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BIOETICA E PLURALISMO

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Beatrice Magni
e Roberta Sala

Editoriale

Nel mese di ottobre del 1987 Bdl fu una delle prime riviste ad affrontare in un numero monografico alcune delle più controverse questioni bioetiche. Se era vero che, come scriveva Stephen Toulmin un anno prima (nel saggio intitolato "How Medicine Saved the Life of Ethics"), la discussione su vita umana e tecniche di cura aveva letteralmente "salvato" la vita dell'etica, restituendole significati e concretezza, abbiamo ritenuto interessante – a distanza di quasi trent'anni – tornare su quelle stesse questioni, per verificare se, come, e quanto esse fossero cambiate.

L'indagine sulle tensioni morali, politiche e giuridiche esistenti tra teorie, ricerche e pratiche cliniche in campo bioetico, nell'ambito di società pluralistiche, è dunque il tema generale di questo numero, che riprende così il suo quasi profetico antecedente (era il n. 99, ottobre-dicembre 1987): in esso il filosofo del diritto Uberto Scarpelli – in un intervento dal titolo quanto mai attuale, "La bioetica alla ricerca dei principi" – cercava di dare una risposta agli interrogativi morali sollevati dal progresso medico-tecnologico e dai nuovi imprevedibili poteri di intervento sulla vita umana a esso connessi.

Le domande di Scarpelli sono in fondo ancora le nostre, e possono riassumersi in un'unica formulazione: etsi deus non daretur*, tutto ciò che è tecnicamente possibile, è eticamente lecito?*

Gli articoli qui raccolti raccolgono la sfida di una bioetica che non si riduca a mero discorso: così intesa, essa rischierebbe di fallire in uno dei suoi compiti fondamentali, quello di prendere sul serio le circostanze in cui gli interrogativi morali e giuridici vengono sollevati. Tali articoli rappresentano l'occasione per la creazione di un laboratorio virtuale inteso come luogo di riflessione teorica e di ricerca. Il proposito che li accomuna, in altre parole, è il tentativo di fare il punto su questioni controverse proponendo soluzioni possibili per i disaccordi o, perlomeno, cercando il modo di ridurli: disaccordi che sono presenti entro lo stesso contesto, tra prospettive plurali e sempre più spesso in conflitto, o in contesti differenti.

I meriti della teoria bioetica sono messi alla prova in prima battuta da Marco Annoni, nel suo articolo sull'uso dei deceptive placebos *nella ricerca e nella pratica clinica. La partecipazione consapevole del paziente alle decisioni cliniche che lo riguardano, ma, ancor prima, la comunicazione che gli viene fornita durante il percorso clinico in cui è coinvolto, possono essere particolarmente problematiche nel caso dell'utilizzo di placebo: si tratta di comprendere se in questo caso si possa parlare di scelte autenticamente libere e competenti. Nel* *confronto con la casistica, le pratiche, i dilemmi della contingenza, l'uso di placebo solleva veri e propri dilemmi su cui Annoni si sofferma, per mostrare come, in ultima istanza, una delle vie più promettenti per ridurre l'uso di* deceptive placebos *consista non tanto nel rafforzare i divieti, quanto nel sostenere e promuovere un maggiore impegno clinico in termini di riconoscimento, interpretazione e analisi riflessiva delle implicazioni morali di decisioni controverse. Nel suo saggio intitolato "L'autonomia 'irrazionale': interventi sul corpo e integrità fisica nel dibattito multiculturale", Marianna Nobile presta particolare attenzione alla multiculturalità delle società contemporanee come ulteriore elemento di complicazione delle decisioni collettive. Si tratta, infatti, di interrogarsi circa le richieste di cura avanzate da individui appartenenti alle diverse comunità, portatori di tradizioni che veicolano valori molto lontani da quelli sui quali si erge la società liberale e democratica. In questo senso si deve ammettere la sfida lanciata alla medicina nel suo insieme, se intesa come prassi terapeutica basata su principi – in specie sul principio del rispetto dell'autonomia del singolo – sconosciuti o non adeguatamente riconosciuti per la loro centralità in alcune di queste comunità tradizionali. Ciò comporta la necessità di valutare non solo l'adeguatezza del modello sanitario proprio delle società liberali, ma anche la forza delle prospettive etiche sulle quali esso si basa. Non meno interessante di questa è la riflessione condotta, nell'articolo intitolato "Bioethical expertise: Mapping the field", da Virginia Sanchini. La tesi centrale è che in un mondo altamente specializzato, in cui la conoscenza è sempre più un'impresa collettiva, nessuno può ergersi a unico esperto di alcunché. Lo stesso vale anche per la bioetica: a fronte di una crescente specializzazione, ci si trova di fronte a una miriade di esperti, che non è neppur detto comunichino efficacemente tra loro. Si pone la domanda su chi possa arrogarsi il titolo di esperto di bioetica e su chi lo sia davvero. Sanchini offre qui una tassonomia che tiene conto sia delle posizioni a favore della presenza di esperti nel dibattito bioetico, sia di quelle più scettiche in merito all'esistenza stessa di expertise e di esperti di bioetica. Nella ricerca del difficile equilibrio tra rispetto e riforma del codice morale, teorie normative e giustificazioni metaetiche spesso si affiancano. È questo il caso dell'ultimo contributo, in cui Sarah Songhorian affronta la sfida che la neuroetica pone alle neuroscienze, attraverso un'acuta indagine sul contributo che la ricerca empirica può e deve offrire alla conoscenza delle istanze morali: quanto, e soprattutto fino a che punto l'analisi empirica può spingersi nel modellare le istanze morali e filosofiche, nonché le nostre assunzioni normative su casi specifici? La sfida raccolta dalle neuroscienze dell'etica è la sfida della bioetica.*

In conclusione, dove tracciare il confine? Quando una decisione è medica, quando è tecnica, quando è morale? Si potrebbe forse affermare che la cosiddetta postmodernità si contraddistingua per la sua competenza nel riconoscere il carattere irrinunciabilmente fondativo di un pluralismo morale dai termini secolari.

Quel che è certo è che la fluttuante collocazione disciplinare della bioetica non è considerata come un ostacolo, perlomeno da parte di chi scrive, ma come una preziosa risorsa, della quale ci auguriamo che questo numero di Bdl possa contribuire a fare buon uso.

30 ottobre 2015

Marco Annoni

Exceptional lies: The ethics of deceptive placebos in clinical settings

Introduction

A "placebo" can be defined as a medical intervention that, although believed to be inert, is administered *as if* it was an "active" medication. Often, placebos are used to elicit a "placebo effect", that is to say, a modification in patients' health outcomes that is due to the anticipation of some clinical benefits rather than to the specific biochemical properties of the administered treatment. Placebos are thus inherently paradoxical entities, for they are defined as something "inert" and yet capable of causing an "effect". But in addition to the philosophical hurdles associated with the concepts of "placebo" and "placebo effect", the clinical use of placebos also raises a host of ethical issues. In fact, placebos usually require doctors to deceive patients "for their own good" and for this reason, along the history of medicine, they have been variously labeled as the "pious fraud" (Jefferson 1898), the "humble humbug" (Anon 1954) or, more aptly, as medicine's "dirty little secret" (Hollon *et al.* 2002).

In this article I deal only with the ethics of using deceptive placebos in clinical settings. In particular, I will criticize two influential positions within the current placebo debate. The first position is the one according to which deceptive placebos do not raise substantial moral concerns because they can be administered in ways that are "not transparent" and yet "not deceptive". The second position, then, is the one endorsed by the American Medical Association (AMA) according to which the use of deceptive placebos without patients' consent must be categorically prohibited. In what follows I argue that both views are flawed because they equally misrepresent key aspects of the morality of benevolent deception in clinical settings.

Contrary to these positions, I will claim that the use of deceptive placebos is morally permissible, but only in exceptional cases. Before we can discuss the ethics of deceptive placebos in clinical settings, however, it is necessary to look at some empirical data about their clinical effectiveness. Do placebos have clinical effects? And, if yes, are deceptive placebos more useful than disclosed placebos? How often and why do physicians use deceptive placebos in clinical settings? To answer these questions, we shall begin by looking at some empirical findings in the field of placebo studies.

1. Do placebos have clinically relevant effects?

In the last decades a converging series of laboratory experiments, clinical trials, and neurocognitive studies has vindicated the existence of placebo effects. Collectively, these studies have shed considerable light on the neurophysiological mechanisms underlying placebo effects (Benedetti 2011). Yet, the extent to which placebos can induce relevant effects in clinical settings is still controversial.

In a series of Cochrane systematic meta-reviews entitled "Placebo interventions for all clinical conditions", Hróbjartsson and Gøtzsche (2001; 2004; 2010) analyzed over 330 trials and concluded that placebo interventions had no "significant clinical effect". Placebos were found to be marginally effective only on outcomes that were subjective (either patient or observer-reported) and continuous – most notably pain. Scholars within the field of placebo studies have criticized these meta-reviews noting, among other thing, that in clinical contexts "placebo effects are likely to be stronger because patients are led to believe that they are receiving an active medication" (Kolber 2007; Howick *et al.* 2013a).

In contrast with the results of these meta-reviews, most of the evidence supporting the case for the clinical effectiveness of placebos is based on the results of high-quality laboratory studies and of experiments conducted in controlled conditions. In particular, in the last two decades, researchers have increasingly resorted to "open-hidden" experiments to separate placebo effects from other variables of the healing context (Colloca *et al.* 2008). In this elegant trial design, the same medication is delivered to patients either in the full view of a clinician who openly describes the procedure and its anticipated effects (expected open administration) or covertly, for example through an intravenous infusion machine (unexpected hidden administration) (Levine and Gordon 1984; Benedetti 1995). The scope of open-hidden experiments is to assess whether it makes a difference to administer a drug while removing some variables from the healing context such as the patient-doctor communication or the bedside presence of caregivers.

In one of these experiments, Amanzio *et al.* (2001) administered four commonly prescribed analgesics to patients in postoperative settings, either in an open or in a hidden way. The study found that the dose of analgesic needed to reduce the pain by half was significantly greater in the hidden administration groups for all four analgesics. Thus, the same dose of a proven analgesic had different effects depending on it being administered in an open or in a hidden manner. Similar effects have been observed with morphine (Bendetti *et al.* 2003a) and in conditions other than pain, such as state anxiety (Benedetti *et al.* 2003a) and Parkinson's disease (Benedetti *et al.* 2003b). In general, open-hidden experiments demonstrate that the effectiveness of therapies depends not only on *what* they are – i.e., their biochemical properties – but also on *how* they are delivered – i.e., the healing context surrounding their administration.

Interestingly, even a single word may sometimes induce dramatically different clinical effects. This has been cleverly demonstrated by a recent trial in which 66 patients with recurring migraine have been randomized using a 2 x 3 balanced-placebo design. As in a standard Rct, half of the participants received the drug – in this case Maxalt, (10-mg rizatriptan, a proven medication for the relief of headache –, while the other half received an indistinguishable placebo. However, all participants were also randomized to three different information conditions: "Maxalt" (positive information); "Placebo (negative information); and "Maxalt or Placebo" (neutral information). Thus, some participants thought they had a 50% of receiving either Maxalt or the placebo; some participants thought they were receiving Maxalt but received the placebo instead; and some participants thought they were receiving the placebo but received Maxalt instead. The results showed that both the content of the pill and its labelling significantly correlated with the final outcome. Maxalt was superior to placebo when both were correctly labeled. However, the placebo mislabeled "Maxalt" was as effective as Maxalt mislabeled "placebo". Thus this study showed how a single word could lead to significant differences in the effectiveness of both established therapies and placebos.

In sum, a growing body of evidence from laboratory studies and clinical trials supports the claim that placebos may sometimes have significant clinical effects – especially for conditions like pain, depression, migraine, and irritable bowel syndrome (Ibs) (Miller *et al.* 2013). However, these results ought to be interpreted with caution for at least two reasons. First, there are relevant differences between research and clinical contexts and studies suggest that placebo effects are higher in the former setting (Benedetti 2011). Second, placebo effects vary significantly across individuals and healing contexts (Kaptchuk *et al.* 2008; Hall *et al.* 2012). As Miller and Colloca (2009, 317) concluded in a comprehensive review of the literature, "[t]he upshot to date is that we lack systematic and definitive evidence of clinically significant benefit from placebo treatments. Accordingly, more clinically relevant research is needed before placebo treatments can be recommended as evidence-based therapy".

In siding with this latter remark, I shall endorse a cautionary position regarding the clinical effectiveness of placebos based on two assumptions. First, the clinical effectiveness of placebos is likely to be limited to conditions that have strong symptomatic components like pain, Ibs, or depression. Second, the clinical effectiveness of placebos is typically modest but may vary considerably across individuals and healing contexts. Thus, while on the one hand we might have good reasons not to recommend placebos as evidence-based treatments across all clinical settings, on the other hand we may still maintain that placebos are not completely deprived of clinical effectiveness.

2. Is deception required for placebos to be clinically useful?

A crucial question concerning placebos is whether they require deception to induce significant placebo effects. Historically, it has been held that placebos must be prescribed deceptively to be effective. Yet, recent empirical studies on placebos "without deception" have questioned this widely shared assumption (Krueger *et al.* 2006; Sandler and Bodfish 2008; Kaptchuk *et al.* 2010).

In a pilot trial by Kaptchuk *et al.* 2010, patients with Ibs were randomized to receive either no treatment or a placebo pill that was honestly described as containing no active medication (an "open-label placebo"). Patient were read a truthful script about placebo responses and informed about the rationale of the study. Perhaps surprisingly, patients who received the open-label placebo reported statistically significant improvements with respect to the control group. Similar results have been replicated in other pilot studies for recurring migraine (Kam-Hansen *et al.* 2014) and depression (Kelley *et al.* 2012), thus suggesting that "taking a pill" may have beneficial effects even if that pill is not deceptively presented as a medication.

While these studies provide a first proof of principle that placebo effects can be induced not only by deceptive placebos, they do not demonstrate that covert and revealed placebos are equally effective. At present, more research is needed to clarify this empirical issue. Nevertheless, several authors have argued that, given our contemporary understanding of the placebo phenomenon, the burden of proof should be on those advocating the equal effectiveness of disclosed placebos (Kolber 2007; Foddy 2009; Barnhill 2011). In fact, compelling evidence suggests that the magnitude of placebo effects is influenced by the strength of patient's expectations about future clinical benefits (Benedetti 2011). Since placebos affirmatively presented as effective medications are likely to elicit stronger expectations than placebos presented as "inert", it is reasonable to expect that deceptive placebos might offer a medical benefit over and above the one of disclosed placebos (Barnhill 2011).

Furthermore, covertly administered placebos can sometimes be used as diagnostic tools, for example to discriminate real and pseudo-seizures in epileptic patients (see section 5). Clearly, utilizing a revealed placebo in these cases would be self-defeating, as the success of the diagnostic procedure may precisely depends on the patient being convinced that she is assuming a real medication.

Thus, in absence of further evidence, I will assume that deceptive placebos provide patients with greater therapeutic benefits with respect to open-label placebos, and that only deceptive placebos may sometimes act as plausible diagnostic tools.

3. How often and why are deceptive placebos used in clinical settings?

Following the initial definition of "placebo", even conventional treatments (e.g., antibiotics) may be used as "placebos" if administered in ways or for conditions for which they are believed to be clinically inert. Accordingly, it is common to distinguish between "pure placebos" (e.g., sugar pills or saline injections) and "impure placebos" (e.g., antibiotics to "treat" a cold) – although this distinction is not always sharp. In the last thirty years several studies have inquired into the attitudes of clinicians toward the clinical use of pure and impure placebos. In general, these studies indicate that deceptive placebos are still widely administered in clinical settings for a variety of reasons.

A 2004 study found that between 46% and 58% of the contacted U.S. internists and rheumatologists recommended placebo treatments (Tilburt *et al.* 2004). This study also found that nearly half of the participants (46%) admitted of recommending treatments solely for the purpose of enhancing patients' expectations, while 62% considered the use of placebos to be either obligatory or permissible in some circumstances. Interestingly, the study also revealed that doctors use way more impure placebos, such as over-the-counter analgesics, than pure placebos.

The first systematic review (Fässler *et al.* 2010) analyzed 22 studies in 23 articles published between 1973 and 2009 and found that the proportion of health professionals using placebos at least once a year varied between 17% and 80% for pure placebos and between 54% and 57% for impure placebos. The primary motivation to give a placebo was patients' desire to receive a medication, followed by the intention to take advantage of placebo effects, and by the will to avoid revealing that all therapeutic options were exhausted. As for the ethical attitudes, this systematic review found that the majority of health professionals considered the use of placebos morally problematic, but that up to 50% thought that it was acceptable whether it was meant for the patients' good.

A more recent study with 1715 UK doctors found that 97% of the interviewed participants reported having used impure placebos at least once in their career, and that 77% of them admitted of using impure placebos at least once a week (Howick *et al.* 2013b). Common reasons to prescribe placebos were: psychological treatment; because patients requested a therapy; to treat non-specific complains, and to calm patients. This study also investigated more in depth physicians' ethical attitudes, finding that 66% of doctors thought that pure placebos were sometimes ethically permissible; 82% considered deceptive placebos unethical; and that 90% thought that placebos were unethical whenever they jeopardized the doctor-patient trust. Similar attitudes were found with respect to the use impure placebos (84%, 82%, and 94% respectively).

