The Place of Philosophy in Bioethics Today

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During a recent plenary session at a bioethics conference, several leading scholars in bioethics expressed the view that there is nothing philosophically interesting left to be done in bioethics. They argued that the majority of the work in bioethics today involves the simple application of existing philosophical principles or concepts.[1] They contrasted this to the early days of the field where philosophers were especially important in helping to establish guiding principles, develop analytical frameworks, and map out concepts (e.g., the principle of autonomy, the concept of decision making capacity, the concept of equipoise, etc.). In their view, now that these theoretical foundations have been established, clinicians, ethics consultants, policy makers, and scholars need only to be trained in how to apply these foundations to cases. This applied work is relatively straightforward and not particularly intellectually challenging, so the argument went. In essence, philosophy's glory days in bioethics are over. Many of the members of the audience seemed to agree with these views, judging by how the discussion evolved. In our experience, this sentiment was not simply a single instance expressed at a one-off event, but rather, one we have seen as increasingly expressed in the field.

As philosophers working in the field of bioethics, we aim to directly address and counter this view. This paper has three aims: (1) to respond to skeptics and make the case that philosophy and philosophers still have a very important and meaningful role to play in contemporary bioethics, (2) to discuss some of the current challenges to the meaningful integration of philosophy and bioethics, and (3) to make suggestions for what needs to happen in order for the two fields to stay richly connected.

I. Why Bioethics Still Needs Philosophers

Philosophers continue to play a fundamental role in bioethical analysis. Resolving normative questions requires principles, concepts, and theories. It requires weighing considered judgments about particular cases against general principles, applying technical concepts from metaphysics and epistemology, and engaging in debates in moral theory and philosophy of science, among other things. These are all domains of expertise of the philosopher. As Sulmasy and Sugarman argue in their book, *The Methods of Medical Ethics*, normative ethics is at the core of ethical inquiry, since it seeks to answer what ought to be done and not be done in a systematic and critical fashion. Descriptive ethics (e.g., of majority views or practices) cannot do this, nor can law. The mere fact that something is illegal or legal does not make it immoral or moral. In the past, professionals widely perceived policies like non-voluntary treatment or eugenic sterilization to be ethical. Just because they were perceived to be ethical at the time does not mean that they were ethical (Sugarman and Sulmasy 2010).

[1] This is especially this case for clinical bioethics, they argued, in contrast to "new" areas such as artificial intelligence or population level bioethics where philosophers might still have more of a place.

Indeed, even major funding agencies such as the National Institutes of Health (NIH) in the United States seem to occasionally recognize that bioethics needs more foundational normative and conceptual work, above and beyond typically funded empirical bioethics and preference surveys. As early as 2000, a NIH National Human Genome Research Institute (NHGRI) report analyzing the ELSI (ethical, legal, social issues) research programs recognized a weakness in their funding portfolio: that it contained mostly studies involving applied or empirical research methods and few purely analytical or theoretical studies ("A Review and Analysis of the ELSI Research Programs at the National Institutes of Health and the Department of Energy" 2000). The report called out the need for conceptual and normative projects such as ones that ask whether it is fair that employers should have to hire employees whose health care is costly, whether it is it fair to provide greater protection for people with genetic predispositions to ill health compared to those whose predisposition results from being born poor or having parents who smoke, and what types of knowledge are needed for people to make an informed decision about the use of genetic medicine. The report acknowledged and bemoaned the underrepresentation of investigators from moral philosophy, religious studies, and anthropology.

We concur and argue, here, that the philosopher, especially the moral philosopher, ought to retain a central role in bioethical inquiry. Philosophy is relevant for contemporary bioethics in at least three specific ways. First, bioethicists currently use frameworks and concepts that are still philosophically contested, in ways that matter for the resolution of bioethical issues. Second, philosophy will continue to be especially relevant for clarifying and addressing issues related to new technology and other emerging issues in medicine. Third, philosophers generate and/or translate new ideas that bioethicists cannot afford to ignore. Below, we expand on each of these points.

1. Advancing Work on Philosophical Frameworks and Concepts Used in Bioethics

Despite the excellent work of the first generation of philosophical bioethics, there are still many concepts and frameworks that are standardly used in bioethics but are contested philosophically. To see this immediately, we need only consider the definition of death. For several decades, most bioethicists considered the definition of death to be settled, or at least a matter of consensus. As a result, medical schools have taught their students the mantra "brain death IS death" and bioethicists often pointed to mistaken media understandings when articles discussed "brain dead patients" who "later died." However, philosophers have continued to dig deeply into the nature and definition of death—and many of them would view the matter as far from settled. In fact, recently bioethics has begun to revisit some of these philosophical debates and re-think the definition of death and associated normative issues (Veatch 2019; Sulmasy 2019). Indeed, the most recent American Society of Bioethics and Humanities (ASBH) Meeting (2020) included multiple sessions challenging the definition of death in adult and pediatric medicine, appealing directly and indirectly to points that philosophers have been making for decades (Fischer 1993; Feldman 1994). Many bioethicists participating in the debate about this issue come from clinical or legal backgrounds and are not aware of the rich body of philosophical literature and thought on this topic—the risk of this disconnect is superficial or even "bad" philosophy and as a result, bad bioethics.

