ETHICS EXPLAINED TO OUR CHILDREN[1]
Plea for an experimental ethics

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"Human kind in the twenty-first century needs to ask itself an unprecedented question: what are we going to do with ourselves. The Universal Declaration of Human Rights categorically states the 'right to life' is humanity's most fundamental value. Since death clearly violates this right, death is a crime against humanity, and we ought to wage total war against it."

Yuval Noah Harari, Homo Deus, p. 2, 21

"As soon as a man does an action because *he thinks he will promote his own interests thereby, he is not acting from a sense of its rightness but from self-interest."*

W.D. Ross, The Right and the Good

Ethics is a way of acting in the world. Ethics is big and small at the same time. Ethics is how to be a good practitioner. Ethics is about how to take care of our compatriots, family, children – yes, every creature in our cosmos now and in the future. Ethics is on being a servant of justice. The Greek word *ethos* means character, habit and convention. It reflects these personal and cultural dimensions ethics. "Act in such a way that the consequences of your action are compatible with the sustainability of real human life on earth", echoes the German philosopher Hans Jonas in *Das Prinzip Verantwortung* (36). It is about doing justice to others, but also about a just society, or even a just world. If you endeavour to act ethically in the world, you use a certain language. You rely on a body of knowledge, which has been tinkered with for 2500 years. A body of knowledge that is work in progress which is permanently under construction. Ethics, like justice, is never finished.
There are two ways navigating your way in the world. You can fly like an eagle, free-floating high in the sky, overseeing the meadows and the cities, making infallible choices through your all-seeing, keen eye. Or you can steal like a cat, wandering through meadows and alleys, finding your way by making sensible, but uncertain choices depending on what you hear, never being sure what's around the corner. The eagle and the cat. The eye and the ear. The grown-up and the child. The philosopher and the pupil. The pure highlands, the muddy lowlands (Schön 1983). It is the same in ethics. Moral questions can be viewed from the sovereign point of view of the contemplative ethicist, or by listening to the muddling fellow human being, groping her way through a moral arena. We prefer the second way but won't forget the first. Without a clarifying overview – an *idea clara et distincta* – ethics is blind; without struggling in a demanding practice, ethics is deaf. Our sympathy is with the struggling nurse or doctor, police officer or soldier, father or mother. The value of the moral point of view must prove itself in practice. Only in confrontation with the predicaments of practice we can answer the eternal question of Immanuel Kant: "*What should I do?*".
Where to start our exploration of the landscape of ethics? Our point of departure is biomedical ethics. Why? More than twenty years ago, Stephen Toulmin noted that medicine has saved ethics from a comatose existence. "During the last 20 years, medicine has" saved the life of ethics ". It has given back to ethics, a

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seriousness and human relevance which it had seemed… to have lost for good." (Toulmin 1982) Medicine has brought ethics back to the path of everyday life. It brought together the fundamental reflection of the academically trained ethicist and moral judgment in daily practice. This article is devoted to this fertile tension. It is not only about an instructional friction (Kunneman) that is inspiring for academic ethics, but also about the question of how casuistic moral research in consultation rooms, offices and shopfloors are a source of genuine moral knowledge. Moral knowledge, which is not only useful professionally, but can also offer moral guidance in our personal lives and public institutions.
We start with a moral impasse at an Intensive Care Unit (1). We unpack this case to answer two questions: 'what is a moral point of view', and 'what is ethics' (2, 3, 4) and present two modern classics of normative ethics: ethics of consequence and ethics of obligation. These two 'classical moderns' help us to answer this Kantian question, 'What should I do?' (5) We then outline some promising insights that biomedical ethics has provided over the last forty years. (6) In that we rely on a book by Tom L. Beauchamp and James F. Childress, *Principles of biomedical ethics*, which for decades has been an important point of reference in the discussion on biomedical ethics. The strength of Beauchamp and Childress is that they are building a bridge between academic ethics and ethics in the professional practice in the hospital. In a next step we show that there has been a casuistic turn in ethics since the 1980's. Bedside-ethics became the crossroad of tough practical decisions in health care and moral reflection and deliberation. (7, 8) We conclude with a plea for an experimental ethics. (9) An approach to ethics that offers us and our children direction and consolation in unprecedented questions that *homo sapiens* faces today, and in the future-to-come.

1. Mister Johnson

> *A patient, we call him Mr Johnson, has been in an Intensive Care Unit for quite some time. Unusually long. He was brought in with "a hole in his stomach." The prognosis was is that things could go both ways with Mr. Johnson. If the therapy works and the patient recovers, Mr. Johnson will be back in the nursing ward by seven days. If the therapy fails, the patient dies. In both cases, the stay in intensive care is of limited duration. Not so with Mr Johnson. The treatment did not work, but Mr Johnson did not die either. Mr Johnson did not want to die. As long as he stayed in intensive care, he could receive the care that kept him alive, although there was no chance of a cure. That was the wish of Mr Johnson and his wife and daughter. If he went to the nursing ward he would die. A difference of opinion arose between the intensivists and IC nurses. Should Mr. Johnsons last wish be heeded? Or was it best to take him to the nursing ward? A meaningful medical treatment was out of the question. However, staying at the ICU was Mr Johnson wish. Probably his last wish. On the other hand, the nurses saw their patient's suffering and felt that they were exacerbating this suffering. Moreover, Mr Johnson occupied an IC bed. This could be unfair to other patients who might need intensive care. Mr. Johnson had now been in intensive care for 40 days. The discussion among intensivists and nurses was at an impasse. What to do?*

2. The moral point of view

What does it mean to look at Mr. Johnson's case from a moral perspective? It starts with asking a question, "What should I do in this case?" We can approach the same decision from different perspectives. What is the right decision in a medical-technical sense? What is the right decision in an economic sense? What is the right decision in a religious sense? Which decision is in accordance with the law? There is no particular area of decisions (or actions) that are "moral" and others that are "not" moral. Whether a decision becomes a moral decision depends on the question posed to the decision. A problem becomes a moral issue because we ask moral questions. Ethics begins with asking this question: "What should we do?"
If we would leave it this way it would without a doubt raise justified questions. After all, the physician who wonders what to do in a medical-technical sense, or the manager who has doubts about what to do in an

economic sense, or the spiritual counsellor who asks himself the question what to do in a religious sense, or lawyers who wonder what the law prescribes, also ask the question 'what should I do?', 'What is the right decision?'. Yet we wouldn't call the questions as they frame them 'moral question'. What the questions have in common is that they are all normative questions: they ask what a good action is and look for a justification for that action, invoking a certain norm, guideline or measure. Apparently, the moral question appeals to a different kind of standard than the medical-technical, business-economic, religious or legal standard. When we approach Mr Johnson's case with a moral question, we wonder what is *morally just* to do in his case. For the time being, we interpret this 'morally just' as 'doing justice to the other'. The question of what to do in Mr Johnson's case becomes a moral question, by asking what is morally just to do in this case, that is, 'what does justice to the other'.

3. Descriptive, normative and meta-ethics

This does not take us much further, but it certainly helps to highlight some important distinctions in ethics as a field of moral inquiry. Distinctions which belong to the vernacular of ethicists and which we can find in virtually every introduction in ethics: *descriptive, normative, and meta-ethics.*

3.1 Descriptive ethics

Our intensivists and nurses might ask themselves how other Intensive Care Units in Dutch hospitals deal with similar cases as Mr. Johnson. They could pay a visit, interview nurses, perhaps join other ICU's and observe in a participatory way. They gain insight into the values and norms in the ICU's on long-term patients, how these are introduced into medical and nursing practice and discussions on how intensivists and nurses deal with such dilemmas. They could also try to find explanations for the emergence of similar moral questions. If they are doing this kind of inquiry, they are practicing descriptive ethics. Descriptive ethics examines, describes and explains current moral behaviour - the morals and customs, norms and values - in a community. Furthermore, the criteria of moral approval and disapproval, and how these find their way into daily action, moral feelings – like disgust, indignation, shame and guilt – that accompany them, and the ways in which the moral status quo is justified, criticized and enforced. (See also Ten Have, p. 19)[3]

3.2 Normative Ethics

When the intensivists return to their ward and present their finding to their fellow intensivists and nurses, no doubt someone will his hand. "Listen, this is all very important. I find it very instructive to see how they deal with 'Mr Johnson's in other hospitals. But that's not really what I want to know. I don't want to know what is being done, but what we ought to do! ' This remark brings us to what many see as the heart of ethics: normative ethics. Normative ethics is not descriptive, but prescriptive. It seeks to establish in a given case what is morally just to do, and why. What is commanded, prohibited and permitted. The oldest normative moral code is the *Decalogue* or *the Ten Commandments*. The commandment (or prohibition) "Thou shalt not steal" prescribes what not to do. It gives a definite answer and guidance on the question of 'what to do' in a moral

[3] There is an extensive cultural anthropological literature on how people in different cultures de facto shape moral responsibility. The questions addressed therein are beyond the scope of this article. An interesting contribution to this research comes from Maria-Sibylla Lotter (Lotter 2012). "Gründe, sich an die Sozialmoral zu halten… ergeben sich aus der immanente Quelle der Moral, aus dem Bedürfnis, sichselbst zu bejahen. The normative Selbstverständnis eröffnet dem eigenem Leben eine Wertperspektive, in deren Licht man auch seine Handlungsmöglichkeiten assertet." (58) "Being able to look yourself in the mirror" is the everyday version of this source of morality, in which self-esteem and shame play a key role, according to Lotter. It goes without saying that self-esteem as a source of moral action is not the same as justice as a measure of moral judgment for deciding on the moral justness of an action.

sense. The intensivists and nurses are looking for this guidance. The description of how other hospitals deal with Mr. Johnsons in itself does not provide a solution. Norms cannot be derived from facts.

