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EUROPEAN VALUES IN BIOETHICS:
WHY, WHAT, AND HOW TO BE USED?

ABSTRACT. Are there distinctly European values in bioethics, and if there are, what are they? Some Continental philosophers have argued that the principles of *dignity*, *precaution*, and *solidarity* reflect the European ethos better than the liberal concepts of autonomy, harm, and justice. These principles, so the argument goes, elevate prudence over hedonism, communality over individualism, and moral sense over pragmatism. Contrary to what their proponents often believe, however, dignity, precaution, and solidarity can be interpreted in many ways, and it is not clear which reading would, or should, be favored by popular opinion. It is therefore dangerous to think that any one understanding of “European”, or any other, values could be legitimately imposed on those who have different ideas about morality in health care and related fields. Bioethical principles should be employed to promote discussion, not to suppress it.

KEY WORDS: dignity, ethics, European values, morality, precaution, principles, solidarity

WHY ARE THEY NEEDED?

Many people in Europe, and particularly in Continental Europe, believe that the values of the Old World are under attack. In bioethics, the four Georgetown principles are often identified as the invader, and most American attempts to deal with moral issues are viewed with suspicion.¹ European policies, it is argued, should be based on European values, which are more reflective, communal, and ethical than the pragmatic codes imported from the United States.

Europe under Siege?

The assumption that Europe is under siege by American values in bioethics provides the starting point of this paper. This assumption is in many ways mistaken and misleading, but there may still be some truth in it.

The model usually targeted in critical comments is the approach introduced by Tom Beauchamp and James Childress, who worked at Georgetown University when they launched the principles of *autonomy*, *nonmaleficence*, *beneficence*, and *justice*.² They asserted that these principles can be employed to tackle all issues arising in medicine, health care, and the biosciences. They also argued that this set of principles can be



founded both on the duty-based moral philosophy of Immanuel Kant, and on the outcome-based ethics of Jeremy Bentham and John Stuart Mill.³

The fear that American values suppress their European counterparts if this model is accepted is obviously misplaced. The values incorporated in the four principles, and the theories on which they can, according to Beauchamp and Childress's initial views, be based, originate from Germany and England, and can therefore hardly be seen to impose an external threat to indigenous European moral thinking. And although the authors have, later on, replaced ethical theories with common morality as the proper framework for their principles, they can hardly be said to have abandoned the Western roots of their model.

Another point worth making is that the Georgetown model has been both criticized and hailed by Americans and Europeans alike.⁴ There is no united New World front attacking the Old World ways, and there is no united Old World front to face the alleged attack.

But there may, nonetheless, be a sense in which the threat cannot be dismissed as entirely imaginary.

What is Wrong with the Georgetown Model?

The "Georgetown mantra", as the four principles are sometimes jointly called, forms the basis of ethics education in many American medical schools. It has also been advocated in England, most prominently by Raanan Gillon; and Tom Beauchamp has recently suggested that the approach could be employed in global, multicultural bioethics education.⁵

The critics of the model have pointed out several potential flaws in the principles themselves and in their application to real life.⁶ Some of their concerns have included that the four concepts have *too little content* (that they can mean anything, depending on the person using them); that they have *too much content* (that people using them are forced to buy into an exclusively American system of values); that there are *too many* principles (that, for instance, nonmaleficence and beneficence should be fused together as a principle of utility); and that there are *too few* of them (that, for instance, the virtues of care, friendliness and charity, crucially important in good health care provision, are not addressed of all, or at least they are not included in the list).

Some of these criticisms can be mutually contradictory, and not all of them are necessarily sound. But at least the last concern, about the missing virtues, can point to a genuine theoretical deficiency in the four-principles approach.

Which Characteristics Should European Values Not Have?

When Beauchamp and Childress devised their model in the late 1970s, it was customary to think, at least in the English-speaking academic world, that the “deontological” and “consequentialist” moral views championed by Kant, Bentham, and Mill were the only viable options in normative ethics.⁷ This is why the authors of the *Principles of Biomedical Ethics* could claim a fair degree of universality for a set of principles which could be justified by appeals to outcomes as well as to duties.