Thus, it appears that deceptive placebos are still widely used in clinical settings for a variety of reasons that include their clinical utility as well as doctors' attempt to satisfy patients' request for a prescription. In general, the vast majority of clinicians use impure rather than pure placebos. Ethical attitudes are polarized, but the majority of clinicians seem to agree that the use of deceptive placebos is morally justifiable in specific circumstances.

4. The Ethics of Deceptive Placebos

Deceptive placebos may sometimes be effective for treating conditions such as pain, depression and irritable bowel-syndrome. Since placebos are generally cheaper than tested medications, one could argue that they provide an appealing and cost-effective therapeutic option. However, placebos often require deception, thus making their use morally questionable in clinical settings.

In the rest of this article I explore the ethics of deceptive placebos, claiming that their use should be considered *prima facie* unethical like any other instance of benevolent deception. To unpack this claim, in the following sections I will criticize two prominent positions within the current placebo debate. The first position aims at avoiding the moral issue of deception by arguing that it is possible to prescribe placebos in ways that are neither "open" nor "deceptive". The second position, then, is the one for which deceptive placebos without patients' consent ought to be categorically prohibited.

4.1 Can placebos be given in ways that are neither "open" nor "deceptive"?

Usually, it is assumed that covertly administered placebos involve some form of deception (Bok 1978; Kolber 2007; Miller and Colloca 2009; Foddy 2009; Asai and Kadooka 2013). However, some scholars have recently argued that it is possible to administer placebos in ways that are neither "open" nor "deceptive". As an illustrative example, consider the following way of introducing a placebo to a patient: "I am prescribing you a pill which research suggests can be of benefit to you. In your circumstances I have reason to believe that it will work, with a minimum of side effects" (Gold and Lichtenberg 2014). Is this statement deceptive?

The answer to this question depends in part on how we define "deception". Scholars pursuing this line of argumentation usually define "deception" as to intentionally cause someone "to have a false belief that the deceiver believes to be false" (Carson 2010; Chisholm and Feehan 1977). Hence, deception always requires the instilment of a false belief. However, it is argued, the above statement does not contain or instill any false belief: placebos can be clinically helpful and physicians who are aware of recent studies on placebo effects may sincerely believe so (Cohen and Shapiro 2013; Gold and Lichtenberg 2014). Therefore, the argument goes, it is possible to prescribe placebos in ways that are neither fully "open" nor "deceptive".

While appalling, the view that "non-transparent" placebos are compatible with clinicians' moral obligations is seriously mistaken. Not only the non-transparent use of placebos still qualifies as an act of deception, but it also infringes on patient's autonomy as well as it creates more occasions for doctors to deceive patients.

First, it can be argued that not informing the patient that the prescribed medication is a placebo qualifies as an act of *deception by omission* because the clinician would fail to correct a false belief entertained by the patient, i.e., the belief "that doctors give only active medications" (Chisholm and Feehan 1977). One could reply that clinicians cannot be sure about the beliefs that patients harbor, and thus that they cannot have an intention to deceive by omission. This reply, however, is unconvincing. As Bok noted, the context in which a therapeutic encounter takes place is not neutral as to the beliefs that both parties can be reasonably expected to entertain: “the doctor’s office or hospital room, the impressive terminology, the mystique of the all-powerful physician prescribing the remedy; they convey the impression that the treatment prescribed will have the ingredients necessary to improve the patient’s condition. The actions of the physician are therefore deceptive even if the words are so general as not to be lies. Verbal deception may be more direct, but all kinds of deception can be equally misleading” (Bok 1974, 20). Today patients may reasonably expect that all the medicines that doctors prescribe have been tested and approved for their specific efficacy. To contravene this widely shared expectation counts as deception, even if the words uttered by clinicians are sufficiently vague as not be literally false.

Second, advocates of the “non-transparent” use of placebos conceive clinicians’ obligations of veracity as if it would only entail an obligation not to lie and deceive. This view, however, is too narrow. Aside from a negative obligation not to lie and deceive, clinicians have also a positive duty to provide truthful information to patients in order to respect they personal autonomy. Arguably, the fact that one is assuming or not an active medication is one of those information that are potentially relevant from a medical point of view. As Kolber observed (2009, 25), “If a person ends up in the emergency room in an unfamiliar locale, he wants to give his treating physician the most accurate information possible about his current medication. With [incomplete] information, the doctor may decline to use highly effective treatments out of fear that it could interact with the medication the patient mistakenly thinks he is taking”. The nature of one’s medication is clearly an essential piece of information that falls under the duty to inform patients in order to respect their autonomy. Accordingly, clinicians using “non-transparent” placebos would still fall short of their duty of veracity because they would intentionally keep patients in the dark with respect to some relevant medical information.[1]

Third, considering the case of “non-transparent” placebos as distinct from the one of “deceptive” placebos overlooks the fact that lying, deception and dishonest concealment often lay on a continuum, and that in practice one easily tends to “spill over” the other. Let us image the case of a deceptive placebo prescribed only to satisfy patient’s request of receiving “something”. Assuming that the physician will not be able to write a prescription for a placebo pill to be dispensed by a pharmacy, how will she present the treatment to the patient? How will the bottle be labeled? What if the patient starts asking

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[1] In this respect, an interesting option could be that of implementing a strategy of “authorized deception” that would allow the patient to decide and eventually consent in advance to the use of benevolent deception or concealment. In this way, it has been argued, it would be possible to respect not only patients’ right to be properly informed, but also their complementary right to decide which information they do not want to receive, i.e. their “right not to know”. For a discussion of this option with respect to the use of placebos see Shaw (2009) and Miller *et al.* (2013)

questions about the medication contained in the pills? What if she wants to double-check online what sort of medication she has been prescribed? Even if the initial statement may not be literally deceptive – although it can be *contextually* so – there is always a risk that it will lead to explicitly deceptive practices. Thus, the promotion of non-transparent placebos is often conductive to more dishonest acts on doctors' part.

In sum, the view that it is possible to administer placebos in ways that are neither open nor deceptive is flawed because (i) in today clinical settings the provision of a "non-transparent" placebo qualifies as an act of deception by omission; (ii) clinicians' duty of veracity entails also the positive obligation of truthfully providing all relevant medical information to respect patients' autonomy; (iii) promoting strategic concealment on a wide scale would create more occasions for doctor to deceive. Thus, it is not possible to have the placebo cake and eat it too: either the administration of a placebo is fully open-label, or else it is dishonest and it needs to be justified (or refuted) in some other way.

4.2 Are deceptive placebos always unethical?

Current ethical guidelines tend to endorse a policy of "categorical prohibition" with respect to the clinical use of deceptive placebos. For example, in 2006 the American Medical Association (AMA) released its placebo policy in the form of an official "Opinion" in which it stated,

> […] In the clinical setting, the use of a placebo without the patient's knowledge may undermine trust, compromise the patient-physician relationship, and result in medical harm to the patient. Physicians may use placebos for diagnosis or treatment only if the patient is informed of and agrees to its use […]

According to this position, in clinical settings it is never permissible to use deceptive placebos without patients' consent. Over the years several commentators have defended similar positions and therefore the AMA Code of Medical Ethics is not alone in advocating a "categorical ban" of deceptive placebos in clinical settings (Asai and Kadooka 2013). Defenders of categorical views do not deny that deceptive placebos may have clinical benefits; rather, they argue that deceptive placebos have a series of short and long-term implications – e.g., for trust, respect of patient's autonomy and patients' or public health – that once factored in justify a categorical ban on their use.

In order to see why the AMA categorical placebo policy stands out with respect to other positions on similar issues, we need to consider how benevolent deception is currently approached in medical ethics. As noted above, today it is acknowledged that clinicians have a general duty of veracity in all their professional communications. This duty is often conceptualized as a *prima facie* duty (Ross 1930; Beauchamp and Childress 2009). *Prima facie* duties are morally binding all things be equal. However, things are not always "equal" and sometimes two *prima facie* duties may conflict. For example, the *prima facie* duty of confidentiality may conflict with the one of preventing harm to third persons –

as in the case of a patient who discloses the intention to murder someone. When two *prima facie* duties conflict, agents should identify and weight the set of reasons supporting each course of action, eventually determining what ought to be done all things considered. Thus, *prima facie* duties indicate the standard moral conduct but allow for exceptions whenever one has compelling reasons to act otherwise.

Conceptualizing doctors' duty of veracity as a *prima facie* duty underscores two important points about how benevolent deception is currently approached in medical ethics. First, there exists a structural moral imbalance between truthfulness and falsehood: other things being equal the former is praiseworthy while the latter is blameworthy. Primarily, falsehood is blameworthy because it threatens patients' trust by undermining doctors' trustworthiness (Pellegrino 1981; Jackson 2001; Hardin 2002), and because it infringes on patient's autonomy and right to informed consent (Beauchamp and Childress 2009). Today the respect for patients' autonomy and the preservation of trust are considered essential conditions for having meaningful therapeutic relationships, and thus the negative moral presumption against deception is held to be rather strong.

Second, although truth telling is crucial for any doctor-patient relationship, there are cases in which other obligations may legitimately override clinicians' *prima facie* duty of veracity. Consider the case of a patient with a ruptured aortic aneurysm who is rushed to the operating theatre. "The anaesthetist knows the patient's chances of survival are poor. Just as preoxygenation is about to begin, the distressed patient asks 'I am going to be all right, aren't I, doctor?" (Sokol 2007, 984). This case presents the doctor with a moral dilemma about benevolent deception: if she replies "You will be ok!" she would tell a lie, but she would not hinder patient's chances of survival; if she tells the truth, instead, she might significantly increase the patient's stress-levels and lower the chances of saving her life. Today this latter option is generally considered undesirable because patients seek the aid of doctors primarily to stay healthy, and not because they want to know "the truth" at all costs. Between the life of a patient and the truth, doctors should always prioritize the former – unless there are very compelling reasons to do otherwise. For this reasons, most scholars believe that whenever the clinical benefits are very high and the harm negligible, benevolent deception may be morally permissible (Beauchamp and Childress 2009; Bok 1978).

But if we acknowledge that clinicians may sometimes legitimately resort to deception, then on what grounds can we justify a categorical ban that applies *only* to deceptive placebos? What distinguishes typical cases of benevolent deception from those in which benevolent deception requires the provision of a placebo? As the reasons against deception based on trust and autonomy are the same in both cases, this difference must concern the balance between the specific benefits and harms of placebos. To further articulate this point we need to consider different ways in which deceptive placebo may harm patients or society.

As for the harm to patients, placebos are always relatively "inert" but never absolutely so. This is true of both "pure" and "impure" placebos, because a placebo is always "a placebo" relatively to a certain condition and according to a certain biomedical theory. Saline injections are not "inert" for rehydrating someone in needs of fluids; sugar pills are not "inert" for people who have diabetes; and lactose tablets are not "inert" for people who are intolerant to lactose. Placebos may have unwanted and sometimes potentially severe side effects. This risk is greater in the case of "impure" placebos: even a homeopathic medicine may unpredictably interact with other substances, and it can always be defective on its own (e.g., the homeopath may have mistakenly used a highly toxic substance in a too high dosage). Furthermore, deceptively administered placebos can sometimes induce psychological addiction (Baumrucker *et al.* 2011). Importantly, prescribing deceptive placebos may lead to overlook present symptoms, thus leaving pathologies undiagnosed (Bok 1978). Patients who "walk away" thinking that they have found an effective medication for they ailments may not look for a second opinion, hence precluding the possibility of undergoing more diagnostic tests.

As for the harm to society, placebos may also have consequences for public health. For instance, using antibiotics as a form of impure placebos might facilitate the creation of antibiotic-resistant bacteria. Also, the cost of unnecessary treatments prescribed as impure placebos is likely to be anything but trivial. As Bok noted (1974, 21) "A great many diagnostic procedures that are known to be unnecessary are undertaken to give patients a sense that efforts are being made on their behalf. Some of these carry risk; many involve discomfort and the expenditure of time and money". If the concept of "placebo" is extended to all kinds of procedures that are unnecessary prescribed to satisfy patients' request "to do something", the costs and harms of unnecessary impure placebos become obvious. Finally, placebos may contribute to the medicalization of society. Prescribing a deceptive placebo to cope with unexplained symptoms promotes the wrong belief that there is "a pill for every ill" (Miller and Colloca 2009), and thus that everything can be cured or treated simply by quaffing some ready-made colored pills.

Therefore, placebos may harm both patients and society. Here, however, it is important to appreciate that this conclusion cannot justify the categorical ban for two reasons. First, deceptive placebos may harm society only if they are widely and consistently used. But if the primary goal of the AMA policy is that of preventing a wide and consistent use of deceptive placebos then the categorical ban is at best superfluous. Given the generally moderate clinical utility of placebos and their implications for trust, autonomy, and health, appealing to clinician's *prima facie* duty of veracity is already sufficient to maintain that deceptive placebos are unethical in the vast majority of the cases. Thus, one cannot justify the enforcement of a categorical ban only by pointing at the possible societal harms of deceptive placebos.

Second, deceptive placebos may harm individual patients, but so does any other medical treatment. Every treatment involves certain risks for patients' health, and these risks are often more serious than those entailed by placebos. At any rate, in both cases the question is not whether certain risks are justified, but whether such risks are justified in relation to the potential benefits. Likewise, the risks of not undertaking further diagnostic exams must always be evaluated in the light of the potential benefits that strategic deception provides in that specific case. Again, the moral issue at stake does not concern just the risks for individual health, but the balance between these risks and the expected benefits. Thus, one cannot justify the categorical ban by pointing only at the harms that deceptive placebos may cause to individual patients.

The question then becomes: does the balance between the harms and benefits of deceptive placebos justify the categorical ban? Here the answer could be "Yes", but only if one assumes that deceptive placebos cannot have substantial clinical benefits. Drawing a parallel with the way in which other cases of benevolent deception are usually approached will clarify this point. As explained above, benevolent deception is often considered unethical in clinical settings. However, there are cases in which the benefits of benevolent deception clearly outweigh its potential harms – like in the one of the "unhopeful anesthetist". These exceptional cases justify the existence of a policy – and of a moral theory – that allows for situational deception.

But if there are no conceivable cases of this kind, then there is no reason to support these policies, or to argue that doctors should have a *prima facie* rather than a categorical duty of veracity. In fact, in absence of such cases, one could argue that a categorical duty is preferable, as it is more straightforward and it would also prevent all the mistakes that doctors might commit in determining what their actual duty is in each case. So, if we cannot image a case in which deceptive placebos have analogous benefits to the case of the "unhopeful anesthetist", then we have no reason to oppose the categorical ban. If this is correct, then much of the rationale supporting the AMA's placebo policy stands of falls with the assumption that deceptive placebos may not have substantial clinical benefits. In the next section, I argue that this assumption is mistaken, as there are cases in which deceptive placebos have both substantial clinical benefits as well as negligible risks for patients and society.

5. Defending the use of deceptive placebos for diagnostic purposes

In this section I argue that there are conceivable cases in which deceptive placebos may have substantial clinical benefits and negligible harms.

Following Kolber (2007), let us consider the case of a clinician who is unsure about whether one patient has epilepsy–a neurological disorder that might induce seizures – or a psychological condition that is able to induce epileptic-like pseudoseizures. The doctor is aware that "[t]he cost of pseudoseizures misdiagnosed as epilepsy can be extremely high, from both a financial and a psychosocial standpoint, with repeated hospitalizations, unnecessary medications, loss of work, loss of driving privileges, and strain on interpersonal relationships all contributing to overall disability" (Slater *et al.* 1995, 580).

There are two effective ways for distinguishing epileptic seizure from pseudoseizures.[2] The first way is electroencephalography. This method is reliable but requires the patient to be actually connected to the machine while she is having a seizure. The problem is that epileptic seizures are episodic and unpredictable, and to monitor a patient for a long time can easily become prohibitively expensive. The second method, then, is to use a deceptive placebo. One study (Slater *et al.* 1995, 582) showed that it is possible to reliably induce pseudoseizures in patients by providing a saline injection introduced by the following script:

> With your permission, we would like to try to bring on one of your events using an injected medication that has been designed to lower seizure threshold. Basically, what the drug does is lover the natural resistance your brain has to having one of your events. It is similar to a medication injected into hospital patients every day, but in your case has been specially prepared to induce seizures. In normal people, the injection does nothing, while in patients with seizures the injection has a greater than 90% chance of bringing on an episode.

The saline injection in this script is a deceptive placebo. This placebo must be deceptive because asking beforehand for patient's consent would deprive the procedure of its diagnostic utility. So, in this situation, is it morally permissible for a doctor to resort to a deceptive placebo in order to diagnose the true nature of patient's seizures?

