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A Search for the Foundations

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TABLE OF CONTENTS

PREFACE

This book, final result of a long term effort who coincides with my scientific coordination of "Ethics and Medicine" Project of Lanza Foundation during its first ten years, collects most theoretically relevant papers of the International Meeting on Clinical Bioethics, held in Padua in 1999, October 19-23.

The Meeting aimed to provide the occasion for comparing theoretical models and formative experiences on Clinical Bioethics, since this was the specific issue focused throught the interdisciplinar seminars organized within the "Ethics and Medicine" Project of Lanza Foundation.

I'm profoundly indebted to the distingueshed colleagues for giving their contribute to the intensive programme of the Meeting both lecturing in plenary sessions on philosophical aspects and analyzing in small groups particular questions concerning Clinical Bioethics.

Most of them moreover have stimulated and enriched the reflection with their experiences in dealing prestigious Centres who have devoted a systematic attention to the foundation of the Clinical Bioethics. I'm particulary grateful to E. Pellegrino and his Center of Clinical Bioethics at the Georgetown University; in particular to R. Dell'Oro; to D. Gracia, director of the Master in Bioethics at the Complutense University in Madrid; to H. Ten Have and his Departement of Ethics, Philosophy and History of Medicine at the Catholic University of Nijmegen; to M. Parker and his Institue for Ethics and Communication in Healthcare Practice at the University of Oxford; to B. Cadoré and P. Boitte and their "Centre d'Ethique Médical" at the Catholic University of Lille; to J. F. Hillhardt and his Zentrum Ethik und Recht in der Medizin at the Albert Ludwigs University of Freibourg; and to P. Drigo, L. Chiandetti and D. Gobber, core-group of Bioethics Committee of Pediatrics Departement of University of Padua.

I hope that the scientific committee of Lanza Foundation will be satisfied in verifying that the specific focus of the Meeting, oriented towards a Clinical Bioethics integrating "internal morality" guided by the goals of clinical practice and "external morality" guided by the wider cultural context, continues to give a stimulating euristic perspective in the international debate.

I want to thank G. Minozzi and R. Pegoraro, past President and President of Lanza Foundation and L. Mariani, president of Scientific committee of Lanza Foundation as well as P. Benciolini and A. Autiero members of the Scientific committee for their suggestions and supports.

I want to thank finally R. Zago, A. Bonanno and K. Calzolari for their precious secreterial support.

Padua, April 2004.

Corrado Viafora

CORRADO VIAFORA

INTRODUCTION

CLINICAL BIOETHICS: A SEARCH FOR THE FOUNDATION BEYOND THE "APPLIED ETHICS" MODEL

Even if from different perspectives, authoritative analyses agree on relating the transformation of medical ethics which occured during the last thirty years to the very transformation undergone by the practice of medicine itself (C. Viafora, 1996).

Sociologists (D. Fox, 1979) have pointed out that medical ethics - understood as the codification of standards of professional conduct - had remained for a long time "segregated" from larger shifts affecting the rest of culture. That "segregation" was justified by the predominant conviction that the codification of medical conduct is the exclusive competence of physicians. Indeed, one can say that medical ethics was the ethics of physicians (D. Von Engelhardt, 1995).

Although for Southern European cultures the emphasis is still on professional deontology, in Northern European as well as in North American countries medical ethics has been progressively framed - at least since the 1960s - within a larger context defined by the word "bioethics".

The first meaning of this shift from traditional medical ethics to bioethics is the new attention given to ethical issues which fall beyond the boundaries of the physician-patient relationship. These issues include, among others, the relation between health care professionals, clinical research and experimentation on human subjects and criteria for the just allocation and distribution of medical resources.

The shift, however, is not confined to the emergence of new topics. It is also of a more formal nature for it includes a new way of approaching ethical quandaries. Bioethics can be seen historically as the inevitable result of the application to the biomedical field of those principles such as pluralism, moral autonomy, democracy and human rights which have been influencing the culture of Western countries for at least two centuries. In this perspective bioethics signals the end of the segregation of medical ethics and its initiation into the era of modernity (D. Gracia, 1989; 2001).

Given that this is the meaning of the transformation from medical ethics to bioethics, it is not difficult to understand why bioethics has been fundamentally understood as a form of "applied ethics." Once they have entered into the process of modernity, medical practice and health care become cultural phenomena embodying the rules of the larger context to which they belong. Consequently, bioethics can very well be conceived as

> "the application of theories, principles, and general ethical rules to the particular problems of therapeutic practice and of biomedical and biological research." (T. Beauchamp and J. Childress, 1983).