To take another example where further conceptual work is required, clinical bioethics often invoke the idea of "interests," appealing to the obligation of clinicians to protect and promote patients' interests through the obligation of beneficence. As any good philosopher will note, however, there is a multitude of philosophical theories of well-being and interests and normative debate about what kinds of interest matter most and why. To give a sense of the range of views on interests, there are: objective views, hedonic views, desire or preference satisfaction views, and informed desire views—to name a few (Sobel 2016; Crisp 2017). Each will give a very different answer to what is in a patient's interests and how we should handle cases ranging from decision making for incompetent patients, to counseling patients about genomic testing and cancer treatment, or caring for very sick neonates (Blumenthal-Barby and Lo 2019).

Or, in public health contexts, consider recent debates about mass vaccination. According to some moral theories, the ethics of exposing people to a risky vaccine, or any other risky public health policy, may depend on whether the victims of the intervention are known at the time the policy is implemented (Frick 2015).[2] More generally, all major ethical theories struggle to explain when and whether it is permissible to expose people to serious risks of death or injury (Oberdiek 2017). These continuing philosophical debates about risk bear on standard public health policies such as smoking bans, restrictions on gun ownership, seatbelt laws, and environmental regulations as well as questions about research that exposes participants and communities to risks and normative debates about the ethics of contagion and quarantine.

In the field of research ethics, scientists, clinicians, and members of Institutional Review Boards often implicitly use moralized concepts like 'dignity' and 'coercion' which are controversial. Bioethicists often call for strict restrictions on potentially beneficial lines of research by appeal to under analyzed concepts of coercion and human dignity, concepts which remain areas of active inquiry in philosophy (Pallikkathayil 2011; Savulescu 2015).

In obstetrics, clinicians often appeal to a dual patient standard, treating both mothers and fetuses and accounting for both organisms' wellbeing in their clinical decision-making. Yet, this standard implicitly appeals to metaphysical assumptions about the distinctiveness of a fetus, which recent philosophical work has contested (Grose 2020). As Grose contends, the absence of philosophical literature on pregnancy has resulted in the issue of the number of organisms in a pregnancy being "underconsidered." One theory – the immunological approach – demonstrates that the gestator's body recognizes the fetus as self, thereby concluding that there is only one organism during pregnancy; this is in direct conflict with the evolutionary approach's verdict of two organisms. Though Gorse states that his interest is not in "concerns about personhood," his considerations have potential consequences for philosophical debates on fetal personhood and abortion. In these cases and others, the conceptual clarity that is the stock and trade of philosophical bioethicists can enhance ethical thinking for obstetricians and other physicians.

In addition to clarity about ethical concepts, philosophers also bring expertise in the application and elaboration of normative ethical principles that remain important in clinical bioethics. To take one familiar example, it has been a long-standing practice in bioethics to invoke either the doctrine of double effect (DDE), or the doctrine of doing and allowing, in order to draw

[2] For a discussion of these issues see Frick, Johann. "Contractualism and social risk." *Philosophy & Public Affairs* 43.3 (2015): 175-223

a bright ethical line between medical assistance in dying and other end-of-life options that may also have the effect of hastening death (such as withdrawal of life-sustaining treatment). As the voluminous philosophical literature has made clear (McIntyre 2019; Woollard and Howard-Snyder 2016), articulating and defending an ethically salient distinction between intending and foreseeing, or between doing and allowing, is far from easy and there is debate about whether those distinctions are morally relevant (Liao 2012). There is still more good work to do on these issues.

More pertinently, the exact application of either distinction to end-of-life treatment options is also not straightforward. For one thing, both doctrines are standardly formulated so as to apply to different ways in which harms can occur. But where patients are suffering from serious and incurable illnesses, death may arguably be not a harm for them but a benefit (another topic that needs and profits from continuing philosophical engagement) (Feldman 1994). In that case, it is not clear that either doctrine has anything at all to say about the ethics of intending death, rather than merely foreseeing it, or actively causing it rather than merely allowing it to happen. Again, though the DDE is a long-standing theoretical framework, much-used in bioethics, there is more philosophical work to be done to understand and justify it.