Beauchamp and Childress may have done well in combining the two doctrines they had in mind, but there is a third alternative they missed altogether, namely virtue ethics, which started to (re)emerge in the 1980s and became instantly popular in Continental Europe.⁸ This “teleological” approach has its roots in the ethical teaching of Aristotle, and the work of Thomas Aquinas introduced it, in the thirteenth century, into Roman Catholic moral philosophy and theology.⁹

I believe that this oversight is the main reason for the Georgetown model’s poor reception in Continental Europe. By ignoring moral (and religious) virtues, and thereby all deliberations about the ideal nature of a good, virtuous human being, Beauchamp and Childress left their views wide open to accusations of *short-sighted hedonism* (the view that people’s happiness here and now is a primary moral concern); *excessive individualism* (the doctrine that people are always more important than the values prevailing in their communities); and *sneaking nihilism* (the view that all our inherited values may be wrong). These are all formidable charges in a culture where many people believe that only a life of self-denial in the name of shared values can secure an afterlife of everlasting joy and bliss.

WHAT ARE THEY?

During the latter half of the 1990s, several attempts were made to identify values which would be more widely recognized in Europe than the Georgetown principles of autonomy, nonmaleficence, beneficence, and justice. In all these attempts, much emphasis was put on prudence, communality, and the intrinsic morality of human actions.

Competing Suggestions

In a collaborative research project funded between 1995–1998 by the European Commission, Peter Kemp and 21 other partners from different European countries examined the values which could serve as a basis for

ethical decision making on the Continent. In their final meeting, 16 participants issued a document entitled the *Barcelona Declaration*, where they identified four fundamental principles, namely those of *autonomy*, *dignity*, *integrity*, and *vulnerability*.¹⁰

In the group's work, the concept of *dignity* was given a paramount role. The gist of the argument was that autonomy, although important, cannot be all there is to bioethics and biolaw, because some human beings cannot be regarded as autonomous on any reasonable account. These beings include, most significantly, embryos, fetuses, infants, the comatose, and the senile. When it comes to their protection, so the argument goes, respect for dignity, complemented and qualified with the notions of integrity and vulnerability, is a better tool.

Another visible concept in European discussions on bioethics has been *precaution*. The "precautionary principle" was first introduced in the controversy over climate change, but it has also been invoked in debates concerning genetic engineering and health-care provision. It is designed, so its supporters say, to encapsulate the idea that scientific risk management is not always enough in cases where irreversible harm could ensue from human activities, especially from the development and implementation of new technologies. We should not act in ways which could be harmful in the future, even if we cannot accurately predict what the harm would be and on whom it would be inflicted.¹¹

A notion that is believed to provide a remedy to the over-emphasis of individualism in contemporary social ethics is *solidarity*. A sense of togetherness, many authors suggest, would offer a firmer basis to practices and regulations in health care and related fields than the contract-based model of justice favored by many American philosophers. Two European journals of ethics have recently dedicated special issues to the concept of solidarity, which has also been frequently used in political discussions.¹²

Dignity, precaution, and solidarity can, I believe, offer an alternative to the Georgetown principles. But what exactly do these words mean, and how can they be employed in ethical arguments? Let me examine the three concepts one by one.

The Many Faces of Dignity

The champions of "European values" often seem to think that there is only one notion of dignity, and that appeals to this notion provide, without further argument, sufficient grounds for banning activities like abortion, euthanasia, assisted reproduction, and research on human stem cells. But this is not self-evidently the case. There are at least five mutually

conflicting interpretations for the concept of dignity, or *human dignity*, and they can all yield different answers to difficult bioethical questions.¹³

First, the Kantian reading says that dignity is based on *rationality*. Kant's own authoritative words in 1797 on this were:

[Man] as a person, i.e., as the subject of a morally-practical reason, is exalted above all price. For as such a one (*homo noumenon*) he is not to be valued merely as a means to the ends of other people, or even to his own ends, but is to be prized as an end in himself. This is to say, he possesses a dignity (an absolute inner worth) whereby he exacts the respect of all other rational beings in the world, . . . and can esteem himself on a footing of equality with them.¹⁴

Kant's original German word, translated here as "dignity", is *Würde*, which means "worth" or "value". But he also used, from time to time, the Latin term "dignitas" in brackets to explain what he meant by this, so the conceptual connection with dignity is justified.