3.3 Meta or critical ethics

No doubt it won't be long before one of the nurses starts wondering out aloud how you can know that you're making a morally just decision. "When is an action morally just?" What do we really mean when we say that an action is 'morally just? When this happens, we leave the domain of normative ethics and enter the domain of meta or critical ethics. Meta-ethics is about 'the critical study of concepts and methods used in deliberation on normative-ethical issues. It is not about judging actions, but about an analysis of what we mean when we use moral concepts, what we do when we deal with normative ethics, how we talk about it, how we make distinctions.'

The case of Mr Johnson shows us that in the messy practice of moral deliberation on the Intensive Care Unit the conceptually clear distinction between descriptive, normative and meta-ethics fades away. Without a clear picture of what we mean by 'morally just' and our moral vocabulary and whether and how we can arrive at a reliable answer to a moral question, the case of Mr Johnson cannot be solved. It would further be morally short-sighted if we did not look for the moral frameworks which are used in other hospitals in the Netherlands answering similar questions like Mr. Johnson's stay on the ICU. Finally, the $ 64,000 question is which moral framework we should use to arrive at a morally just decisions that help us to resolve Mr. Johnson's case. That leaves us again with the question: 'What do we mean by morally just?'

4. What do we mean by 'morally just'?

4.1 Values and norms?

When you take the trouble of asking friends or colleagues the question 'what do we mean when we say that an action is morally correct?' you will see that two answers stand out. The first claims that it are feelings that "say" whether an action is morally just. The second that 'morally just' refers to norms and values. Actions are morally just if they conform to norms and values. The suggestion is that moral judgments are *value* judgments. This suggestion also finds support in biomedical ethics. "In (normative) ethics, the question is asked which norms and values deserve approval or disapproval and on what basis. […] Ultimately we arrive at a judgment by using a value or a norm." (Ten Have 2009: 5-6)

Norms like 'thou shall not kill' are often negatively stated and aim to set limits on actions. As a guideline, they provide direction for future actions. As a standard, it makes it possible to evaluate actions afterwards. Norms are achievable and enforceable. In this norm differ from values. Values are about what is morally worth striving for and inspiring, such as alleviating people's suffering. Values are positive and inspire. "You can't live up to values, but you can live by values." (Ten Have: 21) According to Ten Have (2009), norms are derived from values, and not the other way around. Ten Have, Ter Meulen and Van Leeuwen (2009) claim that thinking about ethics mainly means thinking about values, "that is to say, about those matters that are essential to our lives and our professional practice. (Ibid: 21) Although this ethics of values and norms is close to our contemporary vocabulary, the meta ethical detour in the 20th century shows that there is quite a lot to be said about it.

4.2 20th century ethics as meta ethics

20th century ethics is mainly meta ethics. Until the early 1970s, normative ethics was virtually invisible or shrouded in a theological guise. We can compare this meta ethical reflection on moral judgment and moral

language with the critical reflection on abstract art, like Malevich, Klee, Kandinsky or Picasso at the beginning of the twentieth century. When art becomes abstract, the work of art becomes a problem. The question whether Duchamp's urinal is a work of art provokes the question 'What is a (good) work of art?' This is also the case in ethics. The revolution in science, the industrial revolution, secularization and a world war, destroyed the traditional ground and the naive faith in ethics and everyday morality. The abstract work of art disrupts the realistic illusion of the still life, that a work of art is an image of a reality outside of us. In the same way Dostoevsky's exclamation 'if God is dead, everything is permitted', and Nietzsche's fool, who challenges in the square 'God is dead, and we have killed him', created an *'Umwertung aller Werte'* (Nietzsche), in demolishing the realistic illusion that good and evil are a reflection of a moral reality outside or within us. Just as modern art needs art criticism, modern ethics cannot do without a critical or meta ethics, like investigating the meaning of the question 'When is a judgment morally just?'.
In retrospect, the meta ethical wind calm of the twentieth century turned out to be a boon to ethics. If we retrace the trail, the outcome of this meta or critical ethical reflection is that the moral perspective got on its own two feet. So, let's dig a bit deeper.

4.3 What is a moral judgment?

An important question that concerns meta ethics is what a moral judgment (*value judgment*) actually is. What do we do when we judge morally? Is there such a thing as moral knowledge, in the same way that there is scientific knowledge? In the first quarter of the 20th century the latter question is quickly answered with 'no'. The argument goes like this. Truth is a property of propositions. Only propositions can be true of false. Scientific statements *describe* a certain cut-out from nature, try to explain it, discover laws of nature or statistical regularities and make predictions about its behaviour. 'Meaningful medical treatment is not available for Mr Johnson' is an evidence-based statement about Mr Johnsons actual physical condition related to available treatment. To determine whether this proposition is true or false, it can be compared with similar cases, and if necessary, tested experimentally. If Mr Johnsons condition does not improve, the verdict has been confirmed; if improvement nevertheless occurs, then the proposition is refuted. This is how our knowledge increases. Moral statements such as 'it is imperative to respect Johnsons last wish in life' are of a categorically different order. It is a *prescription* that cannot be empirically tested. It does not refer to 'what is', but to 'what ought to be'. It is a principle, and the justness of the principle cannot be established empirically.

For many meta ethicists in the first half of the last century, this meant that moral judgments are cognitively meaningless. They make no claim to knowledge and cannot be the subject of rational inquiry. After all, if a moral judgment cannot be subjected to an empirical test, on what grounds should it be decided whether a moral judgment is correct or incorrect? What, then, is the intention of a moral judgment?
Meta ethicists give two answers to this question. The first answer is that a moral judgment expresses a moral feeling or emotion. These can be feelings of guilt, shame, disgust, regret, pride, etc. This view is known as *emotivism*. The second view is that moral judgments express value orientations and normative preferences and have the function of convincing others of the importance of these orientations. This view is called *persuaism*. These two views on the meaning of moral judgments show a remarkable similarity with those we raised in our virtual survey, suggested above.
Emotivistic and persuasive interpretations of a moral judgment share the same basic conviction, namely that the justness of a moral or value judgment can be disputed, but not reasonably decided. But the inference that this means that a rational reflection on the moral justness of a judgment is futile is unnecessarily radical, and foreign to our everyday moral experience. The nurses and intensivists are not in a moral impasse, because they believe that the morally just answer they seek is a meaningless endeavour. They are desperate and bewildered by the moral complexity of the situation. It is this complexity that makes common moral beliefs – norms and values – and reasoning problematic. Where ICU 'norms and values' and evidence-based knowledge normally turned out to be a reliable compass, and you could rely on your own moral intuitions, this does not work in the case of Mr. Johnson. Hence ultimately the desperate question: 'When is an action morally just? How can we

know that an action is morally just? ' The conclusion must be that the question of the justness of a moral prescriptive judgment cannot be decided *in the same way* as the truth of an empirical-descriptive judgment. So where to look for guidance?

4.4 Prima facie obligations

Here too, the case of Mr. Johnson can be of help. The intensivists and nurses all appeal to principles to which they consider themselves bound under normal circumstances. Think of principles like 'not inflicting suffering', 'doing well', 'keeping a promise', or 'honouring a last wish'. British meta ethicist D.W. Ross refers to such principles in his *The Right and the Good* (1930) as *prima facie* or conditional obligations. These are obligations arising from the relationship with other persons, which at first sight - *prima facie* – recommend themselves to us, and which only become problematic when they encounter other obligations or serious consequences. The obligations are, according to Ross, self-explanatory: they cannot be deduced from any other source – nor from economics, nor from the anthropological constitution of man, nor from some natural right, etc. It is not only the *prima facie* character that is essential here, but that Ross takes these self-evident moral intuitions as obligations. In doing justice to others it is not the consequences of an action that are decisive, but the obligation to the other.
Moral intuitions or *prima facie* obligations become hotly debated in everyday practice when their follow-up is not self-evident. Such is the case in the moral impasse at the Intensive Care Unit. What to do in such a moral predicament? When, according to Ross, I am facing a decision in which *prima facie* obligations are conflicting, I have to investigate the situation as careful as possible and form a considered judgment on which obligation should be more binding. *Sans phrase*.

4.5 Conclusion

In the end this meta ethical exercise is somewhat disappointing. The mere fact that we have these *prima facie* intuitions does not make them morally just, nor does it decide on their relative value regarding other obligations. The same applies to norms and values. "The genesis of moral norms and values is not the same as their validity. How we arrive at our moral views is independent of whether they are tenable and defensible." (Ten Have et.al. 2009: 13) Nevertheless, the meta ethical detour has provided some foundation. Thinking about ethics does not primarily mean thinking about values, but about how obligations to others can be fulfilled, precisely when they are no longer self-evident. This brings us again in the realm of normative ethics. How to do justice to others?