Analogously to the case of the "unhopeful anesthetist", in answering this question the clinician is confronting a moral dilemma between her duty of veracity and her duty of beneficence. This dilemma appears to be genuine because the use of a deceptive placebo could have substantial benefits for the patient in this case. It can hardly be denied that a correct diagnosis of the nature of the seizure would significantly benefit her, as it would allow for the identification of the best therapeutic path, sparing her significant suffering. Furthermore, it is equally clear that the administration of a single saline injection under medical supervision has negligible risks for patients and public health. Thus there are conceivable cases in which the use of a deceptive placebo may have substantial clinical benefits and negligible risks.

Of course, from the fact that the use of a deceptive placebo might have substantial clinical benefits it does not follow that their use is automatically ethical. As always, the benefits of strategic deception ought to be balanced against not only its harms, but also against its implications for trust and the respect of patient's autonomy. Thus, depending

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[2] Medical research may come up with other methodologies to diagnose pseudo-epileptic seizures. However, this scenario would not counter this example, as it would be sufficient to image a situation in which all the conditions of the above example obtain and these newer technologies are unavailable.

on the situation, one might have different reasons to conclude that benevolent deception is or not the best course of action in a specific context. However, the purpose of this example is not to argue for one course of action over another, but only that of demonstrating that there are conceivable cases in which deceptive placebos may have significant clinical benefits and negligible harms.

To be fair, cases like this one may be rare. A deceptive placebo is seldom the only available means at doctors' disposal, and in most of the cases the limited clinical utility of deceptive placebos, together with their implications for trust and the respect of patients' autonomy, does not justify the use of deception. However, such cases may nonetheless occur and we should be careful not to endorse policies that would preclude substantial benefits to patients without a valid reason.

6. Conclusions

In the last decades a wave of new empirical discoveries on placebo effects have reignited the ethical debate over the clinical use of deceptive placebos. Amidst all the various positions, in this article my intent has been that of criticizing the view that the ethics of deceptive placebos should be seen as a stand-alone issue, rather than as a special case of the more general problem of providing a normative analysis of benevolent deception in clinical settings. As I have argued, I think that this view is misguided, and that it encourages the elaboration of moral theories and the adoption of policies that are either too permissive or too restrictive with regard to the use of deceptive placebos.

In particular, in this article I have criticized two attempts that are similarly aimed at placing the ethics of deceptive placebos outside the moral framework normally utilized to deal with moral dilemmas about benevolent deception in clinical contexts.

The first view is the one according to which there are ways of administering placebos that defy the traditional dichotomy between truth telling and deception. Here I have argued that such an attempt fails because the non-transparent administration of placebos still qualifies as an act of deception by omission; it disrespects patients' autonomy; and it is conductive to more dishonesty on doctors' part. In general, the view that doctors can exploit a "gray area" in between truthfulness and falsehood is not only fallacious, but it also betrays a limited appreciation of the crucial role that veracity should play in clinical contexts.

The second view that I have criticized is that deceptive placebos present us with a special moral problem that requires an *ad hoc* categorical ban. Here I have argued that categorical views like the AMA's one are justifiable, but only if we concede that deceptive placebos cannot have substantial clinical benefits. By discussing the case of a placebo used for diagnostic purposes, I maintained that this assumption is unwarranted because there are conceivable cases in which the use of deceptive placebos can have substantial clinical benefits and negligible harms.

In contrast to these positions, I have argued that there is no reason to set apart the moral case of deceptive placebos from others cases in which doctors confront moral dilemmas about benevolent deception. Accordingly, in approaching moral dilemmas about the use of deceptive placebos, doctors should rely on the same moral framework they use to approach other dilemmas about benevolent deception. With reference to the current ethical standards, in most clinical contexts this entails that the use of deceptive placebos should be considered as being *prima facie* wrong.

This view poses some serious challenges to the way in which deceptive placebos are currently used, the first of which consists in reducing the number of deceptive placebos currently administered in clinical settings. As empirical surveys reveal, today deceptive placebos are still widely prescribed. However, given their limited clinical utility and their implications for health, trust, and autonomy, in the vast majority of the cases the use of deceptive placebos is unjustifiable and thus unethical. Aside from a few exceptional cases, doctors have no good reason to use deceptive placebos.

Interestingly, enforcing categorical bans does not seem to be an effective measure to prevent clinicians from using deceptive placebos. Here, I suspect, the reason is that among all the problems of clinical ethics, those about truth telling and deception are especially tricky for a number of reasons. First, no one is perfectly honest, and we are all to some extent familiar with the benefits that situational deception may offer; prescribing impure placebos is very easy for doctors, and sometimes it may spare them a lot of time and efforts. Second, those who deceive and those who are deceived tend to appraise the moral implications of the same deceptive act in two dramatically different ways: the deceivers tend to justify and excuse their behavior, while the deceived tend instead to magnify its negative implications. Thus, doctors resorting to deceptive placebos are often in a bad spot to judge their own behavior in impartial ways, as they will naturally tend to discount the moral consequences of their acts.

Against this backdrop, I think that the most promising way of reducing the use of deceptive placebos consists not in enforcing categorical bans, but rather in proactively engaging clinicians in reflecting more about the morality of truth telling and deception. If we believe that doctors could justifiably withhold the truth from patients for their own good in exceptional cases, then we must also make sure that they are properly equipped to recognize, interpret and analyze all the moral implications of their decisions.

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Marianna Nobile

L'autonomia "irrazionale": interventi sul corpo e integrità fisica nel dibattito multiculturale

1. Premessa

L'attuale configurazione multietnica e multiculturale della società occidentale impone che ci si interroghi sulle diverse modulazioni della relazione di cura e sulle richieste avanzate da individui appartenenti alle diverse comunità, le cui tradizioni risultano spesso contrastare con i valori delle società democratiche e liberali dei paese ospitanti. In particolare, assume rilevanza la diversa connotazione della nozione stessa di medicina, intesa come prassi terapeutica basata su principi come il rispetto dell'autonomia del soggetto, sconosciuti o non centrali in alcune comunità. Ciò comporta la necessità di valutare non solo l'adeguatezza del modello sanitario proprio delle società liberali, ma anche la forza dei principi etici sui quali esso si basa. In questa prospettiva è imprescindibile prestare attenzione al diritto di perseguire i propri piani di vita senza impedimenti o costrizioni, con l'unico vincolo di non arrecare danno agli altri, quale condizione essenziale per la convivenza (Borsellino 2009). Se si assume il pluralismo dei valori e la varietà di posizioni morali sostanziali, si riconosce la libertà individuale di scegliere i principi ai quali ispirare la propria esistenza, impegnandosi a rispettare la pluralità delle concezioni di bene possibili. Alla luce della difficoltà di dare al "bene" una connotazione oggettiva e universalmente condivisa, si deve, dunque, preferire un modello che dia la priorità alla valutazione individuale relativa a che cosa costituisca il proprio "bene".

In questo contesto si inserisce il tema delle mutilazioni genitali femminili (Mgf), che emerge con sempre maggior urgenza a seguito del considerevole aumento dei flussi migratori e della conseguente diversificazione dei sistemi etici e culturali, facendo appello ai quali gli individui pretendono di avere diritto a compiere scelte e a richiedere specifici trattamenti sanitari. Le Mgf diventano un problema, sul quale è doveroso riflettere, quando la richiesta di effettuare tali pratiche viene avanzata da alcuni gruppi sociali radicati nel contesto occidentale, in nome di consuetudini proprie delle comunità di appartenenza.

In particolare, in questo lavoro si vuole rivolgere l'attenzione alle richieste di mutilazione genitale femminile avanzate da donne maggiorenni e capaci, valutando se l'argomento dell'integrità, adottato per motivare l'opposizione a tali richieste, possa essere considerato una ragione dirimente e ultimativa. Tale argomentazione verrà messa a confronto con le ragioni addotte a sostegno dell'accettazione sociale e della liceità giuridica accordata ad altri interventi, che pure danneggiano l'integrità fisica dell'individuo come, per esempio, alcune forme di chirurgia plastica genitale.

2. Le mutilazioni genitali femminili tra identità sociale e manipolazione del corpo

La prima classificazione di mutilazioni genitali femminili è stata elaborata da una Commissione tecnica riunita dall'Organizzazione Mondiale della Sanità (Oms) a Ginevra nel 1995, ed è accompagnata dalla descrizione della pratica e dalla sua valutazione negativa da parte dell'Organizzazione medesima[1]. La definizione e la classificazione che, tuttavia, vengono usate attualmente per riferirsi al fenomeno trovano origine nella *Dichiarazione Congiunta* sulle Mgf elaborata nel 1997 dall'Oms, insieme al Fondo delle Nazioni Unite per l'Infanzia (Unicef) e al Fondo delle Nazioni Unite per la Popolazione (Unfpa), nella quale si afferma che «le mutilazioni genitali femminili comprendono tutte quelle procedure che comportano la rimozione, totale o parziale, dei genitali femminili esterni o altre alterazioni di questi organi, per motivi culturali o altre ragioni non terapeutiche. Queste procedure sono irreversibili, dannose per la salute delle donne che le subiscono e hanno conseguenze che durano per tutta la vita» (Oms 1997).

L'Oms ha proposto una classificazione standard, aggiornata nel 2008, che distingue quattro tipologie principali di Mgf, pur riconoscendo l'esistenza di diverse forme intermedie. Il primo tipo di mutilazione comporta la «rimozione parziale o totale del clitoride e/o del prepuzio clitorideo». È la forma meno cruenta, diffusa nella maggior parte dei Paesi dell'Africa subsahariana, genericamente definita "sunna" o clitoridectomia. Nel secondo tipo avviene la «rimozione totale o parziale del clitoride e delle piccole labbra, con o senza escissione delle grandi labbra». È l'escissione propriamente detta ed è particolarmente diffusa in Egitto, presso numerosi gruppi etnici dell'Africa orientale e subsahariana. Il terzo tipo di Mgf si attua con il «restringimento dell'orifizio vaginale attraverso una chiusura ermetica coprente creata tagliando e avvicinando le piccole e/o le grandi labbra, con o senza escissione del clitoride». È la forma di mutilazione più distruttiva e corrisponde all'infibulazione. Si tratta di una procedura particolarmente diffusa in Somalia, Sudan e presso alcune popolazioni del Mali. Infine,

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[1] «La mutilazione genitale femminile è una pratica tradizionale profondamente radicata. Tuttavia si tratta di una forma di violenza con conseguenze negative sulla salute fisica e psicologica. È inoltre una discriminazione nei confronti delle donne. L'Oms s'impegna per l'eliminazione di tutte le forme di Mgf, con l'intento di attuare l'effettiva protezione e promozione dei diritti umani delle donne, compreso il diritto all'integrità fisica e al raggiungimento di livelli ottimali di benessere fisico, mentale e sociale» (Oms 1995).

il quarto tipo non corrisponde a una tipologia di mutilazione classificata in quanto tale, ma comprende «ogni altra procedura pericolosa per i genitali femminili per ragioni non mediche, per esempio puntura, piercing, incisione, abrasione e cauterizzazione»[2].

Ancor prima della definizione fornita dall'Oms, l'espressione "mutilazioni genitali femminili" fu adottata nella terza conferenza del *Comitato interafricano sulle pratiche tradizionali che colpiscono la salute di donne e bambini*, tenutasi ad Addis Abeba nel 1990[3]. Benché non di rado osteggiato in quanto giudicato non neutrale, il termine "mutilazione" viene espressamente impiegato per rendere l'idea che si tratti di una violazione dei diritti delle donne, e quindi per contribuire al suo sradicamento.

Per le comunità culturali in cui le mutilazioni vengono praticate, però, l'uso di questo termine può essere problematico proprio a causa della sua forte connotazione negativa che viene percepita come uno stigma, come un segnale di ripugnanza riferito a corpi imperfetti. Peraltro "mutilazione" è un termine che suscita disagio anche nelle società occidentali, proprio perché volto a considerare i corpi delle donne che sono state sottoposte a Mgf come qualcosa di diverso e scandaloso, creando un confine simbolico tra "noi" e "loro" (Pasquinelli 2007). Al contrario, per descrivere la pratica le lingue locali in genere usano l'equivalente dei termini "escissione" o "circoncisione", che possiedono una minore connotazione valutativa, in quanto, comprensibilmente, i genitori rifiutano l'idea di sottoporre a mutilazione le proprie figlie. Anche molti antropologi ritengono più opportuno utilizzare un termine neutrale e *value-free*, quale "intervento chirurgico tradizionale femminile" (Lane e Rubinstein 1996), per riferirsi a queste pratiche. Tuttavia, come rileva giustamente Macklin, il termine "intervento chirurgico" non è affatto neutrale, ma, al contrario, è connotato da una valutazione positiva, in quanto corrisponde a una pratica propria della tradizione medica, volta a ristabilire il benessere del paziente (Macklin 1999).

La disputabilità della pratica, già revocata in dubbio quando sottoposta a giudizio etico, implica un problema epistemologico, dal momento che, utilizzando termini differenti, sembra che si faccia riferimento a pratiche differenti. Un tentativo di scongiurare i pregiudizi negativi intorno alla pratica venne messo in atto alla fine degli anni Novanta: l'espressione *female genital cutting* (Fgc, letteralmente "taglio dei genitali femminili"), che fa riferimento solo all'atto del tagliare in assenza di giudizi valutativi, ha l'obiettivo di sottolineare il rispetto per le culture tradizionali che comprendono tra le proprie forme espressive tale pratica. Eppure, queste formule, apparentemente neutrali e generiche, hanno avuto a lungo il prevalente scopo di tacitare le coscienze (Favali 2002). Molte attiviste, africane e non,

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[2] Unaids, Undp, Uneca, Unesco, Unfpa, Unhchr, Unhcr, Unicef, Unifem, Who 2008.

[3] Nel 1990 l'Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (Iac) adottò il termine "mutilazioni genitali femminili" per descrivere la procedura precedentemente indicata come "circoncisione femminile".

hanno, infatti, ravvisato un rischio nella scomparsa del riferimento alla mutilazione, come se venisse meno parte della motivazione all'abbandono della pratica. Tale motivazione risiede nel riconoscere che il termine "mutilazione" non solo stabilisce una chiara distinzione linguistica rispetto a "taglio" o "circoncisione", ma rafforza l'idea che tale pratica comporti una violazione dei diritti umani delle donne. "Mutilazione" è, altresì, espressione di una disparità di genere profondamente radicata, priva le donne di una parte funzionale del proprio corpo e produce gravi conseguenze non solo fisiche, ma anche sociali, assegnando loro una posizione di evidente subalternità nella società (Unicef, Irc 2005).

Le Mgf si presentano, infatti, come una modalità di regolazione dei rapporti tra i sessi, che, secondo una lettura prevalente, costituisce una violenza di genere. Tuttavia, le ragioni invocate per giustificare un fenomeno tanto antico sono molteplici. Sebbene non di rado le Mgf vengano ricondotte all'ambito delle prescrizioni religiose, è opportuno rilevare che tali pratiche non sono dettate da una specifica fede religiosa, ma seguono piuttosto una distribuzione etnica o geografica. Infatti, in Eritrea e in Etiopia, l'escissione, comunemente associata all'Islam, è parimenti diffusa presso le comunità cristiane copte. Le religioni monoteiste, fin dalle origini, hanno condannato ogni tentativo di menomare l'integrità fisica dei genitali in quanto sacrilegio contro la creazione. Successivamente, tuttavia, si è assistito a un mutamento di atteggiamento degli esponenti del culto, caratterizzato dalla tolleranza nei confronti di tali pratiche e dalla loro giustificazione, nonostante nei testi sacri, come il Corano, non vi siano riferimenti diretti e neppure allusioni[4]. Questo atteggiamento è giustificato, secondo alcuni studiosi, ritenendo che «non è prudente contrapporsi a una usanza radicata di cui i proseliti non vogliono l'abolizione; più saggio è, invece, cercare di convivere con essa. Quando la religione viene a contatto con la tradizione, quest'ultima viene allora assimilata e presentata come parte del culto» (Favali 2002, 113).

Una delle motivazioni più frequentemente addotte per giustificare le Mgf è connessa al controllo della sessualità femminile e all'onore. In alcuni paesi di tradizione islamica, come il Nord Sudan e l'Egitto, la castità è considerata la qualità più preziosa di una donna in età da marito e si ritiene che le Mgf abbiano lo scopo di preservare la verginità e di aumentare il piacere sessuale maschile (Assaad 1980). Proprio in quanto forma di controllo della sessualità femminile ed espressione di una cultura fortemente patriarcale, la mutilazione dei genitali femminili è, altresì, considerata un mezzo per attenuare il desiderio sessuale della donna, al fine prevenire rapporti sessuali prematrimoniali ed extraconiugali, fonte di immoralità (Dorkenoo 1995). Diversamente, in comunità come quelle nomadi e pastorali,

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[4] Secondo Favali, nella religione islamica «l'infibulazione non è né prescritta, né consentita dalla *sharī ʿa*, […]. Il riferimento più noto alla escissione femminile compare nello spesso citato *ḥadīth* di *Um ʿAtiyyah* […], ove la pratica è presentata come una tradizione preislamica che il Profeta cerca di limitare. *Um ʿAtiyyah*, che fa parte del primo gruppo di fedeli al seguito di Maometto, pratica professionalmente l'escissione delle schiave. Il Profeta la informa che potrà continuare a operare, ma solo a una specifica condizione: "scalfisci ma non eccedere". Risulta ovvio da questo passaggio che tale professione esisteva prima dell'avvento dell'Islam» (Favali 2002, 112).

tipicamente presenti in Somalia, gli uomini, impegnati con le greggi, ritengono che l'infibulazione sia un mezzo per proteggere le donne dal rischio di stupro, oppure per evitare l'attacco di animali selvatici, la cui aggressività sarebbe accentuata dall'odore del sangue mestruale (Mazzetti 2007).