This model of bioethics seems to be defined by the search for an *external* point of view, i.e., one which can critically look at medical practice only because it remains in an outside position, so to speak. Yet, the emphasis on such an external perspective is not without consequences: to start with, the ethical reflection ends up losing contact with the clinical context and the medical practice (B. Cadoré, 1997). Moreover, the physician-patient relationship, rather than being viewed for what it is in itself, becomes prey of contractualist models of interpretation, that is, models which being foreign to the particularity of the physician-patient relationship, cannot account for its specific intentionality (W. Reich, 1993; E. Pellegrino and D. Thomasma, 1988). What is problematic in this situation, however, is not only the progressive alienation of ethical reflection from concrete clinical experience. Given the pluralistic nature of our society, it has become difficult to find an external perspective shared by everyone that could function as an impartial point of view. Such a perspective would merely consist on the adoption of a "neutral moral language." (T. Engelhardt, 1986). For its critics, the emphasis on a presumed neutral morality carries, in reality, the mask of a very specific, and by no means, neutral ideology, namely, the "ideology of pluralism" (C.S. Campbell, 1996). Such a position mistakenly pretends to separate the self from "the sources of his identity" (Ch. Taylor, 1989) and can only result in a "minimalistic" ethics completely unprepared to deal with the ethical challenges of medicine and health care (D. Callahan, 1980).

But is it possible at all to keep together *proximity* in clinical practice with critical *distance*?

European approaches to clinical bioethics tend to solve the problem by searching for a theoretical structure that tries to interpret the ends of medicine *from within,* yet assures at the same time the conditions for critical distance. To put it in a somewhat technical way, the problem is to integrate "internal" and "external" morality: the former flows directly from an intepretation of the ends of medicine, the latter conveys the juridical framework and the culture which underlies the practice of medicine (Henk Ten Have, 1995).

Bioethics reflects the polarization of the broader ethical debate between an ethics centered on the notion of *right* and an ethics of the *good.* The polarization identifies, respectively, the libertarian and the communitarian positions. According to the first, the debate, both in ethics and bioethics, must refrain from referring to a particular notion of the good life and simply address the issue of how it is possible to assure the peaceable co-existence of different positions. The other position views the discussion on the many notions of "the good life" as central to the debate: because different conceptions of "the good life" always underlies a certain biomedical practice. It is an illusion to think that it is possible to focus on what is right on the condition that all the notions of the good be neutralized.

Perhaps the polarization just mentioned can be recast in terms of a counterposition between a *procedural* approach in which the determination of what

is right is reached without reference to a particular moral tradition, and a *substantive* approach, which denounces the former as fundamentally abstract and emphasizes the social integration of the individual and the important role of moral traditions (McIntyre, Sandel, Ch. Taylor, S. Hauerwas).

The theoretical structure of medical ethics should be re-defined by trying to integrate internal and external morality. Indeed, an important contribution to the debate may come from a reflection that tries to hold together both rational procedures based upon principles and ethical convictions inspired by particular traditions. In various guises, this argument leads toward a confrontation between the universalist claim attached to procedural rules and the recognition of positive values belonging to the historical communitarian contexts of the realization of these same rules. In this sense, the universalist claim and the contextualist claim have to be maintained together, entrusting to the practical wisdom of "moral judgment in situation" to surmount *from within* the possible antinomy of the two (P. Ricoeur, 1993).

The reference to the specific function of moral judgment and to the importance of practical wisdom as central components in the integration of external and internal morality is not entirely new, but rather carries on a central trait of Western ethical tradition with its emphasis on the essential role of deliberation. In today's clinical context the traditional notion of deliberation must be perfected and integrated by a precise methodology of clinical judgment. The more disciplines and cultural perspectives get involved in the ethical analysis of clinical quandaries, the more emerges the importance of deliberation reached through interdisciplinary dialogue, and the more clearly appears the need for both, a methodology of clinical judgment (D. Gracia, 1991; B. Cadoré, 1995; A. Autiero, 1995; C. Viafora, 1999) and the education of health professionals (P. Poletti, 1995; S. Bastianel, 1997).

These premises can suffice in sketching out the scope of this book. The title itself suggests a model of *clinical bioethics* capable of bringing together two attitudes, i.e., a critical view of health care practice and adherence to the intrinsic ends of medicine. If the term "bioethics" conveys the meaning of the former attitude, the adjective "clinical" expresses the fundamental intention of the latter.