5. Doing justice to the other

Normative ethical theories aim to provide a solution to moral impasses like those in the Intensive Care Unit, where nurses and intensivists have to decide on the life and death of Mr Johnson. It seems that apparently, binding and self-evident obligations cannot be respected at the same time. Normative ethical theories are an answer to what Rainer Forst calls the 'the right to justification'. (Forst 2007) It's this right which already our children claim when they ask, 'why are you doing that to me mom?'
In the history of modern ethics, there are three classically normative ethical theories that to this day are still guiding posts in answering the question of our children. Here we discuss the two modern classics. Below we sketch the third one: virtue ethics. What makes the 'modern classics' modern is that they do not seek the answer the question what makes you a good person – like many pre-modern ethics – but what a justified action is. The core question is 'What should I do?'
The first modern classic is ethics of *consequence*, especially in its utilitarian version, with Jeremy Bentham and John Stuart Mill as main spokespersons. The second modern classic is *deontological* ethics, immortalized by Immanuel Kant (1724-1804). Bentham and Mil's ethics of consequences and Kant's ethics of obligations are two

brilliant responses to the moral predicaments of late eighteenth-century society. Modernization had profoundly changed this world. Think of the scientific revolution that started to gain momentum from the 16th century onwards. The aftermath of the religious wars of the 17th century. The first secularization in the 18th century. The formation of nation states and the heralding of the industrial revolution. Bentham and Kant sketch a moral perspective that swaps the heavenly for the earthly. Their ethics does not appeal to God, but to our reasonableness to resolve moral questions. Together they shape our vocabulary to understand moral questions and how to solve them. Bentham and Kant do not aim to write an ethical theory among other ethical theories. Their aim is to offer a general and universal moral theory. A theory which in principle can provide answers to all moral questions that we as human beings can encounter.

5.1 A discussion at the Intensive Care Unit

An ethics of consequences and obligations can give guidance how to investigate a moral impasse, such as at the Intensive Care Unit. They can offer support how to arrive at a judgment that is "morally just." The moral impasse is also the touchstone for the claim to generality and universality of these two moral theories. We can imagine that the discussion at the Intensive Care Unit could go on like this:

"I don't see how we can improve the health of Mr. Johnson. Whatever we do, there is no health benefit to be achieved."
"That may be, but he and his family must have a final say in how he wants to die. It is his last wish! That must prevail."
"Yes, last wish, but at the expense of himself. I am at his bedside. Every day I witness him suffering more. That is not why I chose this profession. It's my duty to decrease suffering, not to increase it. "
"I also think we should think about other patients who need an ICU bed. They too should have the opportunity to get better."
"Not only the opportunity. They are entitled to intensive care."
"I also find it mentally difficult for colleagues."
"Besides, all those costs… and, no matter how harsh it sounds, Mr. Johnson is going to die anyway. If it's not next week, it's next month."

5.2 Ethics of consequences

In some of the arguments the purpose and consequences of the action are paramount. Striving for and achieving a better health. Health benefits for other patients. Reducing the mental burden of colleagues. Efficient use of financial resources. An ethics of consequences is concerned with the goals (telos) and the outcome (consequence) of an action or decision. Goals motivate actions, but also lead to benefits in which stakeholders have an interest. Utilitarianism, which entered the stage in the eighteenth century, is to this day the leading variant of this type of normative theories.
A utilitarian ethic looks at the utility or outcome of an action. Let's listen to Jeremy Bentham. "By utility I mean a property of an object, through which it can produce a benefit, pleasure, good or happiness." The yield promotes an *interest* for an individual if it "increases the sum of his *pleasures* or decreases the sum of his *pains*." With the word interest, Bentham uses a word that had only just entered moral language of his day. In the 17th century, the word "interest" is used in opposition to passion: cool, computable, and objectifiable interests, to quell the heat and subjectivity of the passions. (Hirschman, 2013). "Interests is one of those words," wrote Bentham, "of which the meaning cannot be derived from another word, and therefore cannot be defined in an ordinary way." Interest is a *prima facie* word. We have interests. *Period*.

Now we might surmise that because each of us has interests, the only moral just thing to do will be to increase self-interest.[4] But this is not the message of utilitarianism. Utilitarianism focuses on the well-being, in terms of pleasure, happiness, prosperity or the satisfaction of preferences, for *all* concerned. The utility principle urges us that, in taking decisions, we must always produce the maximum balance of positive or negative values for all who are affected by the consequences of the decision. Utilitarians differ on the substance of this value. For Bentham, and later John Stuart Mill, it's about pleasure and pain. For others, for example, it concerns health, prosperity or well-being. But the moral conviction they share is the same. Not the *self*-interest, but the interest of *all* is decisive. That is the utilitarian principle: the obligation to provide the greatest good for the greatest number, established from an impartial point of view, giving equal weight to the legitimate interests of each party affected by the decision. Not the *self*, but the *other* makes the difference.
When arguments are formulated in terms of consequences and goals at the Intensive Care Unit, we recognize an utilitarian type of moral reasoning. "There is no health benefit to be achieved" says in so many words that the goal of the action is to achieve health benefits, and that this goal is not going to be achieved. "I prolong the suffering of Mr. Johnson", says that the goal of my action is reducing suffering, but that in this case I am increasing suffering – pain.
The power of utilitarianism lies in the attention to the particularity of the situation, the obligation to strive for the increase of the greatest good – for example health – for all, the impartiality and computability of the balance of interests – Bentham speaks of a *hedonistic calculus* –, an eye for the interests of all concerned and the demand for rationality. If we were to allow our choice at Mr. Johnson's bedside to be guided by 'the greatest good for the greatest number', we would presumably arrive at a reasonable and impartial decision to transfer the patient to the nursing ward, where he can die peacefully.

5.3 Ethics of obligation

Yet at first glance, there seems something wrong with this decision. At this point Immanuel Kant comes in. Can we explain the wish of Mr. Johnson in such a way that if we satisfy his wish, we do something that is beneficial to him? Or is there more to it? Shouldn't we respect his wish, regardless of the consequences? If we follow that line of thinking, we will fall under the spell of Kant's deontology. *Deon* is Greek and means 'that which is binding' in the sense of a duty or obligation. Deontology is an ethics of obligation. 'Only the will is good', wrote Kant. By this he meant that we should judge the moral justness of a decision or a rule of life only by its intention, and not on possible positive or negative consequences.
People can act out of duty or out of inclination. *Prima facie* precepts are not obligations as Kant had in mind, but inclinations or moral impulses, which we follow without thinking about them. Acting with a sense of duty however, involves being motivated by moral principles discovered by the use of our practical reason. If a nurse 'feels' at the bedside that it is wrong to increase Mr Johnson's suffering, this is of course not unjust, but has for Kant no moral value.
This idea is closely related to what Kant understands as autonomy and freedom. A man is not free if his acts are the outcome of social customs or the laws of nature. He then acts *heteronomously*. Reason enables a human being to overcome this power of custom by prescribing the law to himself. This imposing the law on oneself guided by practical reason, is what Kant calls autonomy. Autonomy also resonates with responsibility. You can only be morally responsible for your actions if you have performed them with a certain freedom. Acts can be freely performed only if they are accompanied by some inner reflection. Principles are moral laws that you impose on yourself and want to observe. Respect for reasonableness, freedom and autonomy are thus different sides of the same coin. They establish the dignity of persons which, above all, should be respected.
The idea that only the intention *out of which* a person acts is good, and not the goal *at which* the action is directed, becomes prominent in the distinction between *hypothetical* and *categorical* imperatives.
Hypothetical imperatives are precepts that should be followed to achieve a certain goal. In this we recognize

[4] This is for instance the conclusion of Ayn Rand. See for a discussion of Ayn Rand, compared with Hannah Arendt, Simone de Beauvoir and Simone Weil Eilenberger (2020), *Das Feuer der Freitheit*.

the utilitarian reasoning: action A is the condition to achieve goal G. Categorical imperatives are principles followed for their own sake. One way of stating the categorical imperative is: "Act in such a way that you use your humanity, whether in your own person or in the person of everyone else, always as an end in itself, never just as a means." To put it more simply: "Never treat a fellow human being only as a means, but also as an end." Human beings have an inherent dignity - embodied in their freedom and autonomy - which is worthy of respect under all circumstances and cannot be exchanged for anything else. Moral principles - categorical imperatives - define the rights of a person - or of any reasonable being, says Kant. From this follows the obligation for me to respect that right. It draws a moral line that you should not cross.
This brings to the fore what is lackingin an exclusively utilitarian decision about Mr. Johnson. Some doctors and nurses hold that there are thresholds that we may not exceed. They appeal to arguments of obligations. "We *should* respect the last wish of Mr. Johnson," or "I *should* not increase his suffering" regardless the consequences. Although Bentham has an eye for the interests of Mr Johnson, he lacks the language to express some of them as rights, duties and obligations.