Presso alcune tradizioni culturali, le Mgf costituiscono anche un *rite de passage*, ossia un rituale che possa guidare, controllare e regolare cambiamenti di *status*. «Le mutilazioni – osserva van Gennep – sono un mezzo di differenziazione definitiva: altri mezzi, quali l'indossare un costume particolare o una maschera, o anche le pitture corporali […], imprimono una differenziazione soltanto temporanea. E sono questi [mezzi] che svolgono un ruolo importante nei riti di passaggio, perché si ripetono a ogni cambiamento della vita sociale dell'individuo» (Van Gennep 1909, 64). È un rito, dunque, che segna la differenza tra i diversi momenti di cui è composta la vita umana, trasformandoli in percorsi ordinati dotati di un significato, in cui viene esplicitata la necessità di istanze di identità e di riconoscimento e in cui la trasformazione sessuale rappresenta la modalità grazie alla quale la bambina acquisisce lo *status* di donna.

Va d'altra parte posto in rilievo come le pratiche mutilatorie degli organi genitali femminili, sebbene con motivazioni diverse sollevate in ambito clinico, nel passato abbiano trovato ampio consenso anche presso i paesi occidentali, dove la clitoridectomia era comunemente considerata un trattamento medico volto al controllo delle "deviazioni sessuali" e alla cura dell'isteria, della ninfomania e del lesbismo (Boyle 2002). La prima fonte documentaria di un certo rilievo risale a un numero di *The Lancet* del 1822, che riporta l'esperienza di Graefe, un chirurgo tedesco, che affermava di aver curato con successo, mediante l'escissione del clitoride, una giovane affetta da «masturbazione eccessiva e ninfomania» (Kandela 1999, 1453). Questo tipo di mutilazione "terapeutica" si inscrive in un'opinione diffusa nel XIX secolo, che riteneva la masturbazione la causa di una serie di disturbi funzionali del cervello e del sistema nervoso quali l'epilessia, e che considerava la clitoridectomia un intervento atto a guarire questi mali (Morrone e Franco 2004). Ne parla in maniera dettagliata anche Erlich nel suo testo sulle Mgf del 1986, in cui viene elencata una serie di interventi su donne e ragazze, eseguiti in genere da chirurghi che, per asportare il clitoride, adottavano sistemi che «non hanno niente da invidiare a quelli che si ritrovano nella letteratura etnografica a proposito di pratiche identiche in uso presso i selvaggi, e definite barbare dai "civilizzati"» (Erlich 1986, 68).

Ci si domanda, dunque, quali siano oggi le ragioni per continuare a perpetuare pratiche che non trovano più giustificazione nei contesti sociali contemporanei. Individuare tali ragioni è un compito arduo e forse anche rischioso, in ragione della facilità con cui si può scivolare nelle trappole delle semplificazioni. Inoltre, data l'antichità della pratica, le ragioni iniziali sono andate perdute nel tempo e le varie interpretazioni assunte nelle diverse società, nelle quali sono ancora messe in atto, hanno reso quasi impossibile trovare delle giustificazioni condivise.

3. Le antinomiche ragioni dell'universalismo e del relativismo etico

Alla luce delle precedenti considerazioni, ci si deve dunque domandare se la richiesta di Mgf possa essere eticamente accettabile in un contesto liberale. Dal punto di vista clinico è difficile negare l'esistenza di un danno oggettivo prodotto dalle Mgf, le quali, oltre a comportare gravi conseguenze psico-fisiche, rappresentano l'espressione più paradigmatica della subordinazione della donna al potere patriarcale. Tuttavia, questa lettura non raccoglie un consenso universale e coloro che la sostengono vengono accusati di imperialismo etico o di etnocentrismo, con la pretesa di imporre una determinata nozione di bene come superiore alle altre, considerando universali i propri valori. Tale obiezione può essere ricondotta a una forma di relativismo morale, il quale sostiene che i giudizi morali sono relativi a un determinato sistema etico per cui niente è assolutamente giusto o sbagliato. Ciò che è giusto o sbagliato lo è relativamente a un sistema morale particolare, che fa parte di una molteplicità di sistemi morali, nessuno dei quali può essere considerato universalmente valido o più valido di altri (Magni 2010). In questa prospettiva relativistica non esistono valori universali e nessuna cultura ha l'autorità morale per giudicare la liceità di pratiche e comportamenti propri di altre culture. Il significato delle nozioni stesse di "bene" e di "giusto" cambia nei diversi sistemi morali e, poiché non esistono criteri universali per esprimere giudizi, ciò che è giusto o sbagliato corrisponde a ciò che è, rispettivamente, approvato o disapprovato all'interno del sistema morale di riferimento. Secondo alcuni autori, vi è un'ulteriore accezione di relativismo, detto normativo, secondo il quale, dal momento che i principi morali sono relativi a una determinata società, non è possibile esprimere un giudizio morale su coloro che non condividono i medesimi principi morali di tale cultura[5]. Il relativismo normativo, quindi, trae dalle tesi proprie del relativismo etico una conclusione pratica in merito a come si debba agire[6]. Questa forma di relativismo, generalmente adottata in virtù di un atteggiamento di tolleranza nei confronti delle culture che sostengono principi morali differenti, ritiene che, come riconosce Williams, «"giusto" significhi (o si può coerentemente pensare soltanto che significhi) "giusto per una data società"; […] e che (pertanto) è sbagliato per le persone di una data società condannare, interferire con, ecc., i valori di un'altra società» (Williams 1972, 21). In riferimento alle mutilazioni genitali femminili, è stato quindi rico-

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[5] In riferimento alla versione più antica del relativismo normativo, Lecaldano sostiene che: «chi è relativista sul piano normativo afferma che in etica una soluzione vale l'altra e dunque quando i nostri principi sono in conflitto o in disaccordo con quelli di altri non ha alcun senso cercare vie razionali di accordo» (Lecaldano 1999, 33).

[6] È possibile individuare anche un secondo livello di analisi del relativismo etico, ovvero il relativismo metaetico. «Se il relativismo normativo interpreta la tesi che i giudizi morali sono relativi come implicanti conclusioni pratiche su come agire, – osserva Magni – il relativismo metaetico (o relativismo di secondo livello) la interpreta come implicante considerazioni su come i giudizi morali possono essere giustificati e argomentati, senza presentare direttamente tesi su come ci si debba comportare» (Magni 2010, 91).

nosciuto che l'enfasi posta sul valore relativo dei giudizi morali comporta una mancanza di fondamento dei medesimi, rendendo, in questo modo, illegittimo qualsiasi giudizio sulle pratiche istituzionalizzate da un'altra cultura (Zanetti 2003).

È altresì indispensabile distinguere il relativismo etico e quello normativo, secondo i quali, come è stato osservato, alcune pratiche vengono giustificate in base alla sola appartenenza a un determinato sistema di valori, dal relativismo culturale, che, in quanto teoria descrittiva, si limita a riconoscere l'esistenza di diversi sistemi morali, mettendo in luce come i principi morali dipendano dalla cultura del gruppo a cui l'individuo appartiene. Scrive Sumner: «La morale di un gruppo in un determinato periodo è la somma dei tabù e delle prescrizioni nelle usanze attraverso le quali la condotta giusta viene definita. […] La concezione del mondo, la vita pubblica, la giustizia, i diritti, e la morale sono tutti prodotti delle usanze» (Sumner 1973, 32).

Tuttavia, dal riconoscimento e dal confronto, imprescindibile, con le diverse culture e i relativi sistemi morali «non discende affatto che, sul piano giustificativo, sul quale si tratta di addurre buone ragioni a sostegno della preferibilità di linee d'azione, […] tutte le visioni del mondo, tutti i punti di vista, tutte le convinzioni etiche possano essere poste sullo stesso piano e considerate meritevoli di accoglienza, solo per il fatto di caratterizzare certe culture» (Borsellino 2009, 189). Se così fosse, si incorrerebbe in un errore logico, violando la cosiddetta *Legge di Hume*[7], secondo la quale è logicamente scorretto far derivare proposizioni prescrittive (ciò che deve essere) da proposizioni descrittive (ciò che è).

È stato inoltre osservato che il relativismo etico non renderebbe possibile il giudizio morale[8] e condurrebbe all'impossibilità di soddisfare il requisito di universalizzabilità dei giudizi morali, caratteristica essenziale dell'etica[9]. Il relativismo etico, nelle sue formulazioni più radicali, potrebbe, altresì, condurre a forme di conformismo etico, secondo il quale il relativismo dei valori implica il dovere del singolo di conformarsi alle convinzioni

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[7] «In ogni sistema morale in cui finora mi sono imbattuto, ho sempre trovato che l'autore va avanti per un po' ragionando nel modo più consueto, e afferma l'esistenza di un Dio, o fa delle osservazioni sulle cose umane; poi tutto a un tratto scopro con sorpresa che al posto delle abituali copule è o non è incontro solo proposizioni che sono collegate con un deve o un non deve; si tratta di un cambiamento impercettibile, ma che ha, tuttavia, la più grande importanza. Infatti, dato che questi deve, o non deve, esprimono una nuova relazione o una nuova affermazione, è necessario che siano osservati e spiegati; e che allo stesso tempo si dia una ragione per ciò che sembra del tutto inconcepibile ovvero che questa nuova relazione possa costituire una deduzione da altre relazioni da essa completamente differenti» (Hume 2008, 496-497).

[8] Come osserva Macklin, «se l'etica fosse relativa a tempo, spazio e cultura, allora ciò che i nazisti hanno fatto sarebbe "giusto" per loro, e non ci sarebbe alcuna base per la critica morale da parte di chi non è parte della società nazista» (Macklin 1999, 4).

[9] «L'etica – scrive Russell – è un tentativo di conferire un'importanza universale e non semplicemente personale ad alcuni dei nostri desideri. […] Quando un individuo dice "questo è bene in sé", […] ciò che l'individuo intende in realtà è: "desidero che ognuno desideri questo" o piuttosto "vorrei che ognuno desiderasse questo". […] Il desiderio, come avvenimento è personale, ma ciò che viene desiderato è universale». (Russell 1951, 195 ss.). Cfr. anche Hare 1952.

morali del proprio gruppo, oppure a forme di indifferentismo e scetticismo etico, dal quale deriva il venir meno non solo della fedeltà a qualsiasi principio morale, ma anche dell'autorità stessa della morale (Magni 2010). È quindi possibile affermare che ci sono valide ragioni per dichiararsi contrari alle istanze proprie del relativismo etico e normativo, riconoscendo, allo stesso tempo, che questo non comporta *ipso facto* prestare il fianco all'accusa di assolutismo. Considerare universali determinati valori, infatti, non implica al tempo stesso ritenerli assoluti[10]. È proprio l'assolutismo a caratterizzare le posizioni propriamente etnocentriche, descritte da Michel de Montaigne già nel XVI secolo, secondo il quale «ognuno chiama barbarie quello che non è nei nostri costumi; come veramente sembra che noi non abbiamo altra pietra di paragone della verità e della ragione, che l'esempio e l'idea delle opinioni e delle usanze del paese in cui siamo. Ivi si trova sempre la religione perfetta, il regime perfetto, l'uso perfetto e rifinito di ogni cosa» (Montaigne 1953, 213). Lungi dal ritenere di poter imporre la propria cultura e la propria morale come l'unica valida, in questa sede si riconosce la rilevanza dei valori per coloro che a essi ispirano le proprie vite, assumendo una prospettiva pluralista, che induce a prendere sul serio e a rispettare[11] i valori morali propri dei nostri "contemporanei morali"[12] appartenenti a culture altre, nonostante questi non vengano condivisi universalmente. In questo senso, il pluralismo è, come sostiene Berlin, «una concezione per la quale sono molti e differenti i fini a cui gli uomini possono aspirare restando pienamente razionali, pienamente uomini, capaci di comprendersi tra loro, di solidarizzare tra loro, di attingere luce l'uno dall'altro […]» (Berlin 1994, 71).

In quest'ottica, determinate pratiche appartenenti a diversi sistemi culturali, come le Mgf, devono essere prese in considerazione da un punto di vista basato sul principio del rispetto universale, in osservanza di quello che Benhanib chiama "l'imperativo pragmatico" di intraprendere un dialogo multiculturale basato sulla comprensione reciproca (Benhabib 2005). Anche Macklin ritiene che sia necessario un dialogo interculturale, basato su principi universali, identificati nei quattro principi della bioetica enunciati da Beauchamp e Childress: rispetto per l'autonomia, non maleficenza, beneficienza e giustizia (1999), applicabili anche da altre culture nella forma che ciascuna ritiene più adeguata. È necessario, dunque, non confondere l'universalità dei principi con il loro assolutismo. Infatti, mentre l'assolutismo fa riferimento a principi etici immutabili che non ammettono eccezioni, l'universalità riguarda la portata dei principi, non già il loro contenuto sostanziale. I quattro

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[10] Relativamente alla distinzione tra principi universali e principi assoluti in riferimento alle problematiche legate al multiculturalismo, si veda Macklin 1999, in particolare il capitolo 5.

[11] Secondo Nussbaum lo stesso principio del rispetto rappresenta un valore universale, in quanto corrisponde al «valore di poter pensare e scegliere per conto proprio» (Nussbaum 2001, 71).

[12] Benhabib riconosce la necessità di comprensione, interpretazione e comunicazione con l'altro, sostenendo che «siamo divenuti contemporanei morali, seppure non partner morali, catturati in una trama di interdipendenze […]» (Benhabib 2005, 62).

principi della bioetica sono principi generali che, se interpretati e adattati in funzione dei differenti contesti, permettono di intraprendere un dialogo transculturale. I principi universali possono essere giustificati «in quanto rispondenti a *richieste universali*, soprattutto quella di non subire danno e di vedere riconosciuta la propria dignità. In questo senso i principi non sono "posti dall'alto", ma esprimono istanze provenienti dal "basso", cioè suscitate dalle persone sulla base dei loro bisogni» (Sala 2003, 339).

Fatte queste considerazioni, la richiesta di praticare le Mgf pone in essere un "disaccordo morale genuino o fondamentale", ovvero, un disaccordo che non può essere risolto facendo appello né a considerazioni morali, né fattuali, in quanto si configura come un conflitto nella valutazione morale tra individui che condividono le medesime credenze empiriche e, al tempo stesso, anche il significato dei termini e degli enunciati per esprimere disaccordo (Magni 2010). Ciò non significa, però, fare concessioni al relativismo etico, considerando ciascun soggetto come appartenente a un sistema morale che non può fare appello a criteri oggettivi per dirimere il conflitto. Il fatto che una pratica nel contesto di origine abbia un significato culturale o politico rilevante e che goda del consenso della comunità non è rilevante dal punto di vista normativo, soprattutto nel momento in cui tale pratica viene trasferita in un contesto culturale differente, ove sono presenti altre opzioni di significato relative alla pratica medesima.

4. INTERVENTI SUL CORPO AL VAGLIO DEL PRINCIPIO DI AUTONOMIA: UN DOPPIO STANDARD DI GIUDIZIO?

Se vi sono buoni argomenti per considerare eticamente intollerabili e giuridicamente illegittime le pratiche di mutilazione genitale femminile, qualora siano messe in atto su minori che non possono prestare valido consenso, ci si domanda quale posizione assumere nel caso in cui la richiesta sia avanzata da donne maggiori di età e competenti. Generalmente si registra un atteggiamento di chiusura nei confronti delle pratiche mutilatorie femminili e, secondo alcuni autori, tali questioni «si inscrivono nell'ambito della più ampia riflessione sulla configurabilità del diritto del singolo di incidere e modificare la propria sfera corporea – qui, in particolare la conformazione degli organi sessuali – nel processo di costruzione e definizione della propria identità personale che può intendersi come espressione della personalità di ciascuno e affermazione del diritto alla salute inteso quale benessere psicofisico dell'individuo» (Venuti 2011, 704).

Nell'ordinamento italiano, tra i motivi per cui si ritiene illegittima la richiesta di Mgf avanzata da una donna adulta e competente, viene richiamato l'art. 5 del Codice Civile che, pur consentendo gli atti di disposizione del proprio corpo quale giusto postulato della libertà personale, vieta tutti quegli atti che cagionino una diminuzione permanente dell'integrità fisica, o che siano altrimenti contrari alla legge, all'ordine pubblico e al buon costume. Tuttavia, è opportuno sottolineare che il riferimento all'integrità del corpo contenuto nell'articolo menzionato non richiama immediatamente la fattispecie delle Mgf, in quanto i vincoli posti dal legislatore sono riferiti all'incommerciabilità e alle modalità di circolazione di organi e tessuti propri del soggetto il cui corpo risulta indisponibile[13]. Anche nella *Carta dei diritti fondamentali dell'Unione Europea* il riferimento all'integrità è posto in relazione al divieto di fare del corpo umano e delle sue parti una fonte di lucro. Inoltre, l'integrità fisica è intesa come un diritto, piuttosto che come un dovere del singolo di mantenere inviolato il proprio corpo, tanto è vero che il consenso libero e informato è il presupposto di qualsiasi intervento medico[14].

