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and Social Responsibility

Edited by
Nancy M. P. King
and Michael J. Hyde



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Editors' Introduction

Nancy M. P. King and Michael J. Hyde

THE CALL TO CONVERSATION

In November 2001, the newly formed President's Council on Bioethics (PCB) was charged with deliberating about the benefits and burdens of biotechnology and then publishing these deliberations as a way to "spark and inform public debate." Then-President Bush appointed the noted physician and conservative bioethics scholar Leon Kass to chair the PCB, and charged it, among other things, "to undertake fundamental inquiry into the human and moral significance of developments in biomedical and behavioral science and technology; to explore specific ethical and policy questions related to these developments; to provide a forum for a national discussion of bioethical issues; [and] to facilitate a greater understanding of bioethical issues." (Executive Order 13237). The PCB's charge continued: "The Council shall strive to develop a deep and comprehensive understanding of the issues that it considers. In pursuit of this goal, the Council shall be guided by the need to articulate fully the complex and often competing moral positions on any given issue, rather than by an overriding concern to find consensus. The Council may therefore choose to proceed by offering a variety of views on a particular issue, rather than attempt to reach a single consensus position."

This mandate—to consider deeply and discuss fully—is unique in the long history of presidential bioethics bodies. When President Obama's new Presidential Commission for the Study of Bioethical Issues began its work in July 2010, a return to the more pragmatic mandate of prior commissions had already been announced: "The Commission shall pursue its work with the goal of identifying and promoting policies and practices that ensure scientific research, healthcare delivery, and technological innovation are conducted in an ethically responsible manner." (Executive Order 13521) Earlier presidential bioethics bodies often succeeded in reaching consensus about policy directions, but on more than one occasion members reported agreeing on conclusions while disagreeing profoundly on the reasoning used to reach them. This type of policy consensus is certainly sufficient for some purposes, but it is not necessarily supportive of critical reflection on questions and issues in need of public input. For this reason, despite

its appearance to some as a “debating society,” the now-disbanded PCB modeled a practice of public discourse that others may come to miss (Hyde 2008; 2010, pp. 211–41).

Through this volume we seek to challenge scholars in bioethics and communication to promote meaningful public discussion of how science and medicine affect and should affect our lives. We’ve gathered here a range of voices to explore the role of democratically-oriented argument in promoting public understanding and discussion of the benefits and burdens of biotechnological progress, with the goal of developing and applying a collective wisdom to the trajectory of modern biomedical science. The communication and rhetorical practice of such public moral argument requires experts from the sciences and the humanities to step beyond their respective disciplinary boundaries and assume the ethical responsibility of translating their expertise into forms that help promote public conversation about important matters of concern. The essays collected and organized here are our first foray into the development of a collective voice, made possible by the workings of public moral argument. The last essay, authored by two nationally recognized college debate scholars and teachers who reviewed the essays, offers a critical analysis of what their colleagues did and did not say about the nature of “the public” and its role in moral argument. Public moral argument is certainly called for in today’s ongoing biotechnology debate. Our volume is a response to this call.

PUBLIC MORAL ARGUMENT¹

Scholars of public moral argument make their living by studying the symbolic capacities of human beings, especially as these capacities show themselves in situations that call for the production of discourse as a means for coming to terms with the matters at hand. This call emerges from some perceived exigency, or what Bitzer (1968) terms “an imperfection marked by urgency.” An exigency is rhetorical when it “invites the assistance of discourse” as a way of implementing change that can result in some “positive modification” of the imperfection (pp. 6–7). When language is used to respond to a rhetorical exigency, its technological nature becomes obvious; in these situations discourse is being employed as a tool, an instrument, a means to an end. In this respect, human language can even be described as a biotechnology.

Research in the ethics of health communication examines how language is used as a technology—in particular, how it informs the interpersonal dynamic between physicians and those whom they are obliged to serve. The basic goal of this research is to discover how the communicative and rhetorical competence of the involved parties (e.g., their ability to construct informative narratives) can be perfected in order to produce measurable, effective, and good health-care outcomes. Such research, however, is not restricted to the interpersonal settings of the physician/patient/family

encounter. The well-being of the body politic of democracy requires that a process like informed consent transcend the institutional boundaries of the medical establishment in order to educate the citizenry about biotechnological progress. This educational process encourages the production of whatever public moral argument may be necessary for understanding and dealing with both the benefits and burdens associated with this progress and its perfectionist impulse.