5.4 A Comparison

The emphasis on principles is what makes Kantian ethics so different from a teleological ethics of consequences. When we think in terms of an ethics of consequence, we place minimal importance on the intent behind the act, as long as the act produces a good result. When we think in terms of an ethics of obligation, we consider intentions to be decisive, and consider the consequences of someone's actions of secondary importance, as long as they are the outcome of good intentions on the basis of just principles.
The ethics of obligation goes hand in hand with and is also an answer to the weakness of the ethics of consequences. When the latter is concerned with maximizing individual preferences, it is hard to distinguish immoral preferences or actions from just preferences or actions. Furthermore, all preferences are in principle equal and the calculation of 'the greatest good' can result in a person's fundamental rights being overruled in the interests of the common good of all others. Ethics of obligation, on the other hand, converts certain interests into rights, which must be respected regardless of the consequences. Where interests can be met to a greater or lesser extent, rights create an obligation to respect them. Interests can be harmed; rights can be violated.
On the other hand, the utilitarian effort to balance resources maximization for a good and flourishing life for all cannot be simply discarded. The strength of utilitarianism is that it has an eye for the special circumstances of a decision. Furthermore, the case of Mr. Johnson, to which we keep coming back here, is also about a good and fulfilled life for everyone, under tragic circumstances. Third, it urges us to produce the maximum of common primary goods – freedom, wealth and happiness – for all. Consequential ethical arguments that serve the greatest benefit of all should therefore be part of the assessment of whether a decision or action is morally just. To phrase the American philosopher John Rawls: Increasing ‘goods’ for all is the substance of a decision; rights are its limits.

5.5 A Recalibration of the Language of Morals

This exploration of two modern classical normative ethical theories changes our moral language, which might go unnoticed if we don’t shed a light on it. Ethics of consequence is a language of interests and preferences. It transforms our vocabulary of values and norms into a language that is concerned whether or not legitimate interests are met. Ethics of obligation uses a language of rights and obligations. It transforms our language of values and norms into a language about respecting justified obligations arising from the rights of persons. This helps us to answer to the questions which bothers our intensivists and nurses at the ICU – ‘What to do?’, ‘How do I know that an action of decision is morally just?’, ‘What does doing justice to the other mean?’. We can now come up with a more precise answer that underpins every moral inquiry, ethically and methodologically. Doing justice to the other does not mean following up or testing a set of values and norms. In a moral inquiry

we try to answer the question: 'Which decision or line of action takes sufficiently into account the rights, interests and wishes of all those involved. Now, what do we mean by 'sufficient'? Three remarks.

- First, from a utilitarian point of view, we set the bar high: a decision takes sufficiently into account the interests of all those involved, leading to an optimal balance of interests of all those involved, in which the level of satisfying common interests must be as high as possible.
- Second, from a deontological point of view, the bar is set on the moral minimum: the decision is morally just that best respects obligations arising from the rights of those involved.
- Third, for both counts the 'good reasons approach to ethics', which tells us that a decision must be based on solid grounds: moral decisions require valid arguments.

5.6 The Test

Any normative ethics must be able to provide a satisfactory answer to a moral impasse, like the one at the Intensive Care Unit. Moral impasse – some would prefer to speak of a moral dilemma - means that our *prima facie obligations* no longer answer the question "What to do?" They are silent, or rather, they vociferously contradict each other. The moral impasse marks the moment when we have to submit our moral inclinations (Kant) or moral intuitions (Ross), on which we normally rely, to the question what 'does justice to the other'. A moral impasse makes us aware of the tragedy of moral decisions - their *moral footprint* or *moral trace*. *Any* decision in which something is seriously at stake inevitably also harms an interest or violates a right. Doing justice to the other means to accept the injustice that this entails. For instance, being able and prepared to live with the burden of judgment (Rawls) that the suffering of Mr. Johnson increases as a result of your decision, or that Mr. Johnson dies in a way that is in according to his last will and wish.
Do the ethics of consequences and ethics of duty fulfil their ambition? Apparently not. Both fail precisely because of their strength. Is that a problem? No. If we continue to see moral questioning, and critique in normative and meta ethics, as an ongoing and open moral learning process of humanity. Incompleteness of moral theories is a virtue instead of a vice of normative ethical theories. They risk something, which makes them educational and of great significance.

The turn to praxis in biomedical ethics has given new impetus to ethics and led to a series of new insights which we discuss below. In the first place, discovering and ordering moral principles that claim to apply in biomedical practice, as outcomes of moral learning. The work of Beauchamp & Childress (1977/2013) is of great importance here. In the second place, ethics as a practical learning process, which is central to deliberative ethics. We turn to biomedical ethics first (6). Then we discuss deliberative ethics (7, 8).

6. What to do? The principles of biomedical ethics

The first edition of *Principles of biomedical ethics* was published in 1977. In 2013 the seventh edition saw the light of day. In 1977, according to Beauchamp & Childress, biomedical ethics was a young field. But over the past 40 years, tremendous changes have taken place in the biomedical field. 'In these decades bioethics has transitioned from having no systematic work and not meta-reflection to an enormous literature on the subject.' (Beauchamp & Childress 2013: vii) Biomedical ethics itself is the outcome of a moral learning process in our society, where questions about law, morality and health have become increasingly important. Just look at the quote from Yuval Noah Harari above, which marks a revolution in humanity, still under way. "Since death clearly violates the right to life, death is a crime against humanity, and we ought to wage total war against it. "
The heart of *Principles* are four biomedical principles: autonomy, non-malice, beneficence and justice. Until the 1960s, biomedical ethics was primarily a professional ethics of and by physicians. Their ethics was dominated by the classical Hippocratic principles of non-malice and beneficence. After the 1960s, medical and nursing practice and biomedical ethics became increasingly concerned with the relationship with clients and patients.

That gave rise to the emergence of two other principles: autonomy and justice. Against the background of recent developments in ethics of care, we add a fifth: the principle of attentive care and add 'protecting others form social suffering' to the second principle of beneficence. Together, according to Beauchamp & Childress, these principles are benchmarks of a *moral commonwealth* (Selznick) - a Realm of Goals (Immanuel Kant) - in which doing justice to others takes shape.
In itself it is rather bizarre that we are talking about *biomedical* principles. After all, their significance extends beyond the practice of hospitals and the doctor's office. The fact that Beauchamp & Childress elaborate them for biomedical praxis does not mean that they are not relevant for our common moral world. The principles are also relevant for other professions, and our relationship with fellow human beings in general. Below we discuss these principles, starting with non-malice (1), beneficence and relieving social suffering (2), autonomy (3), justice (4) and attentive care (5).

(1) The principle of non-malice: not inflicting harm or unnecessary suffering

Principle - The *principle of non-malice* or doing no harm - *primum non nocere or, 'do no harm'* - is the translation of the Hippocratic 'I will, after the best judgment and ability and good of my patients, prescribe them a rule of a healthy life and never harm anyone '.[5] It commands us to refrain from hurting others, and adding suffering to someone. In medical practice, competent and responsible action is often not possible without inflicting some form of suffering on a patient or client. By harm Beauchamp and Childress mean thwarting, rejecting or preventing an interest of someone. A harmful act does not always have to be wrong or unjustified. (153) This may concern issues such as exposure to risks, and may concern too much or too little protection, treatment or not, dying or allowing to die, intentional killing (euthanasia) and the protection of incapacitated patients.
The principle of doing no harm is a *prima facie* obligation. It requires justification for acts that cause harm to others. This justification may show that the harmful act is not a genuine violation of the obligation not to harm, or that other moral principles and rules should prevail. (153) The obligation not to cause harm is stricter than the obligation to do good. After all, not causing harm has to do with a moral boundary, which may or may not be exceeded, with significant consequences for the person concerned.

Case - In the case of Mr Johnson, the principle of 'doing no harm' is of great significance. First, for the nurses who, in daily nursing care, felt that they were increasing their patients suffering. They wondered if this was justified. Furthermore, the decision to transfer Mr. Johnson to the nursing ward, by withholding intensive care, would undoubtedly hasten his death. Ultimately, these arguments were not decisive in the decision. But they were part of the intense and permanent dialogue with the patient and his wife and daughter about what would be the best decision in the given circumstances.

(2) The principle of beneficence: improving welfare, and relieving social suffering

Principle – Moral considerations require not only to refrain from harming persons, but also to contribute to their well-being and flourishing. Beauchamp and Childress call this the *principle of beneficence*. (202) This requires more than the principle of non-malice, which basically commands what we shouldn't do. It requires to take positive steps to help others, not just to refrain from harmful actions. In the medical profession, attention to the well-being of patients is the *raison d'être* of medical practice.