Pur riconoscendo la gravità delle pratiche di Mgf, si vuole attrarre l'attenzione sul rischio di inappropriatezza in cui incorrono sia le ragioni che sottendono la loro illiceità giuridica, sia le modalità adottate per vietarle nei contesti occidentali, sempre in riferimento alla richiesta avanzata da donne capaci e maggiori di età. Se la diminuzione permanente dell'integrità fisica è ritenuta la principale ragione per rendere irrilevante il consenso nel caso delle Mgf, ci si domanda come mai non si faccia appello alla medesima ragione in riferimento ad altre pratiche che parimenti provocano effetti permanenti sull'integrità fisica dell'individuo, quali la chirurgia estetica vaginale.

A questo proposito, frequentemente si sostiene che «solo qualcuno la cui volontà sia coartata o altamente irrazionale potrebbe consentire a una pratica di mutilazione genitale sul suo corpo e che, perciò, un consenso valido al riguardo sia, di fatto, impossibile» (Gentilomo *et al.* 2008, 29). Il consenso di coloro che avanzano la richiesta di Mgf, dunque, viene prevalentemente considerato non valido, perché si ritiene sia fondato su preferenze adattive e non autonome[15]. In questa prospettiva, la scelta di subire una mutilazione sarebbe data da una preferenza adattiva, in quanto influenzata da fattori esterni, nonostante si possa affermare che molte, se non tutte, le preferenze espresse da un individuo subiscono un condizionamento. Alcune preferenze adattive sono ritenute, inoltre,

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[13] Infatti, l'occasione in cui venne approvato l'art.5 c.c. risale a una sentenza della Corte di Cassazione del 1934, relativa a una vicenda in cui un giovane studente aveva venduto a un anziano e facoltoso brasiliano una propria ghiandola sessuale maschile (testicolo), per far in modo che quest'ultimo riacquistasse la perduta vitalità sessuale e riproduttiva. In quell'occasione, tuttavia, entrambi gli imputati furono assolti sulla base della scriminante del consenso dell'avente diritto. Si veda, Cass. Pen., 31 gennaio 1934, in «Foro italiano», 11, 1934, 146 ss.

[14] *Carta dei diritti fondamentali dell'Unione Europea* (2010/C 83/02), art. 3.

«1. Ogni persona ha diritto alla propria integrità fisica e psichica. 2. Nell'ambito della medicina e della biologia devono essere in particolare rispettati: a) il consenso libero e informato della persona interessata, secondo le modalità definite dalla legge; b) il divieto delle pratiche eugenetiche, in particolare di quelle aventi come scopo la selezione delle persone; c) il divieto di fare del corpo umano e delle sue parti in quanto tali una fonte di lucro; d) il divieto della clonazione riproduttiva degli esseri umani».

[15] La nozione di preferenza adattiva è stata introdotta da Elster facendo ricorso all'esempio della famosa favola di Esopo *La volpe e l'uva*. Nella favole, la volpe, poiché non riesce a raggiungere l'uva desiderata, riconsidera le sue percezioni, giungendo a credere che l'uva sia acida, quindi non desiderabile. In questo modo, la volpe ridefinisce le sue preferenze, modellando la realtà così da rendere indesiderabile ciò che è impossibile ottenere (Elster 1983).

autoabrogative nel momento in cui entrano in conflitto con gli interessi di lungo periodo della donna, influendo sulle sue opportunità future per una vita libera dall'oppressione come perpetuata nella tradizione patriarcale (Besussi 2004). Da questo punto di vista, le preferenze frutto dell'oppressione, come le Mgf, giustificherebbero l'intervento paternalistico dello Stato, volto a prevenire scelte non autonome che potrebbero provocare un danno per la donna.

Questa argomentazione presenta, tuttavia, delle criticità. Alcuni interventi paternalistici sono comuni nello Stato liberale e giustificabili, in quanto indipendenti da qualsiasi distinzione morale o politica che favorisca alcuni individui piuttosto che altri, ragione per cui possono essere ritenuti compatibili con i principi di neutralità dello Stato[16]. Al contrario, la proibizione delle Mgf è dichiaratamente volta a impedire scelte che appaiono eticamente intollerabili, che presumibilmente non permettono alla donna di emanciparsi da una cultura illiberale e patriarcale[17].

Ora, considerare adattive solo determinate preferenze significa giustificare una concezione perfezionista della politica, in cui lo Stato si erge a educatore, con il rischio di imporre una morale particolare su tutti, anche su chi non la condivide. In particolare, imporre alle donne l'emancipazione da pratiche e tradizioni culturali per loro dannose, significa perpetrare su di esse una diversa forma di oppressione, in virtù del fatto che la libertà non può essere imposta, ma solo conquistata. Imporre a donne appartenenti a diverse tradizioni culturali l'abbandono di una pratica in nome di valori che non riconoscono come propri non ne favorisce l'emancipazione, ma, al contrario, può essere considerata una forma di assoggettamento che non permette loro di compiere una scelta davvero autonoma. Vi sono buoni argomenti, quindi, per affermare che per la donna adulta e competente «vale il principio milliano secondo il quale "su se stesso, sul suo corpo e sulla sua mente l'individuo è sovrano", che implica l'illegittimità dell'intervento pubblico in forme coercitive in nome di un bene (o di un danno) definito dall'esterno, su cui l'interessato non concorda. Di conseguenza è solo ad altre forme d'intervento giuridico e politico, non coercitive, ma educative, assistenziali e promozionali che può essere affidato il problema di farsi carico delle preferenze adattive» (Facchi 2005).

Peraltro, non è lecito presumere che tutte le preferenze espresse delle donne appartenenti alla cultura occidentale siano genuinamente autonome. Per esempio, anche le scelte che implicano il disperato tentativo di uniformarsi a un determinato canone di bellezza, spesso irraggiungibile e causa del sempre più frequente ricorso alla chirurgia estetica, si

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[16] Per una più ampia difesa degli interventi paternalistici in circostanze specifiche, si rimanda a Dworkin 1979.

[17] Cfr. Galeotti 2007. L'argomentazione proposta da Galeotti è riferita, tuttavia, unicamente all'opzione del rituale alternativo, scelta da donne maggiori di età e competenti. Al contrario, in questa sede, si ritiene che le medesime giustificazioni possano essere addotte quando la scelta ricade sulle mutilazioni dei genitali vere e proprie, in quanto le motivazioni di carattere socio-culturale portate a sostegno dalla donna che vuole sottoporsi a tale intervento non differiscono da quelle che caratterizzano la scelta del rituale alternativo.

discostano dall'ideale di autonomia, che, invece, viene richiesto alle donne provenienti da altre culture affinché le loro scelte siano considerate autentiche. Come sostiene Skaine, «quando parliamo delle Mgf e del modo in cui le donne straniere si sentono obbligate a modificare i loro corpi per essere socialmente accettate, non dobbiamo dimenticare che le donne americane fanno la stessa cosa mediante la chirurgia plastica. Ma è ancora più impressionante che 2000 ragazze all'anno negli Stati Uniti si sottopongano a clitoridectomia, in modo che il loro clitoride abbia una misura socialmente accettabile in questo paese. Ed è una procedura raccomandata da medici e genitori» (Skaine 2005, 88-89). Se da una parte si ritiene che la scelta di sottoporsi a Mgf derivi da pressioni volte a far sì che la donna si conformi ad aspettative e tradizioni socio-culturali profondamente radicate, non si può non riconoscere che la decisione di sottoporsi a molte forme di chirurgia estetica sia anch'essa influenzata dalla pressione sociale che costantemente esorta le donne occidentali a conformarsi a un certo ideale di bellezza.

L'editoriale del *British Medical Journal* del 13 luglio 2006, pone l'accento su pratiche chirurgiche come la "designer laser vaginoplasty" o la "laser vaginal rejuvenation", ritenendole l'ultimo capitolo nella vittimizzazione delle donne nella nostra cultura (Conroy 2006). Riprendendo la definizione di Mgf formulata dall'Oms, nella quale si afferma che «le mutilazioni genitali femminili comprendono tutte quelle procedure che comportano la rimozione, totale o parziale, dei genitali femminili esterni o altre alterazioni di questi organi, per motivi culturali o altre ragioni non terapeutiche», risulta difficile sostenere che non vi rientrino anche gli interventi qui citati. L'editoriale del *British Medical Journal* conclude, infatti, sostenendo che «è la medicina occidentale [...] a perpetrare le mutilazioni genitali femminili alimentando la paura che la naturale variabilità biologica sia un difetto, un problema che richiede il bisturi» (Conroy 2006, 107).

Si riconosce, tuttavia, che la donna, appartenente a un gruppo a tradizione escissoria, che rifiuti di sottoporsi a Mgf subisce conseguenze ben più gravi, come l'esclusione dal gruppo, rispetto alle difficoltà che potrebbe incontrare la donna occidentale, decisa a non uniformarsi a un modello di bellezza culturalmente definito, e che, in questo modo, la scelta della prima sia obbligata, più che influenzata, dalla cultura di appartenenza. Ciò nonostante, non si può escludere che, in alcuni casi, la volontà della donna che richiede espressamente una forma di Mgf su se stessa sia autonoma, in virtù di una personale adesione alla tradizione. L'impossibilità di individuare un criterio certo e universalmente condiviso per valutare l'autonomia delle scelte non permette, in ultima analisi, di formulare un giudizio definitivo sull'accoglibilità di determinate richieste di intervento, piuttosto che altre. In questa prospettiva, l'unico ragionevole limite sarebbe quello posto dal medico che, in ottemperanza all'art. 52 del Codice di Deontologia medica, si rifiuti di attuare mutilazioni non aventi finalità diagnostico-terapeutiche. Si ricorda, inoltre, che il principio di autonomia, sebbene comporti il diritto del soggetto di essere sottoposto soltanto agli interventi che abbia consapevolmente scelto, non implica anche il diritto di vedere soddisfatta dai sanitari qualunque richiesta di trattamento, in base al principio di appropriatezza terapeutica[18].

Si potrebbe, altresì, ritenere che anche la chirurgia transessuale, pur se liberamente scelta da soggetti maggiori d'età, dovrebbe essere ascritta alla medesima logica delle Mgf. Il parallelo tra queste e la chirurgia transessuale viene tracciato in ragione del fatto che entrambe le pratiche impediscono un ritorno alla conformazione originale dell'organo e compromettono l'apparato riproduttivo.

Tuttavia, tali pratiche difficilmente possono essere tra loro equiparate, perché, rispetto alla scelta di sottoporsi a Mgf (e anche a interventi di chirurgia estetica), la decisione di cambiare sesso deriva da un profondo conflitto interiore tra sesso e genere della stessa persona. Il conflitto è intrapersonale e la scelta non subisce alcuna pressione sociale o culturale, anzi, spesso viene fatta alterando precedenti equilibri e dando, perciò, prova della genuina e, secondo alcuni, autentica autonomia personale. Ma adottare una nozione di autodeterminazione, che richieda che «la persona autonoma sia straordinariamente autentica, padrona di sé, coerente, indipendente, dotata di autocontrollo, resistente ai condizionamenti, e fonte originaria di valori, opinioni e progetti di vita personali» (Beauchamp e Childress 1999, 129), implicherebbe considerare non autonoma non solo la decisione di sottoporsi a Mgf, ma anche la maggior parte delle nostre scelte quotidiane, in special modo quelle relative all'estetica del nostro corpo.

Alla luce di queste considerazioni appare dunque evidente l'impiego di un doppio standard di giudizio in riferimento alla condanna almeno delle forme più lievi di Mgf e, probabilmente, anche per la richiesta di reinfibulazione. Infatti, gli argomenti etico-giuridici addotti per giudicare illegittima qualsiasi forma di Mgf consapevolmente scelta, dovrebbero essere validi anche per valutare la scelta della donna occidentale di alterare chirurgicamente la propria anatomia genitale. Al contrario, gli argomenti dell'autonomia e della libera scelta individuale sembrano valere esclusivamente quando viene vagliata la scelta della donna occidentale, mentre le preferenze di altre donne appartenenti a culture diverse vengono considerate adattive o, peggio, irrazionali. Tale doppio standard di giudizio suscita, quindi, delle perplessità, perché, se si considera legittima una scelta proprio in quanto scelta libera, non si può pretendere che tale libertà di scelta appartenga solo ad alcune categorie di soggetti, nella fattispecie le donne occidentali. Allo stesso tempo non si può assumere che alcuni individui siano realmente liberi quando scelgono, mentre altri non lo siano solo perché le loro scelte sono considerate ripugnanti dai primi (Sala 2006). Ci si domanda, perciò, perché dovremmo accettare le preferenze adattive delle donne occidentali che vogliono emulare certi modelli di bellezza, alterando irreversibilmente

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[18] Cfr. in particolare l'art. 13 ("Prescrizioni diagnostico-terapeutiche") e l'art. 15 ("Sistemi e metodi di prevenzione, diagnosi e cura non convenzionali") del Codice di Deontologia medica del 2014.

l'integrità del proprio corpo, mentre ci ostiniamo a mettere in questione le scelte, spesso sofferte, di donne adulte provenienti da culture diverse. Occorre forse un ripensamento del concetto di integrità del corpo, proprio alla luce del principio di autodeterminazione, perché il sospetto è che, tutto sommato, la nostra valutazione sia inficiata dal pregiudizio nei confronti di ciò che è straniero, ambiguo e che, per certi versi, provoca disgusto.

5. Verso un ripensamento del concetto di integrità del corpo

L'analisi effettuata su una particolare forma di intervento sul corpo come le mutilazioni genitali femminili conduce a una riflessione sulla relazione terapeutica nella società multietnica contemporanea, prestando particolare attenzione alla configurazione del principio di autodeterminazione del soggetto in relazione al concetto di integrità del corpo. Nel contesto italiano il diritto fondamentale alla salute, garantito dal secondo comma dell'art. 32 della Costituzione, letto in combinato disposto con l'art. 13, assicura la tutela della libertà individuale, intesa non solo come pretesa di astensione rispetto a comportamenti lesivi dell'integrità psico-fisica del soggetto, ma anche come diritto di autodeterminazione dell'individuo rispetto agli atti che coinvolgono il proprio corpo. Autonomia e libertà sono anche i principi su cui si basa la *Convenzione di Oviedo*[19] che, a livello sovranazionale, attribuisce una forte rilevanza giuridica alle forme di manifestazione della volontà relativamente ai trattamenti terapeutici. Prendendo le distanze dalla tradizione classica, in cui la salute era considerata in una prospettiva prevalentemente pubblicistica, l'autodeterminazione assume sempre maggior rilevanza, portando a intendere la salute come stato di benessere fisico, mentale e sociale, ossia come una percezione individuale che risponde non già a criteri oggettivabili, bensì al vissuto delle singole persone.

In una prospettiva di tutela della salute, sebbene non debba venir meno il riferimento ai principi morali di beneficenza, di non maleficenza e di giustizia, per giustificare le regole generali della prassi medica in vista della promozione degli interessi dell'individuo della cui salute si tratta, assume preminenza il principio di autonomia, proprio in ragione dell'impossibilità di definire oggettivamente in che cosa consista il bene del soggetto. In questo modo il principio di autonomia, fondato sul presupposto di uguale dignità e capacità di autodeterminazione proprio di tutti gli individui competenti, assume

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[19] La Convenzione sui Diritti dell'Uomo e la Biomedicina, nota altresì come *Convenzione di Oviedo*, entrata in vigore nel 1999, costituisce il primo trattato internazionale riguardante la bioetica, e rappresenta un pietra miliare per lo sviluppo di regolamenti internazionali volti a orientare eticamente le politiche della ricerca di base e applicativa in ambito biomedico, e a proteggere i diritti dell'uomo dalle potenziali minacce sollevate dagli avanzamenti biotecnologici. In particolare, in questa sede, assume rilevanza l'art. 1, capitolo I (Disposizioni generali), che afferma: «Le Parti di cui alla presente Convenzione proteggono l'essere umano nella sua dignità e nella sua identità e garantiscono a ogni persona, senza discriminazione, il rispetto della sua integrità e dei suoi altri diritti e libertà fondamentali riguardo alle applicazioni della biologia e della medicina».

la valenza di metaprincipio. Vale a dire di un criterio operante a livello "procedurale", al quale è necessario fare riferimento nel momento in cui si deve operare una scelta tra valutazioni morali che fanno appello a sistemi etici diversi (Borsellino 2009).