2. New and Emerging Issues in Bioethics Where Philosophy is Relevant

A second way in which philosophy continues to be important in contemporary bioethics is in the context of new and emerging issues where philosophy is especially relevant to help clarify and address them. Consider, for example, the recent development of brain (cerebral) organoids for research purposes. These are artificially grown miniature organs resembling the brain, created using pluripotent stem cells. Are brain organoids conscious? How do we know? Should we treat them as if they are conscious? Answering these pressing bioethical issues involves delving into philosophy of mind and philosophical views on the nature and value of consciousness.

Many philosophers have been working on the philosophy of consciousness for decades, and there is both foundational and new work in that field that bioethicists ought to be familiar with. One of the leading philosophers working on philosophy of consciousness, David Chalmers, recently gave a talk on the topic of moral status through the lens of consciousness.[3] He articulated the popular view that a being has moral status only if it is sentient and that sentience is tied to consciousness—but he went on to distinguish between broad views of sentience from narrow ones. Broad views are concerned with the capacity for any sort of phenomenal consciousness or "what it is likeness"—ranging from basic perception or sensations to cognition. Narrow views are concerned with the capacity for positive and negative *affective* phenomenal consciousness—to feel pleasure vs. pain/suffering. Chalmers engaged in a series of thought experiment to argue for broad sentientism—a being has moral status just if it has some sort of phenomenal consciousness—even if it cannot specifically feel pleasure or experience suffering. It would take more debate (philosophical and scientific), but this *might* open the door for the view that brain organoids have moral status (at least some partial amount). If one's philosophical views were in favor of narrow

[3] Rice University, October 9th 2020

sentientism, meaning that organoids would need to experience a particular affect, that claim might be harder to get off the ground.

Consider another example emerging from neuroscience. The U.S. NIH BRAIN initiative seeks to fund research on the ethical implications of advancements in neurotechnology and brain science. Their request for applications (RFA)[4] specifically mentions the topic of effects on personal identity and agency from advances in brain stimulation and brain-computer interfaces. This work will require philosophical knowledge of theories of personal identity and agency—and there is a vast amount of literature on these topics in philosophy. There is a danger of conceptual unclarity if one is unfamiliar with this literature—for example, the danger of conflating "personal identity" with "personality." It is unlikely that deep brain stimulation (DBS) will change a person's personal identity in the numerical or persistence sense of personal identity that philosophers often refer to—the person will not literally become a different person (in terms of their psychological continuity and connectedness). DBS may, however, change some of the person's personality traits or characteristics. If DBS changes too many of these traits, or changes them too quickly, we *may* start to worry about impact on personal identity (that the person is no longer the same person) due to disruptions in psychological continuity—but this move would require significantly more argument, which would certainly make central appeal to philosophical theories of identity.

Similarly, philosophical theories of agency generally focus on intentional action and one's capacity to act for a reason.[5] Assessments of the effects of DBS on agency depend on which philosophical view of agency is correct. For example, if a person with obsessive compulsive disorder (OCD) cannot intentionally avoid obsessive behavior then a DBS device could help them return to or more closely approximate their authentic self by controlling their OCD symptoms. On the other hand, if external interventions such as DBS interfere with a person's intentional action, then a DBS device would potentially threaten patients' autonomy. Philosophical conceptions of agency and autonomy offer clarity in understanding emerging neuro-technologies such as DBS (Zuk and Lázaro-Muñoz 2019).

Philosophical analysis can also enhance researchers' and clinicians understanding of other emerging technologies, such as gene therapy, prenatal screening, new forms of assisted reproduction and advances in life expectancy. For example, researchers currently distinguish between human and non-human research subjects, but emerging genetic interventions may create human-like people who are genetically distinct from humans. Any policy toward these beings must consider philosophical debates about the limits of species membership and the significance of species membership. More urgently, expecting parents can now access non-invasive prenatal testing for a range of genetic conditions. As the technology improves, genetic counselors and parents must engage with philosophical debates about whether conditions such as short stature, deafness, or Downs syndrome are disabilities and whether it is permissible for parents to end a pregnancy on these grounds (Boorse 2011; Stapleton 2017; Thomas 2017). Similarly, new technology that expands the frontiers of fetal viability, including ectogestation ("artificial wombs"), prompt re-engagement with longstanding debates about the permissibility of abortion (Stefano et al. 2020; Overall 2015). And advances in life expectancy challenge the traditional

[4] https://grants.nih.gov/grants/guide/rfa-files/RFA-MH-18-500.html

[5] See e.g. philosophers such as Harry Frankfurt, who has articulated an idea of human agency or authentic agency whereby a person is capable of (and acts on) the basis of a reason that she embraces or endorses rather than disowns.

clinical distinctions between ordinary and extraordinary care and prompt reexamination of the philosophical distinction between medical treatment and enhancement.