[5] The principle does not appear in the *Hippocratic Corpus*, nor any other Greek medical treatise. Only in the *Epidemica I* of Hippocrates it is written "Do two things in your treatment of illness: either help the patient or do him no harm." According to Albert Jonson, Galen added "above all": "The doctor must be primarily focused on helping the patient; if he can't, he must not harm them. "

Benevolence and beneficence requires that we strike a balance between benefits, risks, and costs to provide the overall best outcome for the individual personal. Beneficence as a duty must, according to Beauchamp & Childress, be distinguished from ideal charity. (202) Much action that adds good to human live is driven by an ideal but is not obligatory. The authors cite *prima facie* benevolence obligations: (1) protecting and defending the rights of others; (2) preventing others from being harmed; (3) Eliminating circumstances that could cause harm to others; (4) helping persons with disabilities; (5) rescuing persons in danger. As in the case of non-malice, beneficence has a personal and institutional side. Many of the above obligations are regulated by the government. On the other hand, the principle of beneficence plays a role in personal or professional relationships. Beauchamp & Childress provide five criteria to determine whether there may be a *prima facie* obligation to help person X towards person Y (207):

1. Y is at risk of significant loss or harm to life or health or some other fundamental interest.
2. X's action is necessary (singly or in the concert with others) to prevent this loss or harm.
3. X's action (singly or in concert with others) has a very high probability of preventing it.
4. X's action would not present very significant risks, costs or burdens to X.
5. The benefit that Y can expected to gain outweighs any harms, costs or burdens that X is likely to incur. (202)

Social suffering – The obligation to alleviate suffering resulting from social circumstances or policies, which can be avoided by changes in circumstances or policies, is an important supplement to the principle of beneficence. *Social suffering* does not arise from an action (or failure to act) by a doctor or nurse, but from social circumstances that could also be otherwise by changing policies. Social suffering as 'superfluous' suffering (Max Horkheimer) always refers to some injustice that could and should have been prevented, avoided or alleviated.
The principle of relieving social suffering is "discovered" in social medicine of the late 18th and 19th centuries. Morbidity and mortality, for example caused by a cholera epidemic among the working population is not the result of physical weakness, but of the accumulation of poor people in overcrowded cities and deplorable living and working conditions. Since an epidemic or pandemic is a medical and social phenomenon in which people risk suffering and dying unnecessarily, the principle of alleviation of social suffering obliges us to consider what avoidable social causes are behind this suffering and dying, and how to improve social circumstances which are at the root of social suffering.[6]

Case – The obligation to benevolence is relevant when it comes to the quality of life (or rather: of dying) of Mr. Johnson. It also plays a role in the question of whether Mr. Johnson is able to make wise decisions about his own well-being. (Paternalism) Finally, it also plays a role in weighing up the costs of care in intensive care in connection with the determination that there is no longer any medically meaningful action. The relevance of relieving social suffering comes to mind in the current corona-crisis. Think of excess mortality in nursing homes for elderly people as a result of the lack of protective equipment.

(3) The principle of autonomy

Principle - Autonomy comes from the Greek *autos* (self) and *nomos* (rule). Autonomy, according to Beauchamp & Childress, includes as a minimum the ability to direct a personal life, free from the controlling intervention by others and boundaries that stand in the way of meaningful choices and adequate understanding. (101) The autonomous person acts freely according to a self-chosen plan. Someone with reduced autonomy is controlled

[6] Literature on social suffering: Eric J. Cassell (2004), *The Nature of Suffering*; Martin Heinze, Christian Kupke, Christoph Kurt (2000), *Das Maß des Leidens*; Iain Wilkinson (2005), *Suffering*; Iain Wilkinson, Arthur Kleinman (2016), *A passion for society*; Emmanuel Renault (2017), *Social Suffering*; Arthur Kleinman, Veena Das, Margaret Lock (1997), *Social suffering*; Arthur Kleinman (1988), *The Ilness Narratives*; Camilo Sembler (2020), *Soziales Leiden*; Ute Frevert (2017), *Die Politik der Demütigung*.

in some material aspect by others or is unable to implement his own choices and plans prudently. (102) All theories about autonomy see two conditions as essential for autonomy: *negative freedom* (independent of controlling influences) and *agency* (the ability to act intentionally). (102) According to Beauchamp & Childress, people act autonomously who (1) act intentionally, (2) understand their actions and choices, and (3) act without others checking their actions.
Autonomy deserves respect and protection because it is an important condition of self-esteem and self-respect, and the ability to lead a flourishing independent life. Respect for autonomy is more than not interfering with the life of another. (107) The principle of respecting autonomy can be described both negatively and positively. As a negative it stands for the obligation that requires that autonomous actions are not subject to the controlling restrictions by others. (107) As a positive obligation, it means the obligation to promote and enable independent decisions of patients (and fellow human beings), and to share information with patients. The Kantian 'treat others as a goal in themselves' means that we also help others to realize their self-chosen goals of life.
The principle of autonomy can be translated into moral rules like (1) tell the truth; (2) respect the privacy of others; (3) protect confidential information; (4) provide consent for patient treatment (informed consent); (5) Help others making important decisions when asked. According to Beauchamp & Childress, respect for autonomy is a *prima facie* obligation, as discussed above. Other moral principles can sometimes trump this principle. Respecting autonomy can be complex, for example when there is doubt about the ability of a person to decide for oneself or in cases of informed consent.

Case - In Mr. Johnsons case, the principle of autonomy plays a prominent role because of his wish not to be transferred to the nursing ward. By many at the Intensive Care Unit this wish was understood as the last wish of a dying man and his wife. Others wondered whether this was an autonomous act in the light of the criteria we have put forward above. Did Mr. Johnson understand his situation sufficiently? All felt that Mr. Johnson's wish should put much weight on the scale. Ultimately, Mr. Johnson's wish was decisive, and he died in intensive care. But not after the principle of autonomy was compared to the other principles at stake.

(4) The principle of justice

Principle - In the Netherlands, the right to care has been included in the constitution since 1983. In contrast to traditional liberty rights, such as freedom of speech, fundamental social rights are target rights. It obliges the government to provide accessible healthcare for all residents. But it says nothing about how health care should be organized, what the appropriate level of health care is, and how health care as a primary good should be distributed among Dutch residents. All these questions are about the just institutional organization of health care for the current generation and the next. *Distributive Justice* is Beauchamp & Childress's fourth biomedical principle. *Suum cuique* – 'to each his own' is the classic formula of distributive justice.[7] Beauchamp & Childress discuss justice as "the equitable and balanced distribution [of benefits and burdens], determined by justified norms that structure the terms of social cooperation." (241) Conceived from the formal side, Aristotle wrote that "equals should be treated equally, and unequals should be treated unequally." The question is, of course, what should be understood by 'equal' and what is its implication for the distribution of primary goods such as health and health care.

[7] Justice in this distributive sense comes close to what John Rawls calls 'justice as fairness'. Beauchamp & Childress rightly point out that distributive justice broadly "refers to the distribution of rights and responsibilities in society, including civil and political rights. It is distinguished from other types of justice, including *criminal justice* […], and *rectificatory* justice." (241) We should add that we use the general word justice in this article in a more profound sense as a measure of moral judgment – doing justice to the others. The meaning of justice which we have in mind is captured in German in the difference between 'Rechtfertigkeit' and 'Gerechtigkeit', and the Dutch 'rechtvaardigheid' en 'gerechtigheid'. The English 'righteousness' comes to mind. In the Old Testament God is called just and righteous. However, it includes too much a meaning of retaliation to capture the idea of justice as a measure of of moral judgment as we use it.

Unlike in Aristotle's time, and in pre-modern moral history, in modernity it is not inequality, but equality which is the norm. This is how it is stated in the Dutch constitution: "All residents in the Netherlands will be treated equally in equal cases. Discrimination on the grounds of religion, belief, political opinion, race, sex or on any other ground is not allowed." (Article 1) If there is any unequal treatment, it must be justified. Modern theories of (distributive) justice thus deal with equality and justified inequality in the distribution of primary goods, such as health care. Beauchamp & Childress outline six modern theories of distributive justice.

- *Utilitarian theories* (Bentham, Mill): a sum of criteria for maximizing public utility. "To every person in accordance with rules and actions that maximize social benefit."
- *Libertarian theories* (Nozick): individual rights and social and economic freedom and fair procedures. "To each person a maximum of freedom and property resulting from the exercise of liberty rights and participation in exchange in a free market."
- *Communitarian Theories* (McIntyre, Taylor): Underline principles of justice as derived from conceptions of the good developed in moral communities. "To every person in accordance with the principles of equitable distribution derived from conceptions of the good developed in moral communities."
- *Egalitarian Theories* (Rawls): emphasize the equal access to goods in life that every rational person values and invoke material criteria of needs and equality. "To every person an equal measure of freedom and equal access to the goods for the life that every rational person will appreciate."
- *Capabilities theories* (Sen, Nussbaum): identify capabilities and forms of freedom essential to a flourishing life, and ways in which social institutions can protect them. "To each person the resources necessary for the exercise of the abilities necessary for a flourishing life."
- *Welfare Theories* (Powers, Faden): emphasize essential aspects of well-being, such as health, and what it takes to achieve this state of well-being. "To each person the resources necessary for the realization of core dimensions of well-being."

Theories of justice as fairness allow biomedical ethics to judge issues such as fair access and unfair discrimination in health care, vulnerability and exploitation in scientific research, the fairness of health policy and the right to health care, health care and the right to health in a globalizing world, and setting priorities in the distribution of available resources. Theories of justice not only aim to show how a just society should be organized, but also provide a moral framework for critically assessing existing institutions. "Institutions are either just or unjust," wrote the American philosopher John Rawls in his *A Theory of Justice*. 'If institutions are unjust they must be abolished or improved. Justice does not allow for compromise.'

Case – At first sight, justice only plays a role at the macro level of the structure of society. But as the case of Mr. Johnson shows justice arguments also recur in questions about the moral justness of everyday professional conduct and the integrity of organizations. Institutions, organizations and actions form a justice triptych. The argument of justice is reflected in the equal distribution and accessibility of the ICU beds for all patients who need it. It also plays a role in the cost argument as a justified use of available scarce financial resources and time. A moral judgment is not only about those who are today close us, but about mankind in general - now and in the future.