With this concept of clinical bioethics in mind, the book pursues the following aims: (i) to present and confront different foundational approaches to clinical bioethics (ii) to identify the conditions under which it becomes possible to integrate internal and external morality.

After a comprehensive introduction, with particular reference to the ethical crisis in the post-modern age (D.Thomasma), the first section presents two approaches which give an alternative interpretation of the shift from Medical Ethics to Bioethics: the approach proposed by E. Pellegrino (an exemplary internalist approach) focusing on redefining the "good of the patient", which is the basic principle of the Hippocratic tradition and the approach proposed by D. Gracia, (an exemplary externalist approach) focusing on the foundation of Medical Ethics in the perspective of the democratic evolution of modem society.

> "Bioethics - D. Gracia affirms - is a process of deliberation about the individual and collective ends of human life. Consequently, it can not be constrained to the limits of hospitals and schools of medicine. The goals of human life are primarily social and political. And because the ends of medicine are derived from these goals, it is necessary to conclude that bioethics is engaged inevitably in matters that occur out of the health care professions".

Then, we take into account three different contributions, centered on the introduction of new approaches to Clinical Bioethics, which propose specific perspectives in integrating internal and external morality: *a communitarian approach* based on the dialectic interaction between anthropology and ethics (H. Ten Have); *a hermeneutical approach* based on the consideration of the action as a subject to which apply the main rules of the interpretation (B. Cadoré); and *a deliberative approach* based on the dialogical relationship between individual and community (M. Parker).

The second section of the book aims at showing the conditions required to integrate internal and external morality: this approach to the clinical bioethics has been suggested by H.Ten Have (H.Ten Have, 1995, 2001), it justifies the relevance given in the structure of the book to his contribution. In programmatic attempts and debates pursuing the aim of connetting internal and external morality, H.Ten Have identifies the follow steps. The first step is to examine the internal standards and normes that govern the medical practice in the different care contexts in order to obtain a better understanding of the internal morality in terms of good clinical practice. The second step is to analyse and interpret the external morality in order to understanding the cultural contexts regarding health, disease, disability, dying, illness, prevention and health care. These steps requires making use of the results of specific empirical investigations. The third step is to create a new theoretical approach to health care institution, since it is the concrete context in which internal and external morality interact. The modern health care system is a complex network of practices based on different values and using different methods. Focusing the neo-aristotelian notion of practice (A. MacJntyre, 1982) as theoretical starting-point, H.Ten Have suggests as heuristic instrument to frame the ethical problems of the modern health care system the distinction proposed by U.Jensen: the *disease* oriented practice; the *profession* oriented practice and the *community* oriented practice (U.Jensen, 1987). The fourth step is to develop, in the perspective of this community oriented approach, a new conception of clinical bioethics aimed to integrate the normative approach with the ermeneutical approach. According to H.Ten Have, only this integration ("interpretive bioethics") can illuminate and clarifies the complex interaction between the internal and external morality of health care practice.

In this perspective, two series of reflections are offered: (i) the first one concerns the redefinition of the goals of medicine both in relation to the subjetivisation of health (R. Mordacci, P. Zatti); and in relation to the rationalisation of the health care system (P. Vineis, H. Jochemsen). If the reference to the current perception of the health and the evolution of the health-care system leads us to compare internal and external morality in relation to the goals of human life, the last part of the book is

focused on ethical judgment, with particular reference to its epistemological statute (R. Dell'Oro), and to the institutional context of clinical practice (P. Boitte, C. Viafora).

A CRITICAL EXAMINATION OF THE "INTERNAL MORALITY" OF MEDICAL PRACTICE: A SYNTETICAL ACCOUNT OF THE CURRENT DEBATE

In recent times the debate on redefining the goals of medicine has attracted a considerable attention. (M. J. Hanson, D. Callahan, 1999). Some problematic issues have contributed to analyse in depth the normative meaning of the medical practice: physician - assisted death, managed care, judgments of medical futility.