3. Translation of New Ideas from Philosophy Into Bioethics

Finally, third: like medicine, philosophy does not sit still. New concepts and theories develop in philosophy as well. This provides another reason why philosophers will have a perennial role in bioethics. Health workers and public officials need people who can translate new work in philosophy into bioethical analysis and debate.[6] One needs only revisit some of the earlier examples to see how transformative new philosophical ideas can be for the field of bioethics. Consider Derek Parfit's "non-identity" problem (Parfit 1984) developed in the 1980's, which came to revolutionize the way bioethics scholars thought about issues in reproductive ethics.[7] The non-identity problem presents a puzzle: how we can say that some future being was "harmed" by our actions (e.g., decisions about or during reproduction) when were it not for us and those actions, that person would not have even existed (perhaps another genetically different person would). This sort of creative and innovative work continues to be developed in philosophy, and as a discipline, bioethics needs to be on the lookout for, and be ready to incorporate, these insights.

Below, we discuss some more recent examples of new work in philosophy that is relevant for bioethics. It is important to recognize that there are many areas of philosophy outside of ethics that are relevant for bioethics. These include political philosophy, philosophy of biology, philosophy of science, metaphysics, and philosophy of mind. New ideas of relevance for bioethics are being generated in many areas of philosophy.

Take for example, the concept of "epistemic injustice," recently articulated by philosopher Miranda Fricker and elaborated on in a large and growing literature in philosophy (Fricker 2007). In cases of epistemic injustice, a person is wronged in her capacity as a knower—either because she is ignored, not believed, or her experiences are not well understood for unjustified reasons. In bioethics, Evan Riley uses this concept to analyze what he takes to be wrong with "nudging" or shaping patients' decision making. This work goes beyond standard autonomy-based objections to nudging in interesting and enlightening ways (Riley 2017).

Consider another potential example of new work in philosophy that could enrich bioethical analysis: Tamar Gendler's concept of "alief." The concept of "alief" is meant to contrast with the concept of "belief." Aliefs are sets of associations that get activated (usually from habit) and show themselves in behavioral responses. Gendler gives the example of a glass walkway over the Grand Canyon. When walking across, a person may believe that the walkway is completely safe, but alieve something very different. The content of the alief is something like: ""Really high up, long long way down. Not a safe place to be! Get off!!"" While beliefs change in response to evidence, aliefs might not (they change in response to habits or affective associations) (Gendler 2008). The concept of alief might help bioethicists think about cases of unrealistic optimism (clinically) or

[6] Conversely, philosophy arguably also needs people who can translate empirical and scientific findings and their implications into philosophical and theoretical discourse.

[7] See, for example, the entry on the non-identity problem in *The Stanford Encyclopedia of Philosophy*, which surveys some implications for the ethics of procreation.

therapeutic misconception (in research ethics) with new angles and depth. For example, the standard analysis of such cases is that they involve inaccurate beliefs. But, perhaps these cases are not about beliefs at all, but rather aliefs. This shift in analysis raises new and deep questions about the role of aliefs in informed decision making and consent and how to address them. Are the right aliefs (as well as the right beliefs) a necessary condition for understanding and informed consent? And, what does the "right" alief even mean? There is quite a bit of relevant new philosophical material to work with here.

Philosophers of biology are currently engaged in active and fruitful debates about what an organism is and where it begins and ends (Clarke 2010).[8] These new developments may be relevant for longstanding bioethical questions about the temporal boundaries of human lives. They may also matter for newer questions, concerning how we extend in space as well as time. Could it be, for instance, that a prosthesis is a bona fide part of a human body (Aas 2019)? Is a fetus a part of its mother's body, as philosopher Elselijn Kingma has argued, or instead simply spatially contained in it (Kingma 2019)? It is not at all hard to imagine how different answers to these philosophical questions could yield different recommendations for how to proceed in policy or clinical practice.

Future prospects for constructive engagement between bioethics and novel ideas in philosophy abound. Consider recent volumes of the influential *Oxford Studies in Normative Ethics* series. The series aims to present new work in normative ethical theory, and this work is often relevant to ongoing bioethical debates. Recent examples include work that challenges the common idea that "need" (e.g., vs. mere desire, or fundamental "needs" vs. other types of needs) should play a fundamental role in moral philosophy (Fletcher 2018), as well as work that offers a new defense of "threshold deontology"—the idea that there are moral duties that hold regardless of consequences, until a certain level of consequence is reached—for example, if you need to kill one person to save millions (Rosenthal 2018). Both of these ideas are extremely relevant for bioethics.