(5) The principle of attentive care

Principle - The last principle we discuss does not occur in Beauchamp & Childress. It is our addition to the repertoire of *Principles of biomedical ethics* and is prompted by recent developments in *ethics of care*, which, by the way, Beauchamp & Childress do cover. Beauchamp & Childress understand ethics of care as a virtue ethic. This offers us the opportunity to discuss virtue ethics as third classical normative ethic, in addition to the previously discussed ethics of consequence and ethics of obligation.

Unlike interests, benefits, rights and obligations, virtues do not refer to actions, but to persons and their moral character. You can trust and build on a virtuous person. In Dutch we translate the Greek *arete* and the Latin *virtus* very appropriately as ‘deugd en deugen’ meaning ‘being suited for something’. The word virtue makes us think of 'excellence', or rather 'solidity'. Virtus also means strength and robustness. A virtue is a moral character trait that makes you "good" for something in a moral sense, and actively shapes appropriate relationships with relevant others in a ‘good’, solid and robust manner. It is the interplay of ability, strength, spirit and alertness to action that makes a virtue what it is. A moral virtue is a mark of character that is considered morally valuable. Someone who possesses a virtue is formed by this in a recognizable and reliable way.

In line with Aristotle, on whom much of today's revived attention to virtues goes back, virtues are attuned to the situation in which virtuous action is required. We can distinguish special virtues that apply to a profession from general virtues that make you a good person. In the first case it is about the virtues of being a good professional; in the second case, it is about the virtues of being a good - solid and robust - person. Against this background, Beauchamp & Childress can claim that virtues are not only personal and culture-bound but are part of our common morality. (31) We recognize this in the virtues that have stood the test of time. On the one hand, the classical virtues of *temperance*, *fortitude*, *prudence* and *justice*. On the other hand, the Christian virtues of *Faith*, *Hope* and *Charity*. While the classical virtues help to keep the golden mean in challenging and tempting matters, the Christian virtues help to be steadfast and do the right thing in enduring adversity: the confidence that you are not alone in your human existence (Faith), that there is light is at the end of the tunnel (Hope), and even in difficult times egoism can give way to keep an eye on the other (Charity). In summary, virtues shape and strengthen our moral *willpower*.

Virtues in professional roles as a physician, or nurse are about expectations and standards for good professional health care practice. Virtues include the conventions, customs, and procedures of good care. Care practice has a long tradition of cultivating, supporting and strengthening the virtues associated with good care. Beauchamp & Childress list caring, compassion, sound judgment, reliability, integrity, and conscientiousness as virtues.

Can you learn virtues? Can you mould yourself into a virtuous (strong-willed) person? Aristotle's answer is 'yes'. You can learn virtues in practice by practicing them. You become a good person or a good caregiver, tells Aristotle, in the same way as a good guitar player: by playing the guitar well. The virtues of good and professional action are thus learned by practicing them daily, together with others, and by listening to what others – especially skilled and experienced colleagues have to say of our performance as a virtuous practitioner.

Beauchamp & Childress conceive ethics of care as a variant of virtue ethics. Ethics of care finds its inspiration in the feminist critique of the current ethics of interests, rights and obligations in the early 1970s. Rights-inspired ethics revolve around individuality, detachment, impartiality, rationality and equality. (See also Ten Have (2009), Tronto (1993) Ethics of care is based on the fundamental vulnerability and dependence of people, of course in particular patients and clients. Related words are closeness, partiality, emotionality, responsibility and inequality in the caring relationship between caregiver and patient or client, in which sacrifice, and practical engagement and commitment play such a crucial role.

Ethics of care wants to do justice to the imperfections and fragility of existence and is committed to the suffering and needy other. Responsible care means shaping the care relationship in response to vulnerable fellow human beings. Providing care should not only be justified because someone else is entitled to it in a distributive sense, or because it requires the formal respect principles like non-maleficence, beneficence, autonomy of justice. It also requires solidarity, recognition, a sense of intimacy and attention to the needs of the sick or needy. (Van der Kooij, 2014) However, because we consider attentive care as something that clients of patients (or fellow human beings) can *rightly* claim, it is justified to speak of a *principle* of attentive care. Linking care to a principle goes against the grain of ethics of care. After all, ethics of care opposes an ethics of rights and obligations. On the other hand, the principle of attentive care says that the patient or client can also claim it to some extent, and if we do not meet it sufficiently, we commit an injustice. Recognition of the patient in his vulnerability, dependence, suffering and sometimes tarnishing that is something we owe to a patient.

This requires that the doctor or nurse to practice and strengthen the virtue and moral willpower associated with attentive care.

Case – There is no doubt that ethical care concerns play a role in the case of Mr. Johnson. Nurses sympathize and feel compassion with Mr. Johnson. The try to make him comfortable. Without empathy, compassion and responsibility for a vulnerable fellow human being, there would not even be a moral impasse. Virtues of ethics of care make possible to muster the willpower to care for Mr. Johnson in all his hopelessness as good and compassionate as possible (and sometimes even more). It helps to prevent moral injuries and moral distress (but can also turn out wrong). What virtues of care, however, cannot accomplish is to judge what is the morally just to do in the case of Mr. Johnson. The virtues of an ethics of care strengthens the moral willpower but cannot be a substitute for moral judgment.

7. The explosion of rights and the moral impasse

The *Principles of Biomedical Ethics* is an impressive, penetrating and inspiring example of what normative ethical reflection might achieve. At the same time, it is more an arrangement of a collection of moral insights under five guiding principles than that these principles offer a way out in a case we confront at the Intensive Care Unit. It shows us what is at stake but doesn't solve the moral impasse of intensivists and nurses. Moral practice is infinitely more complex than what can be contained in systemizing principles in biomedical ethics. A moral impasse arises because arguments of principle and consequence which at first sight are plausible and convincing collide in unruly practice. It is not the principles that are morally just and do justice to the other, but the outcome of a judgment in which they are weighed, where sufficient attention is paid to the harms of a decision, and where those involved want to bear the consequences of the decision.
This brings us to two further questions. First: what are the origins of a moral impasse like the case of Mr. Johnson? What are the moral predicaments of the impasse? What could be the reason that we have a feeling that in late modernity moral complexity is increasing in professional practice and our daily lives?
Second, if we have answered the first question, what are their consequences for contemporary normative ethics? Does it also mean that we have to take a different look at practical ethics? The first question leads to the observation that the 20th century watches an 'explosion of rights'. The second question leads to deliberative and experimental ethics. The question "What is the morally just act to do?" is supplemented with questions like 'How do we arrive at moral knowledge? 'Who are the agents who produce moral knowledge? 'Can moral knowledge grow?'
Human rights, social rights, women's rights, children's rights, client rights, LGBTI rights, animal rights… The tragic history of the twentieth century is also a showcase of an explosion of rights. What is the moral point of his explosion? Women's rights are a paradigmatic example. In the course of the 20th century, the outcome of the hard fight for 'the emancipation of women' resulted in the formal equality of men and women. The heart of this is the *right* of a woman to make her own decisions in live, to own property, to have a political voice and to be able to realize her own life plan, without the required consent of another - father, husband. In a moral sense, women became autonomous, independent persons, to which justice must be done. If a morally just act is an act in which justice is done to the other, from the first half of the last century fall under the category of 'the other'. From now on it is unjust to treat women only as a means. Every individual woman anywhere in the world is a moral person, an end in herself. *Rights* and *Other* are two sides of the same emancipation medal. The same applies when it comes to client's rights, children's rights, LGBTI rights or animal rights. The fact that the 20th century is an explosion of rights (Bobbio: 1996; Campbell: 2006; Forsé, Parodi: 2005) means that it is also an explosion of 'others'. We consider this as a sign of moral progress.
But this progress also has a flipside. The more rights are granted to 'others', the more rights can be violated. That explains our increase in moral anxiety, distress, injury and trauma – sometimes even a sense of moral decline – that characterizes our current era. It shows an awareness that our obligations to one another have increased, and that it is not easy to respect all obligations sufficiently. The more rights to respect, the more

rights we can violate. In complex moral decisions there is always someone who rights can't be fully respected as we ought to do. That's what we called our moral footprint.
The accumulation of rights/others represents a chronic increase in moral complexity, especially in public services and care, and thus of moral impasses: cases that require moral reflection. This moral complexity is only faintly visible in normative ethical theories or brilliant books such as Beauchamp & Childress. It becomes visible in all those cases, day in, day out, in which a moral decision have to be made. In those decisions, as in Mr. Johnsons case, doing justice to the other is at stake. This also shifts the attention in practical ethics to the question how moral judgments can come about, which are morally just, and do justice to the other. Deliberative ethics seeks to answer this question.

8. Deliberative ethics: Who decides?

In deliberative ethics, the methodical side of normative ethics comes to the fore: the way in which we shape moral reasoning-in-practice. This methodical side is not secundary. It shapes our moral view and prescribes how we can resolve moral questions, in which the outcome is sufficiently justified. A common thread in contemporary practical ethics is (1) the casuistic turn, (2) from a monological to a dialogical ethics, (3) who decides and is involved in moral inquiry, (4) from moral deliberation to moral knowledge.