Scientific medicine was born with the help of public moral argument. Trained by the Sophists of their day, Hippocratic physicians involved themselves in this communication and rhetorical process when defining and defending their *technē* during public debates and while treating patients. For these first men of scientific medicine, the biotechnology of language served the important purpose of calling into being a "medical public" that, owing to its new scientific education, could stand with the Hippocratic physicians in their initial fight against traveling sophistic lecturers and those quack doctors whose practice still admitted the use of magical charms (Edelstein 1987, pp. 87–110; Laín Entralgo 1970, pp. 139–170; Frede 1987, pp. 232–239; Jonsen 1990, pp. 8–9; Hyde 2001, pp. 124–129).

Plato commended this rhetoric of science in his *Laws* (IV, 720c-e). Hippocratic physicians employed it, however, so as to be done with it. As noted in the Hippocratic text *Decorum*, the wisdom that these healers possess and that they must constantly seek as their first priority makes them "the equal of a god. Between wisdom and medicine there is no gulf fixed" (Jones 1923a, V). The point is put another way in the Hippocratic *Law*: "There are in fact two things, science and opinion; the former begets knowledge, the latter ignorance" (Jones 1923b, IV).

The birth of scientific medicine sharpened this long-standing dispute between the arts and humanities and the sciences over the degree of respect that each owes the other. The biotechnology of utmost importance to medicine today is arguably not the word, but rather those other tools that enhance the scientific capacity of medicine to prevent, treat, or cure a host of life-threatening illnesses: tools like immunization against childhood virus diseases, antibiotics for bacterial infections, surgical procedures for organ transplantation, life-sustaining ventilators, respirators, and dialysis machines, cancer chemotherapy, genetic engineering, and embryonic stem cell research. The view of medical science as exclusively to save, enhance, and extend life presents a false but persistent dichotomy: that patients must choose either "the doctor who will cure you or the one who will hold your hand and talk to you." There is need for both—and even as biotechnology advances, it is becoming harder to believe that either can happen without the other. Human beings desire both cure and care (Brody 2009; Hyde 2006, pp. 1–10).

The goals of biomedical technology thus incorporate a key public concern about the meaning of being human. When the case of Terri Schiavo first made news, many bioethics scholars had the initial reaction: "But we've already

solved that problem!" Readers will recall that Terri Schiavo was a young woman who unexpectedly collapsed, and after a period of time was diagnosed as being in a permanent vegetative state. She had no formal advance directive. After an aggressive search for means to restore her awareness, cognition, and dignity, her husband concluded that she could not recover, but her parents concluded that she had been misdiagnosed and was treatable. When the legal battles began over who spoke for Terri, she joined the short list of young women whose medical fates have shaped American views about the life worth living: first, in the 1970s, Karen Ann Quinlan; then, in 1990, Nancy Cruzan; and now, in the 21st century, Terri Schiavo.

Why did bioethics scholars think that the Terri Schiavo problem had been solved by Karen Quinlan and Nancy Cruzan? By enabling the long-term survival of patients in various states of permanent unconsciousness, technology had created both a new diagnosis and a new dilemma. The stories of Karen Quinlan and Nancy Cruzan spurred profound legal and policy changes to address the new diagnosis and the role of families in making health care decisions for adults newly unable to decide for themselves. Yet as Art Frank (1995, 2004) has observed, when patients and families find themselves facing this dilemma, it is always new for each of them. Therefore, the value placed on human life and human dignity in that diminished state must be adjudicated anew, in every new instance, through respectful moral discourse. This discourse often involves a great many stakeholders seeking a voice: not only the patient and the patient's legally authorized decision-maker(s), family, and friends, but also the health care team, the institution, the state, advocacy groups, scientists, and scholars with different perspectives, health insurers paying the bills, and more.

Public moral argument is thus called for to elucidate society's role, both at the end of life and about the ends of life. That role is messy, disputed, limited—and essential. Much discussion of biotechnological advances in the U.S. rests on the rights of individuals to make autonomous choices and on societal decisions not to interfere with willing buyers and sellers. We might simply acknowledge that this (admittedly incomplete) *laissez-faire* position is the role that society has chosen, that it has particular consequences, and that we could, but need not, choose otherwise. But the current, intensifying democratic debate about related matters, such as health insurance reform, has begun to broaden our public vision, to include awareness of cost, a sense of collective responsibility to help others, and the need to work together to set limits we can live with. Science and society have built an exceedingly and increasingly complex community around biomedical technology. Scholars, scientists, policymakers, and the public all therefore need to be able to talk together in this community. This important effort brings together the enterprises of bioethics and communication ethics, with their shared interests in the health of human beings and in the social, political, and technical ways of using language to affect health and health care; hence the essays in this volume.