New work in social and political philosophy, as distinct from individual normative ethics, has much to offer, both in deeper thinking about existing concepts and principles in bioethics and by bringing new ideas to the field. Political philosophers continue to think through the sorts of basic conceptual and normative issues about distributive justice needed to determine how to weigh health claims against one another and against claims to other sorts of goods. Coercion and consent, perennially central topics for both clinical and research ethics, continue to be of profound interest for political philosophy as well, with much active work on these notions that will no doubt be helpful for bioethics (Dempsey and Dougherty 2020).[9] Finally, as philosophy itself has struggled to become more inclusive and relevant to the real world, there has been an incredible efflorescence of work aimed at understanding the mechanisms by which identity-based social injustices arise and are perpetuated. Bioethicists interested in health inequities and related policies would do well to keep abreast of all of this exciting new work in social and political philosophy.

[8] See, among many other things: Clarke, Ellen. "The Problem of Biological Individuality." *Biological Theory* 5, no. 4 (2010): 312–25. https://doi.org/10.1162/BIOT_a_00068.

[9] See, for instance, Dougherty, Tom, and Michelle Madden Dempsey. "Introduction [to a symposium on Sex and Consent]." *Ethics* 131, no. January (2021): 207–9.

Philosophy, as a field, is also currently experiencing a shift in geographical and temporal scope, with philosophers in the Western world engaging more seriously and extensively than ever before with other traditions and perspectives. For example, recent research in psychiatry emphasizes the value of mindfulness meditation, e.g. as a treatment for chronic pain, irritable bowel syndrome (IBS), or as an intervention aimed to promote wellbeing (Chiesa and Serretti 2011; Fang et al. 2010; Zernicke et al. 2013). Other work on the therapeutic benefits of psilocybin speculates that detachment from a sense of self is beneficial to some patients (Carhart-Harris et al. 2016; Bogenschutz et al. 2015). This research appeals to recent concepts and frameworks that are more closely analyzed within the field of Buddhist philosophy, by philosophers such as Monima Chadha and Mark Siterits, for example (Chadha 2015; Siderits 2007). Especially for conditions that the medical field does not currently fully understand or has no cure, such as chronic pain and IBS, it is relevant for bioethicists to explore the issues surrounding these so-called "Eastern" alternatives that may provide relief. As Schmidt examines, healthcare providers could benefit their patients by "prescribing" mindfulness meditation as a part of "new evidence-based secular practices." Some argue, however, that promoting mindfulness conflicts with the concept of liberal neutrality; others assert that the kind of mindfulness practiced in this context "waters down" the Buddhist tradition and thus makes it less effective (Schmidt 2016).

II. Challenges To The Meaningful Integration of Philosophy and Bioethics

Despite its importance and value, philosophy has an increasingly estranged relationship from bioethics. It is less the case that philosophy's "heyday in bioethics is over," as we have heard some proclaim, and more the case that the alliances of necessity that were part of the early days of the field are now gone (e.g., physician leaders who did not have any ethics in their toolbox and brought philosophers in to create one). The question now is how to keep the connections between philosophy and bioethics rich, but there are several challenges and reasons why different interlocutors might think that philosophy is not relevant for bioethics—and vice versa.

Perception of Lack of Impact from Philosophical Approaches to Bioethics Issues

Some might think that philosophical expertise is not important because philosophy is not making a meaningful impact. These skeptics might ask what is so important about philosophy? How does it help things move forward? A flippant version of this view is that philosophy has not done anything since Aristotle. Would bioethics really be better if it included more philosophy? How can we evaluate the impact of philosophy on the field? Funders of bioethics research or programs may be hesitant to fund philosophy because existing metrics are not suited to funding philosophers and they have the view that they would not "get anything out of it" in the same way that they might get results, data, or tangibles from empirical bioethics approaches. Part of this view may involve the belief that there is a lack of progress or new and novel ideas coming from philosophy. Another aspect of this view might include the belief that philosophers too often act as relativists or fail to offer helpful advice via concrete recommendations about "the right" thing to do.

This skepticism is understandable in a sense—distinctions, concepts, and arguments lack the same sort of tangibility as quantitative or qualitative data. Yet, at the same time, consider the fact that it was not data, but rather arguments that birthed the field of bioethics and moved the field forward. Arguments and conceptual analysis activated thinking about problems in new ways. Indeed, arguments changed the way that medicine was practiced and people behaved. It's hard to imagine a more direct or powerful impact than that. Arguments are the reason that (or at least the rational basis for) the fact that we no longer withhold diagnoses from patients, that we allow patients to refuse treatments and make their own decisions, that we allocate organs and scarce resources based on medical facts and wait times rather than "social value," that we treat animals used in medical research differently now than we did in the past, etc.