(1) The casuistic turn

The casuistic turn in twentieth century ethics, which started with Stephen Toulmin and Albert Jonsen's groundbreaking book, *The Abuse of Casuistry* (1988), is a critique of the contemporary (and also today's) common ethical practice. Major medical questions, such as 'is euthanasia permissible', lead, according Toulmin and Johnson, to an endless discussion about beliefs and principles that are rarely resolved. The end is often a moral stalemate. Morally speaking these kinds of discussions don't bring us any further in solving moral impasses. Toulmin and Jonsen propose to decide these questions not at the level of the principles, but in the context in which the moral-practical questions arise. We leave the clarity of the moral highland and enter the moral swamp, the 'indeterminable zone of practice' that requires 'a reflective conversation with the materials of the situation'. (Donald Schön 1983)
The casuistic tradition, dating back to the 16th century, is suspicious of principles, rights and general moral theories, which are detached from cases, history, precedents and concrete circumstances. A moral judgment requires an intimate acquaintance with the particularity of the situation and history of similar cases. (Beauchamp & Childress 2013, p. 399) The case of Mr. Johnson requires casuistic reasoning, not discussing principles in itself. As a result, the *method* of moral reasoning and research is once again central issue in ethics.[8]
We recognize and appreciate the significance of a method of moral inquiry in Bentham's utilitarianism and Kant's deontology. A method of moral inquiry claims to make moral reasoning transparent, verifiable and impartial and produces outcomes that are justified. Jeremy Bentham introduces the *hedonistic calculus*, or the utilitarian rule of calculation. This method of reasoning ought to evaluate a decision, from an impartial point of view, by assigning a relative weight to interests of all who are involved. It looks a bit (but is not the same) like establishing a price of a product on the market. The hedonic calculus should help to calculate what is the total greatest good for all stakeholders. In a simplistic example, the health benefits for Mr. Johnson is nil (0 points), his suffering increases (-5 points), the hospital saves money (+2 points), other patients benefit from a place on the ICU (+10), and the pleasure of Mrs. Johnson increases with the stay on the ICU of her husband (+3). If we calculate to total pleasures and pains, the impartial conclusion is that Mr. Johnson should be transferred to the nursing ward.

[8] For an overview on casuistry and method in ethics see: Jonsen, Toulmin (1988), Miller (1996), Boarini (2007), Sidgwick (1907/1981), Barron, Pettit, Slote (1997)

Immanuel Kant also introduces a method to establish whether we are dealing with a categorical imperative that is obligatory for everyone and must be followed regardless of the consequences. "Act only according to those rules of life which can also be universal moral laws" is a moral practical test for our maxims, or personal rules of life. If I want to lie when it suits me, then I have to ask myself whether I can reasonably hold that "lying when it suits you best" – a personal practice of fake truth – could be a common moral law that everyone should follow – a general practice of fake truth. For Kant the answer is clear: that is impossible. The distinction between truth and falsehood would collapse. Moreover, I would see other human beings only as means for my own benefit.

Bentham and Kant provide a method of moral inquiry and test which conceive moral judgment as *inductive* or *deductive* judgment. In Bentham's case what is morally just follows inductively from the calculation of interests; in Kant's case it is deduced from a moral principle. In the case of Mr Johnson, however, it is neither inductive nor deductive reasoning which is appropriate, but a *weighing* of alternative lines of action. Each of those alternatives is supported by rights and interests of those who have to bear the burden of the decision. Here we come across moral judgment in its proper sense: it is neither a *deductive* nor an *inductive*, but a *reflective* judgment.[9] In considered, reflective judgments we weigh and balance conflicting rights and interests. Such moral judgments in medical practice are often tragic because the moral costs - the *moral footprint* or *moral trace* (Beauchamp & Childress) - are often high. The measure of 'doing justice to the other' or 'taking sufficient account of the rights, interests and wishes of all involved' provides a method that suits this special character of moral judgment.

The casuistic method seeks an answer when an appeal to a moral principles is inconclusive or impede reaching a satisfying outcome. Toulmin and Jonsen even speak of the 'tyranny of principles', which lead to a moral impasse. "Moral certitude is found at the bottom - in precedent cases and traditions of practical judgment - not at the top in a principle of theoretical judgment." (Beauchamp & Childress 2013: 400) Practical moral knowledge must precede on and prevail over theoretical moral knowledge. To arrive at a shared agreement, Toulmin & Jonsen propose to reason analogously from paradigmatic cases: cases that have proven to be 'satisfying' in the past.

However, here we face several problems. Paradigmatic cases can only lead to imitation or variation. But they cannot answer the question *why* a paradigmatic case should (or should not) merit imitation. The casuistic approach recoils from the question "when is an action morally just?" The casuistic answer is 'satisfying', because this was also the case in the past in similar cases. But then, of course we can repeat the same question on past cases, which evidently leads to a *regression ad infinitum*. In essence Toulmin & Jonsen urge us to give up the idea 'moral justice'. Moreover: what to do with cases without precedent, which are so abundant in biomedical ethics? We may conclude that the turn to practice is an important contribution of the casuistic approach to practical ethics. However, it does not supply us with a satisfying method of moral inquiry, as long as we put our trust in moral reasoning. It helps to establish what is conventional in a certain type of cases, but not to decide what is morally just.

(2) From monological to dialogical ethics

Although we have our doubts about the methodical path of the casuistic approach, its contribution to contemporary practical, domain-specific ethics is of great importance. Casuistic ethics is a variant of *deliberative ethics* in which *deliberation* on morally practical questions plays a central role. Deliberative ethics is a communicative turn in ethics in which moral deliberation is not understood as an inner monologue, as is the case with Kant, but as a communal dialogue of persons involved in a moral inquiry.

A sophisticated type of deliberative ethic is the *Diskursethik* by Jürgen Habermas and Karl-Otto Apel. According to Habermas, it is the method of deliberation that is decisive in answering the question whether a norm or

[9] This is an important contribution of Hannah Arendt to the theory of moral judgment. In her contribution Arendt discusses Kant's *Critique of Judgment*. Arendt claims that we can understand moral judgment best as reflective judgment in the sense discussed by Kant in his *Critique of Judgment*.

decision is justified and universally valid and may count as exemplary for others. For Habermas, any deliberation - or moral-practical Diskurs - must meet two conditions if it is to be regarded as a measure of justice. In the first place, the deliberation must be open to the participation of all those who are affected by the decision under investigation, or their representatives - the principle of sufficient participation. Second, the outcome of the deliberation must have the free consent of all who are affected by the decision and must bear the consequences of it - the principle of universality. Habermas realized that in practice these conditions will not always be met. That is why he calls them *counterfactuals*. Counterfactuals serve as a critical test for any outcome of moral deliberation that claims validity and universality.
Deliberative ethics thus focuses on the reasonableness of the moral deliberation in which moral inquiry is carried out. Each conclusion claiming the validity of a norm should be the outcome of an argumentative consensus.
Just as utilitarianism and deontology have their vulnerable side, so has deliberative ethics. For example, it is not self-evident that argumentative consensus among participants in a consultation is the same as moral justness of a judgment. Assuming that the intensivists and nurses would agree on due consideration that it would be better for their peace of mind if Mr. Johnson would be transferred to the nursing ward, there would be unanimity and unambiguity, but we would still question the justness of the judgment. Even if Mr. Johnson agreed. In the end, the ultimate question remains whether 'justice is done to the other', or ‘if the rights, interests and wishes of all those involved are taken sufficiently into account'. The unanimity of the participants in the deliberation may be a necessary, but not a sufficient condition.

(3) Who decides?

The step from monologue to dialogue in ethical theory is of great importance, because in principle it opens the way for moral learning processes in everyday practices. We can speak of the democratization of moral judgment, in which establishing moral justness is no longer the privilege of authorities - from priest to physician - but of anyone with a moral common sense. This is important not only in answering the question who ultimately decides on Mr. Johnson’s fate. It is also essential for answering the question how to develop profound, valid, practice-relevant moral knowledge. The question is then, who should participate in an inquiry of moral issues? What does a moral practice of inquiry look like? Who inquires, and who decides on moral justness?
In classical science theory the answer to this question is clear. Inquiry is a practice carried out by researchers and experts. Researchers and experts collect data, formulate hypotheses, provide research design and develop theories. Scientists subject each other's theories and publications to criticism among their peers. Scientists form a community of inquiry, which includes their own scientific practice. Moral practices outside the realm of science can be the subject of research by social scientists, but moral agents in these practices never become part of scientific community of inquiry itself. In the classical model scientists are a community of inquiry *on* moral practice, but never *in* moral practice.
Ethicists sometimes also holds this view, especially when it comes to research ethics. Normative inquiry by ethical experts is often the source of biomedical ethics. Experts in ethics pass on their scientifically won arguments to the ethical 'layman'. In order to guarantee the rationality of the ethical research, ethical 'lay people' are seen as 'judgmental dopes' (Garfinkel) who must be banned from research practice. Elizabeth Vroom, director of the Dutch Duchenne Project, speaks in this regard about 'the barbed wire around ethical committees'. She points out that in the Netherlands recently 'the distance between society and medical ethics committees has been increased by only admitting members who have a PhD in research ethics.' (Vroom, 2018))
In this model of developping moral knowledge, intensivists and nurses should submit their moral question to an committee of ethical experts who, after careful consideration, would reach their conclusion and hand it over to the Intensive Care Unit.
Deliberative ethics opens a way to reconsider this community of moral inquiry and the relationship to the practice it investigates in two ways. The first revision consists in the extension of the community of inquiry that Habermas also proposed in his *Diskursethik*. According to Beauchamp & Childress, anyone with life- and