The second interpretation links dignity with the *sanctity-of-life* doctrine prevalent in Christian theology, especially Roman Catholic thinking. Pope Leo XIII expressed the idea in an encyclical letter in 1891 like this:

[All] men are equal: there is no difference between rich and poor, master and servant, ruler and ruled, for the same is Lord over all [Rom x, 12]. No man may with impunity outrage that human dignity which God Himself treats with great reverence, nor stand in the way of that higher life which is the preparation of the eternal life of heaven. Nay, more: no man has in this matter power over himself . . .; for it is not man's own rights which are here in question, but the rights of God, the most sacred and inviolable of rights.¹⁵

It has been argued that the references made to human dignity in the United Nations Declaration on Human Rights are historically based on the Catholic teaching.¹⁶

The third interpretation is quite recent, and it makes a connection between *genes* and dignity. This is expressed in UNESCO's 1997 Universal Declaration on the Human Genome and Human Rights, which states:

The human genome underlies the fundamental unity of all members of the human family, as well as the recognition of their inherent dignity and diversity. In a symbolic sense, it is the heritage of humanity. . . . Everyone has a right to respect to their dignity and for their rights regardless of their genetic characteristics. . . . That dignity makes it imperative not to reduce individuals to their genetic characteristics and to respect their uniqueness and diversity. . . . Practices which are contrary to human dignity, such as reproductive cloning of human beings, shall not be permitted.¹⁷

This declaration has received considerable attention since its publication, and its ban on human cloning has been especially heatedly debated.¹⁸

When ethicists in Continental Europe make appeals to dignity, they usually make two assumptions. They believe that the rational, religious, and genetic readings exhaust the uses of the word in ethical debates. And

they think that the philosophical, theological, and biological interpretations assign dignity to the same group of living beings.

The first assumption is false, because nothing prevents people from different schools of thought, and from other cultures, from employing the term. Proponents of utilitarianism, for instance, can argue that prohibitions of voluntary euthanasia deny people the right to die with dignity. According to them, unnecessary suffering should always be avoided, but this moral norm is violated by keeping people alive against their considered wishes. As for more traditional cultures, dignity has often been regarded as an extraordinary quality, possessed only by individuals of specific importance. Seen from this fifth viewpoint, the insistence on equal dignity, shared by the first four readings, can seem immoral and absurd. It is, of course, possible that some usages of the term are more legitimate than others, but, pending further analysis, the notion remains contested.

The second assumption made by European advocates of dignity is false, because all five readings of the concept assign dignity to slightly different groups of living beings. In the Kantian model, dignity belongs to rational agents. In the Catholic doctrine, all human beings created by God, including the unborn and the irrational, are embraced. The genetic reading should, logically speaking, expand the sphere of dignity to artificially produced human beings, whether or not they are seen as an original part of God's creation. Most utilitarians exclude the unborn and the irreversibly comatose, because these human beings cannot suffer, and some of them include other sentient beings, because they, in turn, do have this ability. And people from other cultures have entertained a variety of ideas concerning the worthiness of human and nonhuman beings.

Precaution vs. Assessment of Harm

The principle of precaution, or the precautionary principle, is best known in the context of climate change, and the protection of our natural environment. Formulations of it can be found in many related treaties and declarations.¹⁹ According to one commentator, the principle.

embodies the idea that public and private interests should act to prevent harm. Furthermore, the precautionary principle suggests that action should be taken to limit, regulate, or prevent potentially dangerous undertakings even in the absence of absolute scientific proof.²⁰

Or, as another commentator has put it:

[The Precautionary Principle] is designed to address the existence of scientific uncertainty in areas where our failure to anticipate . . . future harm may lead to disaster. The principle says that in these cases we have to be prepared to act [in a cautious manner] even though our fears of disaster may turn out to be unfounded in the long run. The Precautionary

Principle appeals to our sense of controlling risks, and it assigns responsibility to present generations to think about the consequences of their action for future generations.²¹