While it may be true that we can all think of individual instances of philosophers or philosophical projects that have had a marked lack of impact or have been too relativistic, this need not be the case. There is nothing about philosophy or philosophical approaches per se that entails a lack of meaningfulness or impact. In addition, it is important to realize that while sometimes progress happens via big ideas, sometimes it is small and incremental. This is true in both the humanities and the sciences. Consider philosophical approaches to a bioethics topic that develops an ethical framework for thinking about that topic. Such an approach identifies and develops the ethically relevant considerations, but it may not provide an "answer" about what the right or wrong thing to do is in that circumstance. Nonetheless, far from being too abstract or lacking impact, such a framework provides the tools for the next stage of work, which involves building arguments for or against some action or policy. Similarly, a paper that provides new or more nuanced concepts related to some bioethics topic sets the stage for a robust and rich "next step" of figuring out the right thing to do. Along these lines, consider the foundational work that Beauchamp and Childress did in developing the "4 principles" to guide bioethical analyses. At the time that this foundational work was done, it may have been difficult to quantify or numerically evaluate a work product, but the work clearly went on to have enormous influence and impact.

Structural Issues Facing Philosophers and Philosophical Work in Bioethics

Whereas the abovementioned challenges are largely attitudinal, there are also structural issues that threaten the meaningful integration of philosophy and bioethics as well. One we alluded to earlier concerns the structure of funding for many bioethics centers and for bioethics work. Leading bioethics centers are becoming increasingly "soft-money," meaning that they rely on grants and contracts for their funding. Contracts (e.g., with hospitals) are typically focused on the provision ethics consultation services rather than the production of bioethics scholarship. Grants are typically for empirical and descriptive bioethics work rather than conceptual and normative work. Real or perceived liability concerns tied to contracts or grants may restrict philosophical analysis and argumentation as well. This is a major issue for the production and the support of philosophical bioethics work in the field.

Some philosophers who work on bioethical issues reside primarily in philosophy departments, where they face their own structural and issues. Many top philosophy departments have little or no expertise in philosophical bioethics, perhaps because they perceive the field as lacking in rigor, or as too narrow, focused on issues not of broader philosophical interest. We think

that neither charge is always or necessarily correct – good philosophy can be done on any topic, and the discussion above amply demonstrates that many topics that appear narrow at first turn out to raise broader and deeper issues. Still, philosophers may be concerned that spending too much time on bioethical issues will undermine their status in their home field – not least, insofar as it is much more difficult to publish bioethics in good generalist philosophy journals than in bioethics-specific interdisciplinary journals

These disciplinary-specific journals raise issues of their own. Most medical journals do not allow for the time or space to develop work with deeper philosophical rigor, but those are the journals most read by key stakeholders of bioethics work such as clinicians and policy makers. Thus, philosopher bioethicists face the dilemma of trying to shorten and cut the bulk of their arguments from their work so it can be read and have impact *or* publish in a philosophy or bioethics journal where they can develop their arguments (and potentially, advance their careers) more *but* reduce the readership significantly. For example, consider the impact factors and word limits of representative leading journals in philosophy, ethics, bioethics, and medicine.

Field	**Representative Top Journal**	**Impact Factor**	**Word Limit**
Philosophy (general)	*Nous*	3.497	15,000
Ethics	*Ethics*	1.982	12,000-15000
Bioethics	*American Journal of Bioethics*	7.674	7,500
Medicine	*New England Journal of Medicine*	74.699	1,200-2,00

While we are not taking the position that length is a necessary or sufficient condition of good or deep philosophy, it is certainly true that more words allow for more depth and nuance in argumentation and analysis. While empirical results can be communicated in a few words (e.g., through charts and diagrams), it is difficult to squeeze rigorous philosophical work into 1,200 words (save laying out an argument in formal structure, which we suspect that *New England Journal of Medicine* would not like!). Incidentally, there is a similar issue for conference talks (bioethics conferences often allow ~15 minutes for a paper presentation, and philosophy conferences are typically 1-hour for a paper presentation/discussion).

Clarifying Remarks

Some might object that the challenges we raise are not unique to philosophy and bioethics, but rather to all of the humanities in bioethics. We do not deny this. We focus here on philosophy because we are philosophers and cannot speak in as much depth or nuance with respect to other disciplines in the humanities. But, similar points about both challenges and potential contributions may apply to other humanities disciplines as well.