THE ESSAYS

These essays cluster around three complementary themes, which evolve as the reader progresses through the volume. Our organization of chapters into three parts—Public Moral Argument and Social Responsibility, Moral Relationships and Responsibilities, and the Media, the Public, and the Person—represents our best attempt to trace these themes. However, thoughtful readers will readily recognize ways in which the themes are braided together throughout the chapters, reflecting their salience both for scholars and for public discourse.

One theme, explored perhaps most explicitly by Moreno, Zarefsky, and Coughlin et al. in Part I, examines moral language and moral relationships: that is, the means by which moral engagement is fostered in American society. There are necessary tensions between moral authority and argument and social and political decision-making. Both advocacy and consensus-seeking test the taut balances that democracy requires. Much more attention should be paid to the complex role of uncertainty and fallibility in the face of the need for decision and action. Existing models of public moral argument need to illustrate and teach responsible advocacy and decision-making under uncertainty, in order to model productive relationships between scholars and society. New discourse models may be needed as well, to ensure that democratic decision-making can flourish in a marketplace shaped as much by technology as by ideas.

A second theme addresses the nature of selfhood and moral agency. This is the theme captured in Part II by Churchill, Dresser, Parrott, and Juengst. The language used in discussions of “human nature” and its relationship to critical concepts in biomedical technology, like enhancement and genetics, stems from social, cultural, and religious understandings that merit careful examination, for several reasons. They may be based on outmoded or discriminatory views that should be uncovered and cautioned against. Alternatively, they may reflect rich, nuanced, flexible, and pragmatic perspectives that can expand our collective vision and therefore should be emulated and promulgated. Listening to how people actually talk, and learning how people actually behave, in light of the new knowledge about ourselves that biotechnological progress can provide are essential components of responsible genetic science. In other words, paying attention to what we say, how we think, feel, and act, helps us understand who we are. If health communicators are to play a meaningful role in helping the public make use of information about a set of critical issues—the ways that humans respond to technology, understanding the genetic contribution to health and illness, or the effects of treatment or enhancement on the sense of self—then discourse must be mutual and multidirectional.

A third theme focuses on moral responsibility in public discourse. As elucidated by Condit, Giles and Krcmar, Lundberg and Smith, and most provocatively by Elliott, the scholar's responsibility lies not only in calling

others to account (whether through critiques of manipulative media like advertising or by highlighting the need to link policy meaningfully to accounts of the personal and the public) but also in making the hard choices and taking the risks that can accompany this essential public role. Thus it is essential to consider the responsibility of the individual scholar to address ethical issues that arise close to home, even when they can disturb scholarly distance and complacency; the responsibility of scientists, bioethics scholars and practitioners, and journalists to “get it right” as teachers of the general public; and the responsibility of respectful engagement, even when forging genuinely responsive relationships requires making time and taking risks. Challenging the scholar’s traditional role of careful, dispassionate researcher and teacher goes to the heart of bioethics, asking that those who preach ethical behavior must also practice it, in every aspect of their professional lives. What this means for the social role of bioethics remains to be discovered—or, rather, created—by the writers and readers of this volume and others like it.

HEALTH CARE AND MORAL DISCOURSE TODAY

The need to consider carefully the meaning of responsible public moral argument—and the responsibility to achieve it—could hardly be more pressing than it is today. Moral argument and moral relationships are increasingly articulated not only in words, but in the images, technologies, and settings by which words are framed and delivered. How each of us uses and responds to data and devices, and to the people we encounter and affect by and through them, are key concerns in public health, health care, and health research—and in our social engagement with all three. This is the stuff of bioethics: not merely a set of issues, topics, and cases, but the broadest and deepest consideration of the human implications of the life sciences, beginning—and ending—in our collective and continuing conversation.

NOTE

1. In this section we draw on Hyde & King 2010.

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Part I

Public Moral Argument and Social Responsibility