professional experience is at least *prima facie* considered an 'expert'. His or her arguments are the starting point of every moral consideration and reflection. "Ethics", according to Ten Have, Ter Meulen and Van Leeuwen, "is not a specialist matter, it stems from the desire of people to understand themselves in a better way. That is one side of the coin: the possibility of ethics lies in the moral experience available to each of us." (Ten Have 2009) This means that the community of moral inquiry is in principle open to anyone who is capable of moral judgment. That is not to say that everyone has already an elaborate and considered moral judgment in a case. It simply means that everyone is able to *form* a reasonable moral judgment.
The second revision is that moral research is carried out in practice. That's what happened at the Intensive Care Unit. Intensivists and nurses participated as co-researchers in a moral inquiry of the impasse that arose in their own practice. The inquiry not only yielded an outcome that led to a just solution of their moral impasse, but also to a deeper understanding of complex moral questions about medical technology, autonomy and end of life. The ICU case is an example of deliberative ethics that results in establishing of a community of moral inquiry of all nurses and intensivists. It creats a community of moral inquiry *in* a community of care practice. (Argyris, Putnam, Smith, 1985)
The appeal to everyday moral competences faces however serious objections in biomedical ethics. Bioethicists complain that too little account is taken of the reality that biomedical questions ask too much of our everyday moral consciousness and expertise. "People still trust too much that moral reflection and judgment are a competence that belongs to everyone. This overlooks the fact that the most urgent moral questions involve problems which on the one hand are not only of interests to the sciences but are of significance to society as a whole. On the other hand, they are of such a complexity and difficulty, that additional and specific competences are needed to adequately research and address these questions." (Düwell, Steigleder, 2016: 35) This objection is not without reason. A way out if this dilemma is to distinguish between *ethical reflection* and *moral deliberation*. Ethical reflection and moral deliberation are both part of a deliberative ethic. Both are a praxis and thus ultimately aimed at a praxis. Moral deliberation is about examining the moral justness of an action; ethical reflection is about moral points of view and expert arguments that are brought into play in moral deliberation. What is decisive, however, is that moral judgment and inquiry are not outsourced to experts, but that professional and civic practice itself is made fruitful for the development, discovery and invention of moral knowledge.

(4) From moral deliberation to moral knowledge

In classical normative ethics, moral knowledge comes about through the work of brilliant thinkers such as Bentham, Kant and others. In biomedical ethics until the 1970s doctors themselves established norms and rules for moral action. Deliberative ethics focuses on the moral reflection among those involved - specialists and non-specialists - as it often takes shape in moral deliberation. But with the deliberative ethics and the emphasis on deliberation, a new question also arises: how do we arrive at normative valid and relevant moral knowledge which transcends the limits of moral deliberation? Can moral reflection on questions such as at the intensive care contribute to a normative moral theory? Is there a path from *ethics-based practice* to *practice-based ethics*?
Outcomes of moral deliberations are what data are to scientists: they provide an answer to a concrete question, but they themselves do not yet offer a normative moral theory. There is a big gap between insights that arise at the micro level of moral deliberation and the major moral questions of biomedical and bioethics at an institutional (macro) level. According to the German philosopher Hans Jonas (1979), modern ethics is too focused on questions of action, which makes it incapable of answering the new moral challenges of our time. The prescriptions of the ethics of action are aimed at specific situations and close interaction between human beings. Obligations to future generations and non-human nature however, lie, according to Jonas, beyond the horizon of an action-based ethics. The question then is how to produce moral knowledge that bridges the gap

between action-based ethics and an institutional ethics. Since 2004, the word *moresprudence* has been brought into play, which shows us a promising path.[10]
Moresprudence is a set of moral guiding casuistry, which in confrontation with state-of-the-art moral theory leads to domain-specific and guiding moral knowledge. This confrontation leads to what John Rawls (1971) calls a *reflective equilibrium*.[11] This reflective equilibrium on the one hand sharpens existing normative insights and arguments (norms, values, principles, rules, theories), and on the other hand give rise to prescriptions for institutional practices. For example, casuistic moral research on privacy at an institution of social work, carried out by ethical specialists and professionals, led to an in-depth insight into the relevance of the protection of privacy in public (care) institutions, but also to resources and tools for practices of social care. Whether moresprudence has a future remains to be seen. In any case it is an attempt to shape deliberative normative knowledge, which claims justification and validity, guides institutional practices, enriches ethical theory, and is practically relevant.

9. Ars inveniendi: towards an experimental ethics

"Many wonders in this world, blow your minds,
But nothing is more bewildering than man."

Sophocles, Antigone

As our children will tell us, there is something tragic about all our moral musings: it always comes afterwards and too late. Ethics has never been ahead of its time, and if it believed it was, it always succumbed to totalitarian temptation. For a long time, this was not a problem for ethics. The basic pattern of nature, the world and man were unchanging. Tomorrow's world was the same as the world of yesterday. This brings Hans Jonas to the conclusion that traditional ethics could rely on non-cumulative behaviour. The human condition of man was always the same, and people over and over again acquired the same moral repertoire. Non-cumulative ethics correspond to non-cumulative behaviour. (1979: 28) In the old, premodern world, there is no room for the growth of moral knowledge.
With modernity and its explosive growth and possibilities of technology, this human condition turns 180 degrees. Our only certainty yesterday was that tomorrow's world will be different from today's. One reason why medicine has awakened ethics from its dogmatic slumber is that it becomes increasingly clear that moral questions are not limited to the relationship to one's neighbours and actions. This is the lesson Hans Jonas teaches us. Our Intensive Care case is a telling example. Twenty years ago, Mr. Johnson might not even have made it to Intensive Care. Ten years ago, he would have died before the predicament bothering intensivists and nurses today could come up. The revolution in medical technology, pharmacy and therapy then increased Mr. Johnson's chances of survival, and reduced his chances of dying, leaving intensivists, nurses and Mr. Johnson to the question: "What to do?". Calling for answers, they found out that their mainstream voicemail was silent.
Human re-engineering and human bio-enhancement – following a revolution in pharmaceuticals, bioelectronics and genetics – led to mind-boggling vistas for which our moral brain, and our conventional production of moral knowledge, is hardly prepared. We are urged to think about making an end to a "fulfilled, accomplished, finite life," while the "unfinished, infinite life" according to some is within our reach. Anyone who today buys an egg at a supermarket is asking bioethical questions that simultaneously concern the rights

[10] See for the Dutch discussion: Buitink J. Ebskamp, J., Groothoff (R.), (2012), Kanne, M. & Grootoonk, E. (2014), Rost van Tonningen, F., Karssing, E. (2012), Verstegen, G. (2016), Wirtz, R. & Karssing, E.D. (2012), Wirtz, R.
[11] See: Daniels, N. (1996), Rawls, J. (1971).

of the chicken and the future of humanity. A world in which knowledge increases cumulatively requires an ethics that cannot be satisfied with imitating current moral knowledge. We have to be prepared to invent new moral knowledge, sometimes on the spot. What we urgently need is a moral *ars inveniendi*.
Surprisingly the example science can be of service to us. Just as the experimental opening up of the world is characteristic of science, the experimental opening of our moral universe is characteristic of a future ethic. This is not a plea for moral experimentation (Kwame Appiah) but for an experimental ethics. With experimental ethics we take part in a development in ethics called 'empirical ethics'.[12] Empirical ethics tries to develop normative ethical insights in combining ethical and non-ethical theory and empirical research. With experimental ethics we wish to stress the transformational nature of ethical inquiry. Unlike in the natural sciences, moral deliberation is not possible without real-time transformation of the moral world in which we live and work and which we share. The moment we started with intensivists and nurses discussing 'how do you know that an action is morally right?', their moral universe changed. Experimental ethics is deliberately changing moral worlds in the name of justice. It means that moral questions are investigated, collected and converted into moral knowledge in an instructional meeting of minds of ethical specialists, professionals and citizens. We have already outlined above how this is in line with contemporary developments in ethics. But that does not exhaust our moral resources. "Today," writes Hans Jonas, "man is increasingly the creator of what he has made, does, and can do. Above all he prepares what he will be able to do in the future." But who is this 'man', Jonas asks himself, and then points out that we are dealing here, not with an individual, but with a *collective* - a common process of technical and moral learning.
The moral intelligence of our society does not increase because individuals become smarter, but because the social environment we organize allows for intelligent moral learning processes. In our society, these social environments are *organizations* such as hospitals, nursing homes, social care services, the police force, the army or the inland revenue, etc. Over the last century, we have designed our organizations to be unimaginably effective in a technical sense. In doing that, we have introduced a certain imbalance, especially the prejudice that what is good in a pragmatic sense is also just in a moral sense. Experimental ethics, building on contemporary insights from organizational ethics, organizational learning and empirical research, transforms public organizations into guardians of justice, increases our moral capital, and helps to build our society as a moral commonwealth (Selznick).
As our children, just by being there, teach us: it all starts with allowing for that one, decisive transformative question – "What is here and now morally just to do?". This question helps us see our world under the perspective of justice. It puts me under a spell: what counts is not the world in which I live, but the world in which I want to live.

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[12] See for instance: Ives, Dunn, Cribb (2017), McMillan (2018), Widdershoven, McMillan, Hope, Van der Scheer (Ed.) (2008).

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