Relatedly, one might object that there is nothing particularly unique or necessary about philosophy with respect to normative contributions to bioethics. That is, while bioethics does need to go beyond "what people think" (empirical/descriptive), and on to the normative (what ought we

to do, what is good/bad, right/wrong), it does not follow that we need philosophy for that normative step. These objectors might point out that there are many other sources of normative knowledge beyond philosophy (e.g., religion, politics). Consider for example a normative question about whether or how one ought to vote. There is, so the thought may go, plenty in the realm of ordinary thinking about politics to help provide an answer to the question of whether to vote and who to vote for, without any need to consult philosophers. Perhaps. But can we really be confident in our normative reasoning about politics if we do not know how to carefully consider the moral basis and ethical implications of our political ideologies? It is one thing to feel a certain way about how the world should be or who should get what; it is quite another to justify those feelings, with the kind of rigor and generality required to justify political decisions to those who will be so profoundly affected by them (Rawls 2005).

There are two additional points that bear mention before moving on to suggestions for addressing the gaps and opportunities we have discussed. The first is that we do not mean to imply that all philosopher bioethicists need to be doing translatable or practical work. There is room for more purely theoretical philosophy in bioethics (e.g., development of a theory of the body or body ownership; or, of justice in the distribution of good relevant to health), which other bioethicists can translate (e.g., to pandemic ethics or the ethics of deactivation of embedded cardiac devices or the removal of neural devices). The second point is that we need to consider whether it is important that philosophy be *part of* bioethics rather than a separate discipline that bioethics can engage with. Our paper generally operates on the assumption that philosophy should be part of bioethics, in the sense that, for example, bioethics centers should employ philosophers as core faculty. This is in contrast to other disciplines such as health economics or biology. Whereas bioethicists might draw on health economics or biology, these fields are not traditionally considered part of bioethics. One reason to think that philosophy is different and that it should retain a central role *in* bioethics is because bioethics originated predominantly from philosophy/philosophers and there is a rich tradition and history there – so that bioethics cannot expect to understand itself, without the continued presence of philosophers. A second more substantive reason is that philosophy, as we have argued, plays an especially central role in bioethical inquiry. As we pointed out in the beginning of the paper, bioethics is essentially concerned with the "ought," asking what policies and practices we ought to have or not have, and general, theoretical, and non-sectarian reflection on "ought" is the distinctive, if not entirely unique, domain of normative philosophy.

III. Suggestions to Keep Philosophy and Bioethics Richly Connected

We now offer several concrete suggestions and ideas for the maintenance and re-invigoration of rigorous, engaging, and practically useful integration of philosophers and philosophy into the field of bioethics. Our suggestions call on various actors including funders, leaders, and individual scholars. Salvaging and promoting the meaningful integration of philosophy and bioethics will require a culture change of sorts and many individuals can play an important role in this change.

First, we suggest the establishment of a **Philosophical Bioethics Network** with an active and dynamic web presence. This network would consist of philosophers working in bioethics who could collaborate, host events and workshops, and share information related to new work in philosophy relevant for bioethics. This Network could also develop and make available resources

for methods in conceptual and normative bioethics, which would be useful for bioethicists who struggle to articulate a "methodology" for the non-empirical aspects of their bioethics work and grant proposals.

Second, we stress the need for champions from bioethics center directors and funders. **Center Directors** and institutions will need to be committed to the value of philosophers qua philosophers and hire them and support their time (at least some of it) to do philosophical bioethics. Philosophical bioethics work takes time—articles are longer, and arguments need to be worked out, which often takes more time that reporting descriptive data. Yes, this involves paying people (in part) to literally "sit around and think" (and read and write and discuss). Moreover, philosophers may need to spend some of their time and effort publishing in philosophy (non-bioethics) journals to keep up their credit as philosophers with philosophy colleagues. This commitment will require "champions" in the field—champions for individual faculty members and also for broader efforts like the Philosophical Bioethics Network. This will need to be a collective effort, rather than just one or two Centers supporting all of the philosophical bioethics efforts for the field. There are creative ways to do this even within the constraints of the increasingly soft-money environment of bioethics centers (e.g. building in time for this work and emphasizing its importance when developing budgets and contracts for consultation services and/or grants).

Center directors also need to educate their promotion and tenure committees about the value and worth of philosophical bioethics scholarship. For example, rather than a book counting for *nothing* (or even counting against) promotion and tenure in a medical school, its value should be recognized and emphasized—a 1,200 word essay should not count more than a book simply because the essay is associated with a high impact medical journal. This is not to say that impact doesn't matter—just that thinking about impact needs to be a bit more nuanced, less myopic, and more forward (long-term) focused.

Philosophical bioethics is also underfunded relative to alternative approaches. **Funders** of bioethics research could aim to fund a certain percentage of normative/conceptual bioethics projects annually and bioethics funders could take a lens to empirical proposals and ask whether those projects could be funded elsewhere and give priority to projects that could not. For example, imagine that a bioethics funder is considering two applications that were highly evaluated by reviewers. One involves a large public survey on views about an emerging genetic technology. The other, a purely conceptual project, involves the development of an ethical framework for that new technology. Imagine that the review committee judges that the former project would likely be funded by, say, the National Institutes of Health (NIH) but the latter would not have a chance because it would be viewed as "purely conceptual." Bioethics funders should prioritize the latter. Indeed, they are in a unique position to help advance philosophical bioethics research that is likely to have impact on policy and practice.

