they acted in the case she saw yesterday of an infected toe. There is a temptation for her to start to make a generalisation that it is ethically right to give antibiotics to patients with infected extremities. This sort of generalisation holds no problems for particularism; Dancy accepts defeasible generalisations such as "In standard conditions, red ties look red" and "*Ceteris paribus*, lying is wrong-making" as reasons that "arrive switched on" (Dancy 2004 pp111-117). Such default reasons remain within the holism of reasons and can be switched off by any other reason in the right situation. Dancy attributes the idea of features which have "for the most part" ethical valences to (then unpublished) work by Lance and Little. In the particularist world, then, the guidelines I have argued are *pro tanto* duties with a fixed valence in generalist worlds, become holistic *ceteris paribus* (or default) reasons in particularist worlds. The emphasis for CPD for medical professionals in under particularism is concerned with understanding new or updated guidance in such a way that they can recognise situations where all other things are not the same.

6.4 Conclusions

The current structure of medical ethics is largely generalist in nature; this is hardly surprising as most of the development of medical ethics was done at a time when normative ethics was conducted as a debate between deontologists and consequentialists. This has led to deontological

systems of guidance and consequentialist view of resource allocation in the resource limited NHS (NICE). In a particularist world medical ethics training (including CPD) would be focussed on the development of trustworthy doctors.

7 Conclusion

"Life is the art of drawing sufficient conclusions from insufficient premises." Samuel Butler

The hypothesis for this thesis was stated in §1.8

> ***Particularism implies that normative ethics is not necessary for ethical decision making.***
>
> ***Particularists think that the accepted link between normative theory and ethical action is incorrect and should be abandoned.***
>
> ***Current guidance in medical ethics is based on normative theories.***
>
> ***If particularists are correct, a new understanding of the basis for medical ethics is needed***.

To investigate this hypothesis I have looked at the basis for particularism, particularly as described by Dancy in "Ethics Without Principles" (Dancy 2004). To paraphrase Dancy, particularism is a result of the notion that the features of situations which give rise to action do not have a fixed valence; sometimes the feature that there will be a lot of people there is a reason to go there, sometimes it is a reason to stay away. Features change their valence depending on other features of a particular situation; whether I want to party or study. Moral particularism argues that there is nothing special about moral reasons that would mean the features which give rise to moral judgement behave in a way different from non moral reasons. That it is a lie is sometimes a reason to refrain from saying it and sometimes a reason to say it. Dancy introduces the term "holism" for the proposition that all reasons are capable of changing their valence depending of the particular situation. Holism of reasons and particularism oppose the accepted generalism of most of Twentieth Century normative ethics which Feiser describes as a "search for an ideal litmus test of morally proper behaviour" (Fieser 2000, p138). Dancy says he is

especially concerned to oppose Rossian deontology which sees moral reasons as *pro tanto* duties which always act in with the same moral valence.

The theme of this thesis is firmly in the field of practical and professional ethics. Generalism and particularism are meta-normativetheories, to try to understand how they can have an effect on action guidance in the real world I have extended the notion of thick and thin concepts to cover moral principles. I have taken a principle to be a statement such as "When the following features obtain $\{f^1 \ldots f^n\}$, Xing is the right action". Thickness here is not a binary divide but a continuum from a fully thin principle of "always do that which, all things considered, is the best thing to do" in which the feature set is empty and the principle applies in all situations in all possible worlds, to a principle where the feature set is a full description of all features of the world in which Xing is right. Neither of these extremes is capable of providing meaningful action guidance in practical and professional ethics. Action guidance from generalist normative theories is possible when the feature set is sufficiently full {Xing will cause pleasure, the pleasure caused is not sadistic}.