Rispetto al principio di autonomia, il profilo più significativo, al quale è opportuno prestare attenzione soprattutto in una prospettiva multiculturale, dove si assiste alla richiesta di mettere in atto pratiche che non rientrano nella comune prassi sanitaria, è quello relativo alla delimitazione dell'ambito entro cui ciascuno può disporre della propria integrità fisica. Si è potuto, infatti, osservare come, nel caso delle Mgf, trovi accoglienza, nell'inquadramento etico e normativo, l'idea che l'autodeterminazione abbia un limite, individuabile, nello specifico, nella protezione che si riserva all'integrità fisica, la quale assume la qualifica di diritto, affinché il corpo non sia violato o manipolato da terzi, ma anche, in alcune circostanze, di dovere, quello di mantenere integro il proprio corpo. Il concetto di integrità è, pertanto, connotato dai requisiti di inviolabilità e di indisponibilità, sebbene il soggetto, del cui corpo si tratta, non possa essere espropriato del diritto di governare la propria vita (Rodotà 2011), in una prospettiva che non concepisce più il corpo come dotato di confini che lo separano dalla mente, ma afferma l'unità psico-fisica dell'individuo, l'interrelazionalità tra corpo e sé.

Nella riflessione filosofica si può rintracciare, sin dalle origini, una contrapposizione tra visione dualistica e unitaria del rapporto tra anima e corpo[20], che sul piano giuridico ha condotto a considerare il corpo come soggetto o come oggetto di diritti. Tale contrapposizione, a sua volta, ha trovato espressione nella dottrina dello *ius in se ipsum*, secondo cui l'individuo sarebbe al contempo soggetto e oggetto di diritto, quale premessa al riconoscimento di un dominio individuale del soggetto sul proprio essere fisico (D'Arrigo 1999). Attraverso questa elaborazione si è venuto affermando un modello che tendeva a ricondurre la regolazione del corpo entro lo schema rigido dato da quel particolare diritto soggettivo, che è il diritto di proprietà. Tuttavia, alla luce della concezione dell'individuo come indivisibile unità tra corpo e persona[21], si è giunti a ritenere inattuabile il

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[20] Nella filosofia antica e medievale la relazione tra corpo e anima è stata interpretata secondo due prospettive: la prima, di ascendenza orfico-pitagorica, vedeva nel corpo un'entità radicalmente eterogenea e separata rispetto all'anima; a tale concezione si ispira Platone quando sostiene che il corpo è la tomba dell'anima (*Fedone* 66b), ossia un ente corruttibile e mortale di cui l'anima, privata del suo stato meramente intellettuale ed eterno, sarebbe prigioniera; la seconda prospettiva, elaborata da Aristotele, sostiene che corpo e anima non siano due sostanze separate, bensì elementi separabili di un'unica sostanza: il corpo è la materia intesa come potenzialità, l'anima è la forma in quanto attualità; come potenzialità, il corpo è dunque uno strumento dell'anima, benché, a differenza di uno strumento inanimato, abbia in se stesso il principio del movimento e della quiete (*L'anima*, II, 412 b, 16).

[21] Tale elaborazione si richiama all'etica kantiana, secondo la quale «l'uomo non può disporre di se stesso, perché non è una cosa: egli non è una proprietà di se stesso, poiché ciò sarebbe contraddittorio. Nella misura, infatti, in cui è una persona, egli è un soggetto, cui può spettare la proprietà di altre cose. Se, invece, fosse una proprietà di se stesso egli sarebbe una cosa, di cui potrebbe rivendicare il possesso, poiché è impossibile essere insieme una cosa e una persona, facendo coincidere il proprietario con la proprietà, in base a ciò l'uomo non può disporre di se stesso.

rapporto di disponibilità sul corpo che lo assimili a una cosa separata da chi lo identifica, in ragione dell'impossibilità di distinguere nell'individuo stesso un soggetto e un oggetto di diritto. Come ha messo ben in evidenza la Corte Costituzionale già nel 1986, «il corpo umano […] non può essere considerato avulso dalla persona». Piuttosto che fare riferimento al bene dell'integrità fisica come oggetto di diritto, è opportuno, dunque, parlare di un diritto che tuteli il corpo come espressione della persona umana. La Costituzione impone, infatti, di impostare il problema in termini di libertà di disporre del proprio corpo, ossia in termini di libertà di autodeterminarsi in ordine a comportamenti che in vario modo coinvolgono e interessano il proprio corpo (Romboli 1991), abbandonando, in questo modo, l'idea di corpo separato dalla persona e sul quale l'individuo esercita i propri poteri di disposizione. «Diritti del corpo, non sul corpo, – scrive Rodotà – dove il Mio non allude più a una vicenda patrimoniale, alla logica proprietaria alla quale persona e corpo sono irriducibili» (Rodotà 2011, 74).

È, pertanto, opportuno domandarsi se esista una definizione universalmente condivisa di integrità del corpo. Secondo alcuni, dietro il concetto di integrità del corpo si cela una concezione naturalistica del corpo che occulta le manipolazioni culturali attraverso cui ogni cultura costruisce diverse idee di e sul corpo (Pasquinelli 2007). Se su ogni corpo è impresso il marchio indelebile della cultura di appartenenza, allora dovremmo ritenere che non si possa propriamente parlare di naturalità dei corpi. L'integrità fisica non è altro che una costruzione culturale particolare dei nostri corpi, spesso inconsapevole della loro dimensione simbolica, che è molto facile da decifrare in altri corpi, in quanto oggettivata dal nostro punto di vista naturalistico. Sia i nostri corpi, sia quelli degli altri sono simboli che rispecchiano la cultura peculiare alla società di appartenenza e che predispongono a destini di autonomia o di oppressione. «Più spesso corpi assoggettati che liberi. Sia che assumano la forma di una atavica soggezione alla più oscura delle tradizioni sia che si presentino alle performance umilianti del machismo mediatico. […] Per ogni cultura sono infatti le convenzioni, i valori e i simboli a decidere quale è la soglia oltre la quale un comportamento o un intervento sul corpo diventa una violazione della sua integrità. Mentre, al di sotto di quella soglia, qualsiasi intervento apparirà del tutto naturale […]» (Pasquinelli 2007, 15-16).

Si riscontra, inoltre, una certa ambiguità del concetto di integrità fisica, che rimanda a una duplice concezione del corpo, inteso, da una parte, come confine invalicabile, e dall'altra come segno della piena esplicazione della propria personalità. «Lo statuto del corpo si può pertanto definire come *limen*, come soglia che al contempo distingue e congiunge, in quanto viene a occupare una posizione di frontiera, uno spazio transizionale dove la volontà si origina e dove finalmente si manifesta attraverso l'identità: ed è questa capacità espressiva ciò che rende il corpo soggetto e oggetto di trasformazioni e

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Non gli è consentito vendere un dente o un'altra parte di se stesso» (Kant 1984, 189).

scambi, di spostamenti, rovesciamenti e reversibilità» (Rossi 2012, 222). In questa prospettiva, l'integrità del corpo non può essere considerata come un valore in sé, bensì come strumentale rispetto all'individuo, con riferimento alle diverse esigenze di tutela dello stesso. Essa deve confrontarsi con tutte le scelte che attengono alla costruzione e alla modificazione del proprio corpo, con la più ampia integrità della persona, che comprende non solo l'integrità fisica e psichica, ma si estende ad altri valori connessi alla dignità della persona, tra i quali il diritto di ciascuno di governare liberamente il proprio corpo (Rodotà 2007). Il corpo diviene, quindi, strumento di espressione della personalità, ma anche rappresentazione simbolica della propria identità, influenzata da «fenomeni di politica dell'identità che elaborano modelli di rappresentazione sociale del sé» (Pucella 2010, 121). Ciò comporta una rilettura del concetto di integrità del corpo in una dimensione identitaria che giustifica un certo grado di "menomazione" della mera integrità fisica, se effettuata in vista della salvaguardia del benessere mentale e sociale del soggetto. Infatti, se, a partire dalla definizione di salute dell'Oms, la salute non è più intesa come un concetto puramente biologico, bensì come un concetto psico-sociale, strettamente connesso all'ambiente in cui si vive, la trasformazione del corpo può essere necessaria per costruire un'identità capace di comunicare, ma anche per costituire le condizioni dello stare bene con se stessi, prima che con gli altri.

Senza pretendere di poter dare una risposta definitiva, che risolva le ambiguità legate al concetto di integrità del corpo, in questa sede si ravvisa la necessità di un ripensamento di tale nozione, alla luce delle sempre più urgenti problematiche poste in essere dalle richieste avanzate da soggetti adulti e capaci, in virtù dell'appartenenza a universi culturali spesso molto distanti dal nostro. Come precedentemente osservato, da più parti viene messo in dubbio il ruolo della libertà nella costruzione culturale dell'integrità fisica da parte delle donne che si sottopongono a pratiche come le mutilazioni genitali femminili, in ragione del fatto che determinate tradizioni culturali non prevedono che le donne siano titolari di un diritto di autodeterminazione. Tuttavia, l'impossibilità di individuare un criterio certo e universalmente condiviso per valutare l'autonomia delle scelte non permette di formulare un giudizio definitivo sull'accoglibilità di determinate richieste di intervento piuttosto che altre[22]. Il caso delle mutilazioni genitali femminili è un chiaro esempio di come l'argomento dell'integrità del corpo non possa essere considerato una ragione dirimente e ultimativa per proibire tali pratiche, soprattutto se messa a confronto con gli argomenti addotti a sostegno dell'accettazione sociale e della liceità giuridica accordata ad altri interventi, che pure danneggiano l'integrità fisica dell'individuo, come,

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[22] Un altro esempio degno di nota, a cui, purtroppo, non viene prestata la dovuta attenzione, è rappresentato dalle pratiche di *breast ironing* (letteralmente "stiratura del seno"), originarie del Camerun, che consistono nel premere ferri da stiro roventi sul petto delle bambine per diminuirne i seni, al fine di prevenire conseguenze non volute dovute ai cambiamenti fisici legati alla pubertà, quali molestie sessuali, gravidanze precoci e stupri. Per un approfondimento si veda Tapscott 2012.

per esempio, la circoncisione maschile, gli interventi di chirurgia plastica genitale o di chirurgia correttiva degli organi sessuali. Pur ribadendo l’intollerabilità di tutte le pratiche non consapevolmente scelte che comportano una mutilazione nel corpo (e spesso anche nella psiche), il rischio risiede nel mettere in atto, prendendo in prestito un’espressione di Nussbaum, una “politica del disgusto”[23], che, facendo appello all’integrità del corpo, maschera il ribrezzo unanime nei confronti di rituali considerati barbarici, in quanto violano il corpo, in modi diversi rispetto a quelli generalmente tollerati. Ciò che conta, in fondo, sembra essere esclusivamente l’implicita conferma che possiamo ottenere dalla nostra rassicurante integrità del corpo, a cui affidiamo la salvaguardia dei nostri valori in opposizione ad una presunta arretratezza culturale di coloro che tali valori non condividono.

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[23] L’espressione “politica del disgusto” è, in realtà, usata da Nussbaum per spiegare l’esclusione degli individui con orientamenti omosessuali dalla titolarità di alcuni diritti civili (Nussbaum 2011).

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Virginia Sanchini

Bioethical expertise: Mapping the field

1. Introduction: defining expertise

In a specialized world, where knowledge has increasingly become a collective enterprise, nobody can master all the fields. This has led to the generation of a myriad of experts, each of whom is specialized in a precise domain or subdomain (Rasmussen 2005). The definition of experts, generally considered, does not seem particularly controversial. An *expert* is someone who possesses a proficiency in a specific domain. This, in turn, has been quite unanimously interpreted as equivalent to the possession of some knowledge and skills in a specific limited professional field. However, the opinion as to whether such knowledge should be just superior (Steinkamp, Gordjin and Ten Have 2008) or even exclusive (Ericsson *et al.* 2006) in order to consider its possession as expertise, varies from author to author. Moreover, having an expertise seems to differ from possessing a *competence*, since the former is a broader concept involving both knowledge and skills, while the latter is a narrower concept just limited to skills (Steinkamp, Gordjin and Ten Have 2008). Starting from the consideration that expertise deals with skills and knowledge, but that these two features characterize expertise in a very different manner, two kinds of expertise have been identified: the *performative* expertise and the *epistemic* expertise (Weinstein 1993). An individual is an expert in the performative sense if the same is able to perform the skills related to the specific domain of expertise in an effective and proper way. By contrast, an individual is an expert in the epistemic sense if the same is able to offer strong justifications for a set of propositions in a specific domain. Hence, the performative expertise deals with the act of doing something well in a specific domain, whereas the epistemic expertise deals with judgment and with the theoretical capacity of properly justifying the positions belonging to their specific area of expertise. Within this very last account "a claim is an 'expert opinion' if and only if it is offered by an expert, the expert provides a strong justification for it, and the claim is in the domain of the expert's expertise"(Weinstein 1993, 58). Given this picture, it is not surprising that people with training in bioethics are often referred to as 'bioethics experts' and/or 'bioethical experts'. However, the question "who is the bioethical expert?" does not appear so easy to answer. Such a difficulty is arguably ascribed to several reasons, two of which deserve particular attention here. The first one deals with the controversial nature of bioethical knowledge together with its potential consequences, such as lack of widely accepted standards, distrust towards experts, as well as disagreement between them. The second reason has to do with the negative consequences that could follow from the presence and permanence of bioethical experts in our societies in terms of non-experts autonomy, judicial independence and equality. Therefore, if the first set of reasons aims to demolish the concept of bioethical expertise, the second set of reasons tries to show the incompatibilities between the bioethical experts as professionals and the grounding ideals of liberal democracies.

This paper is structured as follows: first of all, the two sets of arguments against bioethical expertise and bioethical experts are presented and properly addressed (§2 and §3). By doing this, it will be shown to what extent these objections are not definitive and why they leave the door open both to the existence of bioethical expertise and to bioethical experts as legitimate figures if interpreted in some specific ways (§2 and §3). Secondly, the currently dominant view of bioethical expertise and the main interpretative accounts of bioethical expert are presented (§4). Finally, it will be shown what elements of these theories will be taken into account here in order to develop the proposal of bioethical expert in its public setting role within democratic societies (§5).

2. Objections to bioethical expertise

2.1 The lack of consensus argument[1]: disagreement amongst bioethical experts

One of the most important objections raised towards the idea that a bioethical expertise can actually exist is connected with the factual observation that bioethical experts disagree among themselves about what constitutes a correct behaviour, a good life, the most legitimate solution to ethical dilemmas, etc. (Bambrough 1976). If the potential candidates for the title of bioethical expert disagree on the constitutive features of their discipline and on its content, how can we decide who the real experts are? This objection has been articulated in different ways. On the one hand, it has been claimed that, even if some layers of disagreement are also present in other disciplines, the disagreement surrounding ethical issues is qualitatively different and/or deeper – some would say "more intractable" (Cowley 2005) – than the one present in non-ethical disciplines. Through the words of Ruth Shalit, people endorsing this view would say that "The surgeon's recommendation rests on an agreed-upon set of facts and criteria […]. The philosopher's recommendation depends on a set of criteria that is not agreed upon, but varies from culture to culture and, more and more, from individual to individual. One man's cate-

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[1] Both the terms "lack of consensus argument" and "lack of factual basis argument" have been taken from the paper of Steinkamp, Gordjin and Ten Have (2008). Following this first suggestion, the other objections have been defined accordingly.

gorical imperative is another man's heresy" (Shalit 1997, 24). One the other hand, other scholars have put forth the idea that agreement between the experts of a discipline has to be considered as the necessary condition for the existence of the discipline itself. However, since (bio)ethics has always been dominated by disagreement amongst those who declare themselves as bioethical experts, bioethical expertise cannot surely exist (Bambrough 1967).

Three counter-objections against "the lack of consensus argument" might be raised. The simplest way to counter this objection is to show that disagreement is pervasive to all academic fields, which means that it is a common feature between experts of several disciplines. Moreover, it has been observed that the degree of disagreement often attributed to ethics is exaggerated, and that disagreement within this field could be even less extreme than in other fields.[2] Finally, it could be argued that even if we were unable to debunk the claim that the ethical domain is dominated by perennial disagreement, agreement between experts has never been demonstrated as a precondition of expertise.

2.2 The lack of standards argument: lack of clear identification standards

A second objection raised towards the existence of bioethical expertise is that, differently from other professional fields where there are standardized institutional paths for defining and legitimizing those actually belonging to the field, bioethics as a professional domain of knowledge lacks clear and, above all, unique identification standards (Suter 1984).

The fact that there is no unique and institutionalized *cursus honorum* that those aiming at becoming bioethical experts should go through is certainly true.[3] However, on the one hand, this appears partially related to the controversial nature of the epistemological status of bioethical enterprise. Indeed, the presence of different but equally valid answers to the question "What is bioethics?" and, mainly, "What is the purpose bioethics aims to reach? What are the tasks bioethicists are asked to fulfil as professionals?" seems to explain, and even legitimize, the absence of a unique professional training that should characterize the experts in this field. On the other hand, it could be replied that there is a sort of certification coming from those disciplinary boundaries practically instructed. Indeed, certificates, degrees, masters but, above all, pub-

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[2] McConnell, for example, shows that even if supporters of different methods of applied ethics, such as deontologists and utilitarians, but also act utilitarians and rule utilitarians, would surely disagree concerning *the reasons* supporting different moral rules, they would share much more moral rules than the ones non-ethicists would be willing to admit (McConnell 1984, 206-207).