An interesting issue of "The Journal Medicine and Philosophy" edited by R. Veatch and F. Miller (6, 2001) has esamined in particular the concept of the internal morality of medicine with the aim of clarifing its meaning and value. This issue, conceived as lively symposium, proposes two papers "pro" thesis of internal morality, and two papers "contra". In the first paper "pro", E. Pellegrino (E. Pellegrino, 2001) in a revised version of a paper delivered at International Meeting on Clinical Bioethics held in Padua (october, 1999), now published in this volume, offers an explication of the internal morality as graunded on the phenomena of medicine, with particular reference to the nature of the clinical encounter between physician and patient. In the second paper "pro", F. Miller and H. Brody (F. Miller-H., Brody, 2001) develop a critical examination of the conception of the "internalist" perspective advocated by E. Pellegrino toward an understanding of the internal morality notion in an "evolutionary perspective". That evolution for them takes place in dialogue with the human history and culture.

The two papers "contra" rejects the internal morality concept on the basis of the following critical considerations: (i) we dont need an internal morality attributable to medicine "qua" medicine, we can resolve the moral problems in clinical practice by the systematic "specification" of the external, i.e., common morality (T. Beauchamp, 2001); (ii) an internal morality for the medical practice is impossible, because it is impossible to know the ends of the medicine without knowing the ends or goals of human living (R.Veatch, 2001)

In the last essay of the *Journal,*J.Arras, as critical commentator, concludes that, even if is very difficult to discern a set of moral norms internal to medical practice, neverthless the notion of internal morality can be defended as giving a general orientation toward the "virtues necessary" to practice the medical profession (J.Arras, 2001).

The solution proposed by J.Arras recognizes that there are good reasons in the work of both the defenders and the critics of the internal morality thesis. Instead of viewing internal medical morality as a guide to the resolution of substantive moral problems, Arras proposes to advocate internalism by assigning it a more modest function, for witch the proper function of this morality is not to solve problems, but rather to give physicians an identity as professionals, rather than a self-interested

tradespeople, and a basic education in some key medical virtues (courage, compassion, truthfulness, etc) (J.Arras, 2001).

In conclusion of this syntetical account of the debate about the internal morality of medicine exemplarly proposed by the *Journal*, my opinion is that there are at least two reasons which prevent from an adeguate understanding of the attempt to an integration between internal and external morality: the first reason is the functionalistic conception of the medical profession; the second reason is the enphasis in the normative dimension of ethics and bioethics.

TOWARD A REINTERPRETATION OF THE INTERNALIST PERSPECTIVE ON THE BASIS OF THE PRACTICAL NATURE OF THE MEDICAL RATIONALITY

Theoretical presuppositions

An adequate understanding of this attempt can be finded on the stimulating reinterpretation of the internalist perspective of E.Pellegrino, one of the early proponends of the internal morality concept, elaborated by R.Dell'Oro (R.Dell'Oro, 2003).

The start-point of this reinterpretation is a clear identification of the limits both of "essentialistic" and "functionalistic" approaches to clinical bioethics. According to Roberto Dell'Oro, the essentialistic approach derives the internal ends from the peculiar nature of medicine, on the basis of a phenomenological analysis of its constitutive components. In this approach, medicine cannot receive some "goals" which are different from its constitutive "ends". Medicine will be always and everywhere a healing act oriented to the fact of illness; a relation based on trust routed in the clinical encounter and having as *telos* the patient's good. The reason for considering this approach as essentialistic is based on its presumption of identify the essential nature of medicine "a priori", outside of history. In contraposition to this essentialistic approach, the functionalistic approach considers the ends of medicine as derived from a completely contractualistic process. Therefore medicine don't possesses any internal end and the criteria of medical ethics don't are different in nature from the general principles of "public ethics" or "common morality". They are only a "regional" application and specification of these principles, without any reference to the phenomenological specificity of the medical practice. The reason for considering this approach as functionalistic is referred by R.Dell'Oro to the presuppositions that: (i) the ends of medicine must be considered as a contractualistic determinatiion of the individual's ends; (ii) the interpersonal dimension of the clinical encounter is substituted with a merely transational relationship, entirely determined by the particular socio-cultural context.

According to R.Dell'Oro, the solution of the contraposition between the essentialistic and functionalistic approach can be given by focusing the practical nature of the medical rationality. Just because the medical rationality is practical in

nature, i.e., it refers to the action and therefore to the free determination of the human will, it is clear, on the one hand, that the ends of medicine must be defined in the historical way; on the other hand, it is clear that the even necessary contextualization of the medical practice don't can deny to this practice the space of its relative autonomy in determining its ends.

In conclusion, the consideration of the practical nature of the medical rationality can mean to interpret the ends of the medicine facing to tension between anthropological presupposition and phenomenologycal essentiality. In this reinterpretation, the internal morality of medicine becomes an *open system*, in which the internal ends are internal not because exclusively determined by the medical profession, but because they inspire the determination of the patient's good, which is the specific end of the medicine "qua" medicine. In a more radical sense, the good that medicine must make possible is not "internal", nor "external", because the concrete determination of the patient's good emerges within a relational process based on the dialogue and communication.