As the principle of precaution has gained popularity in environmental ethics and policy, it has also found its way into European discussions concerning medicine and health care. The first indication of this was an appeal to precaution in two European Council directives on genetically modified organisms in 1990. Since then, issues like blood banking and human genetics have also been addressed in similar terms.²²

The proponents of the principle argue, in the quoted passages, that its aim is to prevent harm, to limit potentially dangerous undertakings, to anticipate future harm, to control risks, to manage responsibly the world's resources, and to be accountable for the consequences of our actions for future generations. These goals could easily be shared by liberal and utilitarian ethicists. But since the point of precaution, as a specifically European principle at least, is to provide an alternative to the ideals underlying the Georgetown model, a distinction should be made between cautiousness in the sense intended here, and the straightforward assessment of risks of harm.

Risk can be defined as the possibility or probability of harm or damage.²³ But ethically relevant harm and damage can be defined in many ways, and attitudes towards the acceptable level of probability can vary considerably. In one corner of the conceptual map only clearly predictable concrete injuries to people or property are seen as serious risks. More cautious views also take into account the indirect and uncertain effects of our choices, psychological and social as well as physical harm, and prevailing attitudes concerning what is good and what is bad. At the other end of the continuum, theorists have argued that when our actions could conceivably have catastrophic consequences, the evaluation of probabilities is superfluous. We should simply refrain from activities which could have extremely bad outcomes.²⁴ Alternatively, it can be held that damages and violations which seem merely symbolic and immaterial can, in fact, inconspicuously pave the way to unspeakable disasters.²⁵ We should not "play God" or test the limits of what is "natural" in fear that we could meet with divine or cosmic punishment.²⁶

What is the location of precaution on this conceptual map? There are four main options. The first is to identify cautiousness with common prudence, and to note, for instance, that we cannot always rely on risk analyses prepared by parties with vested interests. The second possibility is to resort to the theory of games and decisions, and to argue that the strategy called "maximin" approximates reasonably well the precautionary principle. According to this strategy, we ought to choose the action or policy

that guarantees, as far as we can tell, the best outcome in the worst scenario we can think of.²⁷ The third option is to assert that uncertainty as such can be used as an argument against technological development, and for protective regulations. If the unforeseen consequences of our actions could be disastrous, precaution dictates that we should not undertake them.²⁸ The fourth alternative is to say that it is not wise to challenge or endanger prevailing moral views, because they provide the cement of social life and human interaction.²⁹

The popular appeal of the precautionary principle is based on the ideas of common prudence and maximin decision making. The actual policy recommendations made by the proponents of the principle are, however, based on the more controversial interpretations. In environmental matters, the argument from unforeseen outcomes is regularly evoked, and in health care, the protection of moral values seems to be more important than the avoidance of more concrete harm on individuals.³⁰ This can be problematic, as everything we do *could* have disastrous consequences, and agreement on the values which *should* be safeguarded by precaution is not easy to come by.

One possibility is to argue that the concept of precaution simply shows the limitations of rational decision making. Since we cannot predict all the outcomes of our actions, nor agree on the most important moral values, we should not pretend that we have scientific grounds for our ethical and political choices. The practical strength of this line of argument depends, however, on the alternatives that can be given to the assessment of risks of harm.

Solidarity vs. Justice

Solidarity is often portrayed as the European counterpart of justice.³¹ It is related to, but should not be confused with, the liberal and utilitarian accounts of fairness and equality. Liberals usually emphasize the protection of the rights of individuals, and utilitarians focus on the equal consideration of, and equal respect for, the needs and interests of individuals.³² In both models, the state is seen as a primary force behind the coercive organization of social life. Solidarity, in contrast, is in European debates linked with communities rather than official state functions, voluntary rather than enforced activities, spontaneous rather than organized events, and reciprocal rather than contractual exchanges.³³

Solidarity in its non-liberal and non-utilitarian meaning was introduced to ethics by Christian thinkers, who in the early twentieth century invented the doctrines of “solidarism” and “personalism”. According to these, individuals and societies cannot, or should not, be distinguished too

sharply, since they are fundamentally thrown on to each other. Instead, the interconnectedness of people should be taken as the cornerstone of ethics.³⁴