[3] Actually, we might argue that this claim is only partially valid. Indeed, even if it is true that bioethicists might have very different backgrounds (philosophy, medicine and law are the most common ones), a homogenisation regarding specialised educational paths can be nevertheless present.

lications on peer-reviewed specialized journals and as well as participation in widely known bioethical conferences, can be considered at least preliminary criteria for distinguishing those who cannot be surely considered as bioethical experts from those who might enter in this category (Archard 2011).

2.3 The lack of trust argument: lack of trust towards bioethical experts advice

A third objection raised towards the existence of bioethical expertise can be ground in the lack of trust that non-experts show with respect to bioethical experts' expertise. The supporters of this line of thought claim that bioethical expertise does not exist since, unlike all the other fields where non-experts are prone to follow experts' advice, in (bio) ethical domains people generally observe the unwillingness of non-experts to follow the advice of bioethical experts. To give an example, patients that are also non-experts in medicine, are usually prone to recognize the expertise of physicians when providing medical advice. This means that very rarely non-experts in medicine would question, for example, the diagnosis, the prognosis or the therapeutic option provided to them by physicians.[4] Differently, suggestions and/or advice concerning bioethical issues provided by bioethical experts do not usually receive a higher consideration just because declared by experts in the field, but could actually appear annoying and even illegitimate. Actually, even if this objection might appear very interesting from a sociological standpoint, it nevertheless does not seems philosophically decisive. Indeed, even if the recognition of expertise provides non-experts with good (even if not sufficient) reasons to follow expert's advice, the mere fact that non-experts do not recognize bioethical experts' expertise cannot be necessarily interpreted as a signal of the latter's lack of expertise (Archard 2011).

2.4 The "lack of factual basis" argument: (bio)ethics as a subjective field of knowledge

All the aforementioned objections are simply possible ways through which the doubts towards the professional stance of bioethicists could be properly engendered. However, there seems to be a deeper reason lying behind all of these doubts, that is, that (bio) ethics, also intuitively, seems *qualitatively* different from non-ethical kinds of expertise. To give an example, to have an expertise in climbing seems easily definable, even if we ourselves are not experts, and different modalities (indoors and outdoors, on natural and manmade structures) and types (rock, ice, and rope) of climbing could be identified. By contrast, the profound and apparently unavoidable disagreement characterizing ethical matters makes the definitive identification of the bioethical expertise a very complex

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[4] Actually, the analogy with the medical domain is not altogether fair. As the Stamina and Di Bella' cases (just to quote the most famous ones) have shown, there is an always growing sceptical attitude also towards the medical profession.

task. The intuitive feeling that the controversies surrounding ethical discussions are of a different kind from the ones characterizing other domains of knowledge, when further analysed, has been explained by pointing out the impossibility of finding an objective ground from which ethical judgments might be unequivocally made. Using again the example of climbing, even if a disagreement over how to climb a mountain existed, this would no longer be comparable to the disagreement characterizing the debate over the ethical acceptability of abortion and/or euthanasia. According to the supporters of this view, the qualitative gap between (bio)ethics and non-ethics domains might be ascribed to the different kind of contents they deal with. More specifically, (bio)ethics deals with values and not with facts; and since facts are assumed to be objective, whereas values are considered as subjective, facts might be universally true, while values are dependent upon the specific individual. As a consequence of this line of thought, ethics (and *a fortiori* bioethics) is not an objective field of knowledge. This, in turn, prevents the existence of a uniform and genuine expertise in the field of (bio)ethics (McConnell 1984; Cowley 2005; Varelius 2008).[5]

This objection has been formulated in many different ways, amongst which two appear here particularly relevant.

The very first formulation of this critique should be attributed to Terrance McConnell. In one of his pioneering works, by assuming that in order to have an expertise in a specific domain this domain has to be objective, he argues in favour of the definition of ethics as a subjective field of knowledge. In particular, he claims that "a matter is objective if there are correct and incorrect answers to questions arising from it" (McConnell 1984, 195). If this general criterion is applied to ethical domain, it follows that ethics could be considered as an objective kind of domain given that, in cases of disagreement about ethically legitimate options, we were able to say that at least one, among several, is surely wrong (McConnell 1984, 196). Hence, (bio)ethics, at least allegedly, cannot be considered as an objective field of knowledge since there is no objective ground able to legitimize the distinction between right and wrong and that, in turn, could grant that, between two opponents, one is surely wrong.[6] A differ-

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[5] This first observation does not constitute an objection towards the idea that there might be someone who possesses an expertise in the academic field of bioethics, that is, someone who demonstrates a certain degree of knowledge of the major bioethical theories, approaches and topics. On the contrary, this first observation, if valid, would deny that the bioethical expert is someone who is significantly better at formulating moral judgments, that is, at determining what should be done. For a better systematization of this distinction see Rasmussen (2011) and Vogelstein (2014).

[6] Actually, McConnell reasoning is not so straightforward. Indeed, he starts setting the aforementioned criterion for objective knowledge, but then he leaves it aside in order to argue in favour of what he defines "a slightly modified version of the no moral expert argument", according to which we should be able to infer the subjective nature of moral knowledge by the fact that there are no such figures as moral experts. At the very end of the paper he arrives at the conclusion that objectivity in ethics (as well as in any other field) does not depend upon the pres-

ent way of formulating this objection has been through the analogy between ethics and science. According to the supporters of this view, since the most exemplary paradigm of objectivity is science, (bio)ethics could be considered as an objective field of knowledge provided that it can take on the characteristics of scientific disciplines. However, since science deals with factual matters while ethics deals with personal perspectives (Shalit 1997; Cowley 2005), ethics cannot be considered as an objective discipline at all.

Several counter-objections could be provided to the "lack of factual basis argument" in both its formulations. First of all, the very notion of objectivity itself is far from being unproblematic. Indeed, the ongoing metaethical debate precisely addresses the problem concerning the existence of moral facts. Moreover, this issue does not pertain only to ethics, as the notion of objectivity is problematic even in science (see for example Daston and Galison 2007).

However, let us assume for the sake of the argument that it is possible to argue that some disciplines deal with "objective facts". Even in this case, three counter-objections could be raised. First of all, it is not necessarily so that objectivity in ethics should be of the same kind as in science. Indeed, as some scholars have argued, ethics should not be compared to science, since the two differ significantly: if the latter deals with factual evidence, the former deals with justificatory reasons (Yoder 1998). Secondly, even if we assumed that this answer fails to reply to the criticism, since "the reasons in question are supposed to be just as objective as the facts they are meant to replace" (Cowley 2005, 275), this critique is not altogether fair. Indeed, there are positions within the debate, such as metaethical realism and metaethical naturalism that would claim that moral facts actually exist (Boyd 1988; Sturgeon 2002). Finally, even if we agreed that science is the exemplary case of objectivity, and therefore that ethical judgments should be comparable to factual evidence in order to be objective, it can be shown that science is also value-laden (Longino 1990; Douglas 2000).

Finally, the two formulations of this objection lie on a very robust assumption, which is not further justified: that expertise requires objectivity (McConnell 1984). However, if we accept McConnell's assumption, we should be forced to deny that a lot of professionals that we consider as experts are actually as such. As a matter of fact, we usually recognize the possibility of expertise also in areas where it seems we do not have objective knowledge. For instance, we are willing to recognize that there are such professional figures as history of art experts and art critics even if an objective definition of "beauty" as well as of "masterpiece" is clearly missing.

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ence of experts, since their role could be also conventionally established. This concept could be better explained through the analogy of wine: even if whether wine tastes good might be ultimately a subjective matter, there are some shared criteria to establish whether the wine is actually good (McConnell 1984, 214-215).

3. OBJECTIONS TO BIOETHICAL EXPERTS

3.1 The no solutions-based argument: lack of decisive and unequivocal solutions to bioethical dilemmas

One of the main objections to the idea that some professionals in (bio)ethical disciplines exist is rooted in the observation that bioethical experts, even if labelled as such, are not able (or, at least, no more than laypeople) to provide straightforward and unequivocal solutions to moral dilemmas (McConnell 1984, 201). The specific conception of 'expert' clearly refers to experts as problem solvers. Accordingly, it could be argued that experts are those who are able to solve problems arising in their specific fields of competence. In others words, experts should be able to provide solutions that non-experts would not reach by themselves. Moreover, these solutions should be timely and unequivocal. Hence, since bioethicists (and, generally speaking, ethicists) are neither known for providing useful suggestions concerning ethical matters nor able to solve ethical dilemmas once and for all, they should not therefore be considered bioethical experts.

This critique is easy to debunk. First of all, it could be claimed that the definition of expertise here implicitly endorsed – experts are those who solve problems present in their domains – is neither a formal requisite nor a shared and widely accepted criterion for the attribution of expertise. Indeed, as we have already seen, usually experts are defined by the possession of superior and/or exclusive knowledge in a specific domain that allows them either to better justify judgments within their discipline (the aforementioned *epistemic expertise*), or to perform some skills within their domain of competence (the so-called *performative expertise*). It could be argued that those who criticize the attribution of expertise to bioethicists do so on the basis of a specific interpretation of performative expertise: in this case amongst the skills the bioethicist should possess, problem-solving occupies a privileged position. However, even if interpreted in such a way, the answer does not appear satisfactory enough, because it is not able to explain why problem-solving should be the *conditio sine qua non* for the attribution of expertise, and not just one among other required skills.

A second way to counter this objection is to say that problem-solving goes far beyond the tasks of bioethical experts, since this activity presupposes not just the knowledge of moral theories and principles that should be applied to the specific case in order to solve it, but also the knowledge of the specific non-moral facts that appear nonetheless fundamental for the overall consideration of the dilemma to be faced. And, since the knowledge of what we might call 'moral facts' could be legitimately considered part of bioethical expert's expertise, the same does not seem to be argued for 'non-moral facts' (McConnell 1984, 202-203).

A third way to oppose this objection is to preliminarily accept the problem-solving criterion and to show how paradoxical (or at least counterintuitive) its consequences would be. The final result of this reasoning is the rejection of the criterion itself. More explicitly, if we accepted as a criterion for the expertise the capacity to provide unequivocal and straightforward solutions to problems arising in the expert field of knowledge, we would be obliged to acknowledge that almost no one is actually an expert. Consider, for example, the field of medicine. If problem-solving is a valid requirement, physicians should be considered as experts only if they prove to be able to solve patients' medical problems in a definitive and fast manner. However, it happens sometimes that they are in doubt as to what the nature of the patient's medical problem is and, most of the time, even if at the very end they solve the problem, this activity could require time and several attempts. Nevertheless, very few people would infer that physicians are not experts in medicine (McConnell 1984, 203).

3.2 The knowledge-shared argument: shared content between experts and non-experts

Another very important objection raised concerning bioethicists as experts of ethical matters, is what has been defined here as "knowledge-shared argument", according to which bioethicists are not experts, since expertise means exclusive possession of a knowledge, and knowledge possessed by bioethicists is not exclusive at all. This objection has been formulated in many different ways, but two appear particularly noteworthy: "the argument from common rules" and "the argument from common sense morality".[7]

The argument from common rules claims that if the bioethicists' expert knowledge lies in the knowledge of moral principles and rules, this knowledge is surely in common with that of non-experts. Those who defend this view claim, for example, that the imperatives of not killing, not stealing and not torturing, even if known by bioethicists, are not exclusively known by them. Indeed, most ordinary people, if questioned, would defend the same rules. "Thus, for the most part, philosophers do not want to advocate rules and principles that deviate sharply from the views of ordinary people. It is clear that moral philosophers, qua moral philosophers, are not experts concerning factual knowledge […]. It now seems, though, that they are not experts regarding moral rules and principles either. And, if they do not have expertise regarding these, it is implausible that they are moral experts" (McConnell 1984, 204).

The reply to this objection lies in the distinction between the *content* and the *justification* of bioethical knowledge. The idea is that what determines the exclusiveness of ethical knowledge is not the content of such knowledge, but the way in which this knowledge is possessed and justified. And, if the content of ethical knowledge (such as moral rules) might be easily identified both by experts and non-experts, the way in which this content (the moral rules) is justified, is by no means something in which experts surely surpass non-experts. In other words, bioethicists can justify their beliefs in a way that common

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[7] The argument from common rules has been presented in other terms by Scofield *et al.* (1993), whereas the argument from common sense morality has been presented by Archard (2011), but defined in these terms by Vogelstein (2014).

people cannot.[8] This is what legitimises their professional stance as bioethical experts (McConnell 1984).

The argument from common sense morality (Archard 2011) partially differs from the argument from common rules, and it is probably the most common and recent defence of the knowledge-shared argument. Since expertise is an exclusionary and restricted concept, and since both philosophers *qua* bioethical experts and non-experts build their reasoning upon common sense morality, we cannot ascribe a specific expertise to philosophers *qua* bioethical experts that non-experts would not possess. In other words, moral philosophers are not (bio)ethical experts because they do not possess a particular knowledge, but a knowledge that is possessed by all people (Archard 2011). Three main counter-objections have been provided as a reply to the argument from common sense morality. First of all, J.S. Gordon has pointed out that Archard's argument is bound to the acceptance of a premise, without which the entire reasoning falls down: the foundation of moral theory over common sense morality (Gordon 2011). Moreover, as Vogelstein has shown, Archard confused equal access to moral truth with equal liability to it. Finally, even if we might accept that ethical theory is nothing but the systematization of common sense morality, and that bioethical expertise in a strict sense is limited to the clarification of common sense morality, it does not follow that such a clarification and systematization will not prove to be useful (Vogelstein 2014), thus attributing to bioethical experts not so much skills of discovery, but rather skills for collecting and systematizing (which, in turn, could have some discovery potential).

The supporters of the two aforementioned arguments aimed at showing the nonexistence of bioethical experts, highlighting either the incapacity of bioethicists to provide straightforward and unique solutions to moral dilemmas, or the shared nature of expert knowledge, which would prevent them from defining themselves as experts in ethical matters. The two following arguments, rather than aiming at showing the nonexistence of bioethical experts, try to show their illegitimacy. In other words the two following arguments do not deny that figures like bioethical experts could actually exist, but try to show why their existence as professional figures should be inhibited rather than promoted.

3.3 The slippery slope argument: (bioethical) experts' presence inhibits non-experts judgmental capacities

The third argument against bioethical experts is what is defined here as "the slippery slope argument". As the title itself suggests, this argument aims at showing the slippery slope we might fall down if we promote the flourishing of bioethical experts in our societies. In particular, such an argument claims that relying too much on bioethical ex-

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[8] Put in this way, this claim leads to the idea that there is a kind of justification that only bioethicists possess and are able to use. Obviously, this is not the case, since bioethicists, in order to justify their positions, use the tools of formal and informal argumentation (not self developed tools).

perts, as advisors for the solution of moral dilemmas, will prompt the transformation of human agents into moral cripples (McConnell 1984). Indeed, if we get used to relying on experts for every kind of decision concerning the moral dimension, we will become unable to solve those new ethical problems new situations will present us by ourselves, eventually giving up our own autonomy. The idea lying behind this objection is that since ethical expertise is intrinsically different from other kinds of expertise, we cannot, as we do in other cases, relate to experts for the solutions of problems arising in this domain. If, for example, we should completely rely on a physician for the treatment of an illness, the same cannot be said when the problem arises in an ethical context, since we are all required, even if at different levels, to possess some ethical knowledge (McConnell 1984).

Replying to this objection requires showing the limitations of slippery slope arguments in general, and applying these limitations to this specific case. As it has been repeatedly shown, slippery slope arguments are not solid arguments, since their validity cannot be analytically inferred from their premise, but it relies on future projections whose validity can only be verified in the future. In other words, it could be true that, by relying on experts, common people might in the long run become incapable of making ethical judgments (even the simplest ones) on their own, but this statement cannot be verified in the present. It will be proved to be true if and only if the situation described here can be confirmed in the future. Moreover, it seems plausible to claim that the consequences suggested by this argument can only occur in the case in which agents rely almost totally on bioethical experts (McConnell 1984).

3.4 The inequality based argument: (bioethical) experts within democracies: an oxymoron?

The last and more relevant obstacle to the identification and definition of bioethical experts is that such figures appear in ideological conflict with "the democratic turn" of Western contemporary societies, thus obliging us to profoundly rethink the professional role of the former. According to this explanation, the issue of bioethical expertise, concretely expressed through the presence of experts, appears particularly problematic as it can be considered a specific case of a broader problem: the paradoxical relationship between expertise and democracy. Why is there an incompatibility between expertise and democracy? And why is this incompatibility accentuated when the expertise in question is of a (bio)ethical kind? The answer to this question might be easily provided with the following analogy: why should allow constitutional courts to decide on the proper interpretation of the constitution, rather than parliaments? The argument for the former is that this is a legal matter that requires a technical competence that members of parliament do not have. Looking beyond this analogy, we could similarly claim that the democratic ideal requiring that any decision influencing the life of a person is taken also by that person, clashes with the exclusiveness inherent in the concept of expertise, and, above all, with the decisional power attributed to it. The inequality-based argument is hence grounded on the incompatibility between expertise and the democratic principle of equality (Scofield *et al.* 1993; Turner 2001). Understood in this way expertise turns out to be a problem for democracy since the former "is treated as a kind of possession which privileges its possessors with powers", thus appearing as "a kind of violation of the conditions of rough equality presupposed by democratic accountability" (Turner 2001, 123).