Third, we stress the point that **philosophers working in bioethics Centers** need to stay engaged in philosophy by attending philosophy talks and conferences and to establishing connections with the philosophy department in their institution or a neighboring one. We will need philosophers who can "translate" these concepts and ideas and bring them back to bioethics. For example, Francis Kamm's longstanding philosophical work has implications not only for the

development of self-driving cars (Kamm 2020b), but also for the practice of rationing in our current COVID-19 crisis (Kamm 2020a). At the same time, philosophers working in bioethics centers will need to understand that the majority of their institutional colleagues are not philosophers and so the translation of philosophical ideas needs to be clear and practical in those contexts. It also needs to be done in the spirit of service, communicating a desire to be helpful and advance thinking rather than being argumentative for the sake of being argumentative. Professional academic philosophy comes with accepted social norms of critique, argumentativeness and defensiveness. The social norms are different in academic medical centers where many bioethics centers reside. Philosopher bioethicists need to learn the culture of both worlds and move between them—not a small feat.

Fourth, we suggest that **philosophers who work on bioethics issues and have their academic homes in philosophy departments** need to do their part to re-align with bioethics Centers. They must resist the culture of turning inward and discussing practical and moral issues only amongst other philosophers. Doing this will allow them to not only make strides addressing pressing questions faced by society, but it will also allow for the opportunity to add depth and complexity to their philosophical work. For example, philosophical theories of autonomy might be challenged by realities such as ambivalent patients and adaptive preferences—realities introduced by clinical cases and empirical studies that encourage theoretically deeper and more nuanced accounts of autonomy (Moore et al. 2021). Philosophers need to encourage good philosophy students and trainees to enter into bioethics. This involves rigorous training of graduate students and fellows as well as connecting them early to bioethics questions and to bioethicists (philosophers and non-philosophers alike). Finally, philosophers need to find ways to present themselves as non-relativists—a charge we have heard all too often against philosophers.[10] In order to engage in normative guidance on real-world issues, people should see philosophers as a potential source of actual moral guidance on what the right (or wrong) thing to do is in a particular situation.[11] Regardless of where they work, philosophical bioethicists benefit from engagement in the real world and clinicians, patients, citizens, and policymakers benefit from engagement with philosophical bioethics.

Finally, we suggest that **philosophers teaching bioethics in medical and professional schools** ought to re-frame their thinking about what those students want and what they are capable of. In our experience, if you teach students good philosophy, they will love it. Over the years, many of our students have expressed a hunger and need for the sort of logical argument and reasoning found in the work of scholars such as Peter Singer, even though they do not always agree with it. The fact that they do not agree with it motivates them all the more to take on the challenge of evaluating the arguments in a rigorous way. Teaching philosophical bioethics may take more time than is typically allotted to ethics in medical school curricula. Most of us who teach bioethics in medical schools are familiar with the all too common "philosophy light approach" which involves 6-8 weeks of introduction to core principles of bioethics and discussion of cases, but is

[10] It is important to distinguish relativism from the idea that there are sometimes multiple rationally justifiable views on a topic. We thank [removed for blind review] for this point.

[11] There is debate, however, about the nature of "moral expertise" (Veatch 1973). For a helpful analysis of the types and nature of moral expertise and especially the way in which an ethicist/philosopher may have moral expertise, see Veatch R. Generalization of Expertise. *The Hastings Center Studies*. 1978; 1(2): 29-40.

largely empty of serious analysis, deep dives, and justification of positions. This void even applies to some advanced training/fellowship programs in bioethics. It is imperative that fellows and graduate students receive training in basic core concepts in contemporary philosophical bioethics as well as skills such as constructing and evaluating arguments. For medical students, attempts should be made to at least introduce them to this way of thinking as a part of core or required bioethics courses and then delve more into it through electives.

Conclusion

We do not mean to imply that philosophy is the only discipline that has an important role to play in the field of bioethics. Our point is simply that philosophy still has a very meaningful and important role to play in bioethics—not just the branch of philosophy that is ethics, but many other branches of philosophy as well. If anything, philosophy has a central and expanding role to play in bioethics. The field of bioethics could benefit from acknowledgement of this in light of recent skepticism. It could also benefit from concerted efforts to construct infrastructures that keep philosophers and philosophy meaningfully engaged in bioethics. We have outlined some ideas here and are looking forward to hearing from and working with those who wish to become involved in these efforts.

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