Methodological suggestions

An adequate integration between internal and external morality requires a more robust conceptual frame in order to clarify the semantic of both internal and external morality. It also requires a methodology of ethical jugment. The following considerations aim to suggest an argumentative scheme in order to integrate within the analysis of clinical practice internal and external morality (Viafora, C, 1999).

Before illustrating the different areas of this scheme and their specific functions, an important meta-ethical premise must be focused. The priority explicitably given in this argumentative scheme to internal ends of medical practice implies approaching clinical bioethics and its system of argumentation from a *teleological* point of view, itself grounded in the Aristotelian tradition. The opposite *deontological* approach inspired by Kant is thereby put in a secondary position. Yet, this don't completary clarify all the presupposition adopted. Someone, like A. MacIntyre, tends to play the two approaches one again the other. On the other hand, P. Ricoeur interprets their relation as dialectical. Pratical jugment derives from both approaches and ultimately the argumentational structure is grounded on the reciprocity of deontological and teleological moments.

In this perspective, the starting-point of a systematic argumentation in clinical bioethics is the *moral experience* internal to clinical practice. Such experience refers to the ends witch constitute and define the practice itself, providing a guiding paradigm, that may be identified in the following moral issues: protection of life, promotion of the patient health, respect of his personal dignity and fairnes in the allocation of community resources. Even if this ethical paradigm cannot provide a normative scheme, neverthless it is a source of moral creativity and personal motivation.

The application of this ethical paradigm always takes place within *a particular clinical context*: the obstetric context, the pediatric context, the geriatric context, the oncological context, the intensive therapy context, etc.. The specific ends defining

each clinical context will provide the first bases for articulating the ethical paradigm of the clinical practice. The forms of respect for the personal dignity of the patient vary according to the context in witch it is played out. The ethical reasoning has to articulate the meaning of respect for each situation, recognizing for the intrinsic possibilities of good it possesses. Referring to the general category of respect without taking in to account the particularity of the respect for which it should make sense, will lead to abstract solution.

Right next to the area comprising the ends of the medicine is the area of the *virtues*. If the ends internal to the practice of the medicine may play an important function in setting up an horizon of ideals, and the clinical context, in turn, provides the situation background against which the different moral questions are to be framed, yet, these two criteria are valid only when they are appropriated at a personal level and when they form the personality of the moral subject. This is, indeed, the specific function of virtues. Thanks this process of personal appropriation, virtues come to define the particular sensibility which directs the moral agent, influencing his global motivational structure.

The importance of different clinical context and corresponding sensibilities in interpeting the ends internal to clinical practice can be fully appreciated within a larger *cultural context*, where are "the sources of the self" (C. Taylor). The frame of values which substantiate a particulare culture of life represents the hermeneutical background for understanding clinical practice. Moreover, such a background structures the perception of the ethical problems and contributes to the determination of their general features. The meaning of life, of suffering and death, of illness and health are always embedded within a particular cultural texture: a symbolic matrix which – implicitly or explicitly – fashions the interpretation of the clinical practice and its internal ends. The awareness of such a cultural frame is important for the ethical analysis. Since the ends of clinical practice are seen within the general precomprehension, it becames easier to identify the particular level of an ethical conflict. It is, first and foremost, one of anthropological presuppositions rather than different normative solutions.

Taking the moral experience internal to clinical practice as starting point of the ethical analysis, does not thereby imply abandoning any influence to normative principles. The funcion of principles within the ethical analysis is to regulate and to order the ends of internal morality, when this ethical claims conflict with one another for the complexity of the particular cases. Ultimatly this regulating function of the principles consists in a formal strategy where by the application of the ends of the moral practice to particular cases becomes possible. As a *clinical* strategy, its starting point will be the clinical encounter. As an *ethical* strategy, the application of the norm to the particular cases must obey to the principles of universalization. If this strategy gives the formal condition for their application, the specific contents of the bioethical principles, according to the integration of internal and external morality, can be reinterpreted by the following sequence: first, the principle of beneficence; second, the principle of autonomy and third the principle of justice.