In more complex situation many morally relevant features may be present and the feature set will be correspondingly large, so that a statement of the principle which guides the agent to X will be correspondingly thick. In generalist ethics a feature which is morally relevant in one situation will always be morally relevant in another situation in which it appears and will always act in the same moral direction. Causing pleasure will always have a positive valence, being sadistic will always have a negative valence. Where many features are present it is necessary to balance the *pro tanto* duties for and against Xing to see if Xing is right. For the particularist, features which have a moral valence in one situation need not have the same (or any) moral valence in another. Particularists also see the complexity of situations, they do not deny that in real situations moral reasons might oppose each other and some balancing might be part of the action guidance, they

do deny that the fact that a feature was a reason in favour of Xing in one situation means that it will be a reason in favour of Xing in another where it occurs.

Current medical ethics is based on generalist normative theory. I have argued that for this to be action guiding in complex situations it must be sufficiently thick, this thickness is often embedded in guidance documents ranging from text books on medical ethics to DoH publications and NICE recommendations. These documents form part of the normative ethical framework which guides medical professionals. Some of these documents deal explicitly with ethical issues (such as the DoH Guidance on Consent), while others have recommendations which contain implicit ethical features (such as the IR(ME)R regulations).

I have taken trust to be a main feature of the doctor-patient relationship and thus of medical ethics. There is a perceived crisis in trust in the UK in the early Twenty First Century and the development of trustworthy systems is widely regarded as a prerequisite for the reestablishment of trust in politicians, media personnel, bankers, doctors and so on. Regulated open systems aimed at ensuring trustworthiness are to be introduced for banking and the newspapers at the time of writing.

Medicine is ahead of this game and many guidance systems already in place contain the necessary ingredients for trustworthiness (for example, if my doctor follows the DoH guidance on consent, my autonomy will be protected). In this generalist system doctors are given basic training in the underlying theory, often in the form of the "four principles", and application through GMC and DoH guidance documents. Continuing education (such as CPD) is the key to maintaining trustworthiness as the guidance evolves in the evolving health service.

To consider how this would work in a particularist system I have looked at the differences in the decisions made by particularist and generalist doctors and the implications this would have on the doctor patient relationship, in particular on the trust relationship. I have extended the

Hooker/Dancy (Patty and Gerry) example to consider when the generalist and the particularist would be prepared to break NICE guidelines on prescribing. In parallel with Hooker's claim it is reasonable to think the particularist is more willing to prescribe against NICE's recommendations as she does not see them as carrying a *pro tanto* duty. In this situation the doctor is making the ethical decision directly; having read NICE's document she sees it as not counting in this case. Rather than relying on a framework of trustworthiness, a patient will be trusting the doctor directly. I have cited two cases from my experience in early phase clinical trials to see how decisions are made by those I classify as particularist and those I classify as generalist.

The doctor in the particularist world sees each situation, each interaction with a patient, holistically. The advice from the four principles, the GMC or DoH etc do not represent *pro tanto* duties for her; they may be default *ceteris paribus* reasons for particular courses of action, they will often be things she should consider when reflecting of what course of action to take, but in some situations she might decide they do not count.

In both the particularist and the generalist world the ethical practice of medicine requires some understanding of the special relationship between doctor and patient and between the medical and associated professions and society. Training for professionals in medical ethics should equip individuals with the tools required to practice their profession. The emphasis in a particularist world would be on developing the moral character of these professionals so that they do not make moral mistakes when they believe a feature of a situation means that guidance such as, "for the most part it is not justified to give a patient an absorbed dose of X-radiation unless it will benefit that patient" does not count when writing a protocol for a clinical trial.

I have suggested that this would mean a fundamental change in the way medical ethics is taught. The generalist reliance on principles and adherence to guidelines would be weakened and a new

emphasis on the career long development of moral character and understanding would be introduced.

The hypothesis is then at least partially true; if particularism is correct then a change in emphasis in medical ethical training would be required, as would a new emphasis on the development of moral character. However codes of practice and guidelines would still be necessary to help professionals deal with the complexity of modern scientific medicine; the role of these codes would no longer give *pro tanto* duty, but rather put the emphasis on default *ceteris paribus* advice.

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