“Solidarism” and “personalism” are both Christian doctrines, but it has been argued that religion is not a necessary part of understanding the true nature of solidarity. All that is needed is the conviction, shared by the followers of Aristotle, Hegel and Marx (but not Kantians or utilitarians), that individuals are “embedded in social contexts”. From “the fundamental social embeddedness of individuals” it can, according to two contemporary writers, be deduced, for instance, that the European welfare state is “the incarnation of solidarity as a pre-rational fundamental value”.³⁵

An important distinction can be made between the *universality* of justice and the *local scope* of solidarity. This raises a question regarding the distribution and redistribution of goods in and across societies. How far should solidarity extend in matters concerning material welfare? Should we see ourselves as “thrown on to” only our compatriots, or are we also interrelated with people in the developing countries, in which case we should also think about them in our health-care decision making?

Proponents of solidarity have responded to questions like this by saying that ethical concepts do not always need to be universally defined. The liberal notion of justice, they argue, is impersonal, cold and calculating, because it is supposed to be the same everywhere. A better, more caring, way to deal with the variety of the human condition, they say, is to let ethical concepts “breathe”, to let them find their own expressions in the interaction between people in their shared “lifeworlds”. A lifeworld (from the German word *Lebenswelt*)³⁶ is not the physical environment in which we coexist with inanimate objects, plants, and animals, but a social realm where we live in shared embeddedness with other human beings who belong to the same culture. Solidarity makes justice, or fairness, dependent on the values shared in *our* lifeworld and *our* society.³⁷

A word of qualification is required at this point. Although I believe that the foregoing description captures an important sense of the notion of solidarity, it is by no means the only possible interpretation. Solidarity is a rich concept, and its contents cannot be exhausted by any one analysis of its historical background and implications. Many other equally legitimate readings can be found in contemporary ethical and political discussions.³⁸

Prudence, Communalism, and a Deep Sense of Values?

The examination of the principles of dignity, precaution, and solidarity seems to show, above all, that more conceptual work needs to be done before we can hope to find an unambiguous set of European values for bioethical

decision making. Closer scrutiny reveals that all three notions have several meanings, and that the choice of these meanings, rather than the choice of the notions themselves, decides the normative implications of one's views. In practical terms, this means that bioethical disputes cannot be settled merely by using buzz words. Sentences like "euthanasia violates dignity" and "euthanasia enhances dignity" are neither true nor false, unless we know what "dignity" means in them.

If we take seriously the idea that European values should be as far removed from *hedonism*, *individualism*, and *nihilism* as possible, the actual ideals we are after might simply be *prudence*, *communality*, and *a deep sense of values*. It is possible that a level-headed combination of these could offer the alternative to the Georgetown principles European ethicists are so determined to find. But here, too, a lot of work is required in the future.

HOW SHOULD THEY BE USED?

Those who believe that a distinctly European set of principles or values exists can hold a variety of views concerning their application in bioethics. One possibility is to argue that, for instance, dignity, precaution, and solidarity should form the basis of national and international regulations within the European Union. Another alternative is to state that these principles, rather than the Georgetown model, ought to be assumed in bioethics education and legislation everywhere in the Western world. And yet another option is to claim that prudence, communality and sensitivity to truly moral concerns, as defined by European ethicists, would offer a firm foundation to global bioethics as a whole.

All these suggestions are, I believe, potentially dangerous. Europe does have a history of dictating what is right and what is wrong to the rest of the world, and the results have not always been encouraging. It would not be a good idea to attempt to colonize (again) the world with European sensitivities, or all European countries with a subset of European sensitivities.

If, however, notions like dignity, precaution, and solidarity could be used to promote discussion on significant aspects of bioethical issues, they should be so used. The Georgetown principles do not hold the monopoly of truth in health-care ethics, and neither do other liberal or utilitarian attempts to conceptualize the realm of morality. Debates concerning the content of prudence, communality, and sensitivity, and their proper role in ethical decision making, could contribute considerably to our understanding of the normative issues surrounding medicine and health care.

Seen from this angle, the “European” or “non-European” nature of the rival values, concepts, and principles becomes irrelevant. It does not really matter where they came from, if they can be used to promote sensible bioethical discussion.

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