The first principle to rank the ends internal to clinical practice will be the *principle of beneficience*. Its overal goal is the good of the patient, whether at a

diagnostic or therapeutic level, for the phase of prevention or rehabilitation. The very health care profession implies a public promise to act for the patient's good. According to this promise, a health care professional acts ethically if she takes the patient's good as a general end. In general terms, the principle can be formulated like this: *act in such a way that the consequences of your intervention will be for the patient's good*.

Negatively, the principle imposes the obligation to do no harm to the patient.

Positively, its promotes the patient's good by assessing the proportion between the benefits and the risks of any medical intervention. The emergence of a movement for the patient's emancipation and the development of modern medicine in its diagnostic, therapeutic and rehabilitation power, have triggered conflicts and levelled objections to the principle. Indeed, the possibility of conflicts between physician and patient is increased by the need to take into account the patient's subjectivity and the wealth of options available for treatment.

In case of persistent conflict between a suggested medical treatment and the patient's will, the last word ought to be left to the patient. The principle of autonomy prevails because the patient remains always responsible for his life and decisions. In general terms, the principle can be formulated as follow: *act in such a way as to respect the patient in his personal dignity and in his right to responsibly decide whether to accept or to refuse a suggested treatment.*

Negatively, the principle of respect implies refraining from interference and intrusion. Positively, respect for autonomy demands that the physician adequately inform the patient and involve him in decision making process. Respect for autonomy goes hand in hand with the need to assess what the patient really wants. Of course, upon establishing its authenticity, the patient's will must be respected.

If the principle of beneficence directs the actions of the health care professional toward the medical end, and autonomy deals with the particular responability of the patient, it is the principle of justice that represents and articulates the needs of society. The increasing costs of health care need to be limited. Yet, cost containment cannot be a primary concern of the physician, especially when this affects the personal relation with the patient. Setting limits is, rather, a political problem since the responsibility for the common good is entrusted to political power. At the level of political intervention, the moral bottom line is defined by the principle states the following: *in the allocation of health care resources act in such a way that privileges and burdens be distributed fairly, i.e., without discrimination in the treatment of persons, unless this is required and justified for the advantage of those who are most in need*.

The specific contribution of clinical ethics to the problem of allocation is to ensure an effective administration of the community's resources. The principle of justice challenges the medical profession in renewing menagement of resources by the medical profession. The latter, in turn, is preserved against the intrusion of political decisions affecting cost containment from tempering in any way wiht the intrinsic ends of clinical practice. The challenge to clinical practice today is being levelled from both sides: the perspective of *distributive justice* and of *commutative*

justice which can be expressed in the following way: *act in such a way as to grant to each person the some degree of respect and consideration*.

The urgency to retrieve such a notion of justice derives from the development of new diagnostic and therapeutic treatments. The degree of application of such new treatments extends to every sphere of life and unmasks the most intimate aspects of each person's life. In areas like reproduction, death and dying, genetics, the dangerous possibility of intruding, selecting, and ultimately, discriminating against individuals always exists. Bioethics cannot count upon the legacy of the modern philosophycal tradition in rearticulating the meaning of commutative justice. The language of rights borrowed from this tradition has, indeed, led to the recognition that each person deserves the same respect and consideration. Yet, it hasn't provided the answer to the question concerning "who is the other" entitled to respect and consideration. More specifically, the main flaw of the modern philosophycal tradition can be found in its inability to grasp the meaning of the biological dimension in the subject's constitution. This inability has proven full of consequences for ethics as well. Suspending the biological dimension from ethical consideration has prepared the ground for possible discrimination. If, in fact, the biological dimension cannot exhaust all aspects of the human being, it represents, nevertheless, the necessary condition to be taken into account in order to protect each person. An attitude of protection toward physical life does not entail a biologist interpretation, it simply provides a shield against an opposite proclivity toward selection. Indeed, anyone can claim the right to be treated as "the other" and to be included in the moral community on account of his or her body.

The deontological sequence of beneficience, autonomy and justice has been unfolded in its meaning – to order the ends intrinsic to clinical practice – and it has, therefore, come to its final limit. Limit in double sense. First, the principle of justice draws the line between what is negotiable and what is not. In the latter sense, the principle of justice imposes upon the individual's coscience duties which are absolute. Kant calls them perfect duties: the individual's autonomy does not dispose of them and for this reason cannot refuse to obey. Second, the limit is also a limit of content. In dealing with issues of distributive and commutative justice, clinical ethics extends beyond its specific competence and steps, respectively, into the field of politics and law.

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PART 1

CLINICAL BIOETHICS: COMPARING THEORETICAL MODELS