A different and more problematic way of interpreting the relationship between expertise and democracy as an oxymoron, arises within the domain of normative political theory, once expertise is defined not in terms of superior knowledge, but of different viewpoint. This variant of the inequality-based argument will be here defined "the state-neutrality argument". If we think of knowledge as a quantity and, therefore, of expertise as a higher quantity of knowledge to which more power is directly connected, we are in front of the already mentioned inequality-based argument. As it will be properly shown in the next paragraphs, this objection can be circumvented either by letting non experts becoming experts, increasing their knowledge through education – the famous and traditional aim of scientists known as "public understanding" – or by separating the two components of the expertise ideal – knowledge and power –, and by arguing that there could be a kind of expertise that, despite requiring superior knowledge, does not provide its possessors with superior power. Differently, if we interpret expertise according to "the state-neutrality argument", things start getting complicated. Indeed, if possessing an expertise means having a different viewpoint with respect to that of non-experts, expertise surely conflicts with the ideal of neutrality generally ascribed to the liberal state. According to this argument, liberal states should exhibit an impartial behaviour with respect to different standpoints and opinions in order to ensure a genuine, fair and open discussion. Hence, since the very concept of expertise assumes that some standpoints count more, expertise is per se incompatible with a liberal framework (Turner 2001, p. 124). Therefore, both the inequality-based and the state-neutrality arguments criticize the concept of expertise (as well as the power which follows directly from it) for its inevitable inconsistency with the tenets of liberal democracies, whether equality between citizens or state impartiality is emphasized. This already problematic relationship appears further worsened if we refer the concept of expertise to the (bio) ethical enterprise, where, as we have seen earlier, anyone' standpoint seems even more equally legitimate and, therefore, any interference into non-experts' choices appears even less justifiable. To conclude, for many scholars/people the very idea of an expertise in (bio)ethics violates a central normative intuition of our liberal democracies, namely that on ethical matters individuals should ultimately decide on their own.

This objection, in both its formulations, appears rather problematic to debunk. Indeed, the "binomial" knowledge-power on the one hand, and ethical knowledge-decisional power on the other hand, can be considered as a reasonable observation, worthy of serious consideration. However, what seems to be arguable is that there could still be some legitimate space for bioethical experts within societies as long as this binomial relationship characterizing the concept of expertise, as previously formulated, is dissolved.

4. The theoretical background

4.1 Preamble: experts vs. *expertise and ethics* vs. *bioethics*

What has been said so far is that the growth of knowledge has made a sort of distinction of labour ever more pressing. Such a phenomenon has been put by many at the origin of the creation and proliferation of experts, who are generally defined as those who possess some knowledge and skills in a specific area. This process, as a matter of fact, clearly involves very different disciplines, and of course (bio)ethics too. However, when properly analysed, both the presence of a bioethical expertise and bioethical experts meets some opposition, on the one hand because of the particular nature of bioethical knowledge and, on the other hand, for the alleged oxymoronic relationship between experts in bioethics and democratic forms of decision-making.

As just shown, neither the objections towards the idea of bioethical expertise, nor those against the existence of bioethical experts have proven to be decisive. This leaves the space open to some possible interpretations of the concept of bioethical expertise and of the role/s of bioethical experts.

The problematization of these two very complex issues seems to require some preliminary terminological clarifications. First of all, the debate on bioethical expertise appears to be confusingly dominated by the unexplained and interchangeable use of the expressions “bioethical expertise” and “bioethical experts”. One might hypothesize that what has been defined here as confusion is just the presence of the two different lines of investigation characterizing the current literature on this topic, one interested in the content of expertise, while the second focused on the role of experts. However, this very simple explanation does not seem to be correct, not just because usually there is not a clear distinction between these two levels (sometimes even within the same study), but also because the connection between the content of bioethical expertise and the role of bioethical experts is definitively unclear. The only connection that clearly emerges is that the disagreement surrounding the professional stance of bioethical experts seems partially bound to the deeper disagreement characterizing the content of bioethical expertise. And, what largely happens in the literature, is that the two levels are so radically overlapped, that some authors, starting from the controversial nature of bioethical knowledge, infer the illegitimacy of bioethical experts; whereas some others, from the potential utility, or even the by now inevitable presence, of bioethical experts within our societies, struggle to justify in any possible way the existence of an uncontroversial bioethical knowledge. Secondly, another area of confusion concerns the interchangeably use of expertise / experts in ethics, and expertise / experts in bioethics. As already pointed out above, even if this distinction could be primarily considered as the proof of the presence of the different disciplinary levels of analysis, the real explanation actually seems to be related to the controversial epistemological status of bioethics as a discipline and to its relationship with ethical theory and moral philosophy in general.

4.2 What is bioethical expertise? The standard argument

In a very recent paper appeared in *Bioethics* in 2014, Eric Vogelstein defines the set of knowledge and skills quite unanimously[9] attributed to bioethical experts by supporters of the bioethical expertise ideal as "the standard argument" (Vogelstein 2014). The standard argument is the dominant theory of bioethical expertise since it is grounded in the dominant explanation of the epistemological status of bioethics: bioethics as applied ethics. According to this argument, originally formulated by Peter Singer (Singer 1972, 1982 and 1988) and then developed by many philosophers with different variations, we might consider that practical ethicists (and, among them, bioethicists) possess some degree of expertise by dint of their competence in moral reasoning. The standard argument claims that bioethical experts possess both skills and knowledge in moral subjects. Amongst the skills held by the bioethicists we might find both some *general* critical-thinking skills and some more *specific* critical thinking skills applied to the ethical domain. As to the formers, we could find the ability to reason formally and consistently, to avoid errors in one's own argument and to detect fallacies when they occur in the arguments of others; as to the latter we have those abilities dealing with the application of these general skills to the moral context, such as, for example, how to apply argumentative tools to moral issues and cases. Concerning the knowledge bioethicists are supposed to have, we might find the understanding of both moral concepts – theories and principles of applied ethics – and moral arguments – as the most important reasons in favour of and against the specific positions related to the traditional topics of applied ethics (Singer 1972, 1982 and 1988; Szabados 1978; McConnell 1984; Ackerman 1987; Brink 1989; Moreno 1991a and 1991b; Weinstein 1994; Crosthwaite 1995; Nussbaum 2002; Sharvy 2007; Varelius 2008; Agich 2009). To summarize, according to the standard argument, there is an expertise in bioethics since

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[9] As explicitly stated in the text, the standard argument (in its different formulations) can be considered as the dominant but not the unique view of bioethical expertise. Even if explicitly referred to the expertise of the clinical ethicists, and not to the expertise of the bioethicists generally conceived, Steinkamp and colleagues examine two additional "theories" of ethical expertise: the phenomenological account by Dreyfus and Dreyfus according to which ethical expertise refers to an almost totally intuitive moral competence (1990), and the Habermasian-based account rethought by Casarett and colleagues in which the ability of reaching consensus starting from disagreement is considered as the core competence of clinical ethics expertise (1998).

there are some contents that an expert in the field should know, such as moral theories, accounts, traditions, principles, etc., but also because there are some skills pertaining to the application of such theories and models to concrete situations requiring solutions. Hence, bioethical expertise appears as a concept bound to the belief that there is a core of knowledge – namely what falls into the domain of ethical theory – and a privileged reasoning procedure for applying this core of knowledge – namely argumentation – widely recognized by the vast majority of bioethicists. Actually, despite sounding as an almost homogeneous trend, the standard argument is usually spelled out in very different forms. Indeed, although the emphasis on argumentation leads to the centrality of justification, the way in which justification is interpreted each time, deeply modifies the content of the standard account and, therefore, of bioethical expertise. To give some examples, Jan Crosthwaite defines an argument as justified as long as it is supported by reasons, without requiring that these reasons are infallible (Crosthwaite 1995). Yoder makes a step further in the definition of justified reasons, arguing that a position is justified if the reasons supporting it are mutually consistent from a logical standpoint. Therefore, according to Yoder, what matters is not the initial position endorsed by the agent, but the coherence between the agent's moral judgments (Yoder 1998). Finally, Weinstein formulates what can be considered the most demanding version of the standard argument. He considers ethical expertise as a form of epistemic expertise, and in particular, as the normative subdomain of it. Being a kind of epistemic expertise, it deals with the capacity of providing justifications within a specific domain rather than with the practical ability of performing some tasks in a proper way. Moreover, dealing with the normative level of investigation, it refers to the prescriptive power of judgments, ideally able to solve dilemmas by providing strong recommendations. As a consequence, ethical expertise is defined as the ability to provide strong justifications for a claim in the ethical domain (Weinstein 1994). Even if he seems to deny that his account requires the existence of moral objectivity, his idea of strong justification could nonetheless lead to such interpretation[10].

4.3 Who are bioethical experts?

4.3.1 Conceptualizers vs. Problem solvers

The standard argument is the most widely accepted answer to a very specific question: where does the expertise of bioethical experts, if any, lie? Once this question is answered, another question needs to be asked: what follows from this expertise in terms of power and roles granted to them? This means asking where the threshold to experts' power should be set, once their field of expertise has been clearly defined. I would argue

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[10] See, for example, Yoder 1998.

that the best way to answer this question could be constructed in the light of the argument proposed by Norbert Steinkamp, Bert Gordijn and Henk ten Have (2008).[11] Their claim is that those who have tackled the issue of bioethical expertise seem to endorse one of the two following theories: the *narrow theory* of bioethical expertise or the *broad theory* of bioethical expertise.

According to the narrow theory of bioethical expertise, bioethical experts should be considered conceptualizers of moral issues. Indeed, because of their ability in formal and argumentative reasoning and knowledge in ethical theories, bioethicists might be more appropriately engaged in a conceptualizing, rather than problem-solving activity. This, in turn, means defining the bioethical expert mainly as a thinker, whose primary task is to define the nature of the problems to be addressed and to take care of the formal analysis of the moral problems and arguments, while remaining detached from the potential practical implementations the case might get to. The argument supporting such a theory is twofold. On the one hand some philosophers have suggested that the majority of moral disputes could be easily solved and even avoided if the parties agree on the meaning of the concepts they are talking about (Beauchamp 1982). This observation rests on the recurrent idea according to which what we often interpret as a moral dilemma, that is, dilemmas regarding moral choices caused by conflicting and mutually incompatible values, is instead bound to semantic and interpretative reasons. Following this reasoning, disambiguating the terms is the preliminary strategy towards the solution of moral dilemmas (Beauchamp 1982)[12]. On the other hand, before defining the main concepts involved in the topics under discussion, an often underestimated preliminary step is in fact crucial: the identification of the problems that deserve some attention. As some scholars have indeed pointed out, problem-solving and concept definition are just secondary tasks of the bioethical enterprise, since sometimes the problem lies in the lack of a clear definition of what are the problems that actually require a solution (Caplan 1989).

Opposed to the narrow theory of bioethical expertise, some philosophers have proposed what has been subsequently defined as the broad theory of bioethical expertise. This theory states that, in virtue of their more competent and informed justificatory abilities,

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[11] Actually, by "bioethical expert" the authors explicitly refer to the clinical ethicists, leaving aside the debate over the role of bioethicists in the public arena as well as in other domains. However, since in their distinction of the two "theories" of bioethical expertise, they take into consideration not just the debate over the role of bioethicist in the clinical domain, but the entire debate over the topic of bioethical expertise, I consider this distinction as valuable and valid when applied to my primary focus of interest, which is public bioethics.

[12] Even if at a completely different level, the same observation has been put forth by some theorists of the deliberative democracy ideal, who consider the disambiguating activity as one the grounding reasons why deliberative approaches to democracy should be preferred with respective to aggregative approaches. For a deepen analysis of this topic see Gutmann and Thomson (2004).

bioethicists should be assigned a problem-solving role in cases of moral dilemmas and disagreements. There are two interpretations of this theory, a radical one and a moderate one. According to the less radical version of this theory, the justificatory abilities of the bioethicists are superior to those of lay people because the former are usually more refined, thanks to the frequent exercise and knowledge of moral concepts and theories that bioethicists have. However, this does not mean that experts' judgments are infallible, but just that they are more likely to be less fallible than those of not bioethicists (Crosthwaite 1995). The more radical version of this argument argues instead that bioethical expertise is nothing but the normative reflection that primarily includes the capacity of providing strong justifications for a claim in a specific domain. Precisely the emphasis on the strength of the justifications rather than on the consistency between the premises and the following consequences shows what this second version assumes and cannot avoid: the appeal to moral objectivity. According to the supporters of this last view, bioethical expertise is hence possible if and only if there are objective moral truths, which in turn might be considered guarantors of the distinction between justified and unjustified arguments (Weinstein 1994).

4.3.2 Philosophers vs. *non-philosophers? Who is more competent as a bioethical expert?*

In addition, another controversial question dominating contemporary literature concerning this topic is whether philosophers (and, particularly, moral philosophers) represent the best qualified people to be moral experts, or whether some other professional figures might be better equipped. There are three answers to this question. First of all, there are those who completely reject the idea that bioethical experts should be professionals with a philosophical background, the so-called "argument from common sense morality", that has been already explained in section 3.2 entitled "The knowledge-shared argument: shared content between experts and non-experts", originally formulated by Archard (2011). Second, there are others claiming that, given the aforementioned skills and knowledge, there is no doubt that moral thinkers (e.g. professional philosophers) are the best equipped to be bioethical experts (Vogelstein 2014). Finally, we find those who support an in-between position and argue that, even if there are no specific competences that philosophers, qua bioethical experts possess and that non philosophers cannot acquire, philosophers can fulfil this role better because of clear and contingent reasons, for instance the fact that philosophers receive general training in understanding formal reasoning and a specific competence in moral theories (Singer 1972, 1982, 1988).

5. Conclusions

This paper aimed at providing the reader with a taxonomy of the very complex (and not always systematic) philosophical debate on bioethical expertise. As it has been shown in the first part of this work, there are several objections to the existence of bioethical expertise and the legitimacy of bioethical experts. However, several counterarguments to those objections have also been discussed, so that one can still claim that both bioethical expertise and bioethical experts can legitimately exist, provided they are appropriately conceived.

In particular, as to the former (*where does the expertise of bioethical experts, if any, lye?*), there seems to be some knowledge and skills quite unanimously attributed to the content of bioethical expertise, the so-defined "standard argument". In our view, a slightly modified version of the standard argument should be endorsed, able to combine the already considered elements of the standard argument with some features typically characterizing public bioethics' domain. However, the main focus will shift from the centrality of coherent judgment to that of *reasonable position*, where the latter's validity is no more bound to the coherence among the overall agent's moral judgments or between the agent's moral judgment and an alleged moral truth, but to the fact of being potentially justifiable through mutually acceptable reasons. The way in which this last expression is interpreted here refers to its definition in political theories of deliberative democracy.

Instead, as to the latter (*what should be the role granted to bioethical experts?*) we suggest the view according to which public bioethicists should be conceived as *ethical experts* but not as moral experts, which means, according to us, that that they possess some specific knowledge and skills, but that these knowledge and skills do not legitimate them to decide in place of others. Following this distinction, it seems possible to argue that bioethical experts can surely be considered as *conceptualizers* of moral issues, but not as problem solvers, hence siding in favour of the so-defined soft theory of bioethical expertise. However, beyond the soft account just mentioned, we do a step further, claiming that, even if bioethical experts are not entitled to indicate the way to make a moral choice, they can, nonetheless help others to do this, that is, *facilitate* this process.

Finally, following some considerations already pointed out by Peter Singer, we endorse the thesis according to which there are some contingent reasons that, at least temporarily, support the idea that philosophers are best equipped as bioethical experts.

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Sarah Songhorian

Neuroethics: The relation between philosophical reflection and empirical research

1. Neuroscience of ethics: A methodological challenge

The aim of this paper is to focus on the most relevant methodological challenge that neuroethicists have to face when dealing with the neuroscience of ethics (Roskies 2002), that is with the contribution empirical research in general and neuroscience in particular can make to our knowledge of moral issues. Before considering any substantial thesis in the debate, those who are interested in neuroethics have to try and answer a tricky question: how, and to what extent, can empirical analysis modify philosophical theories? That is, how can the way things *are* influence the way they *should* or *ought to be*?

If, for instance, neuroimaging studies would modify our conception of free will or of moral decision-making, one would have to understand first how this interaction is possible.

I will claim that the role of empirical findings is showing the most likely bases upon which certain constructs of the philosophical debate are built. Yet a worry can arise concerning the relation between empirical findings and theoretical analysis and it has deep routes into the philosophical debate. The interpretation of Hume's "is/ought" passage, the division between fact and values (for a discussion see Putnam 2002), and Moore's argument against the naturalistic fallacy (1903) have made any attempt to consider scientific discoveries into the philosophical debate hard.

> G.E. Moore's diatribe against the naturalistic fallacy in 1903 set the stage for most of twentieth-century moral philosophy. The main protagonists over the next sixty years were intuitionists and emotivists, both of whom were convinced by Moore that empirical science is irrelevant to moral philosophy and common moral beliefs. Even in the 1970s and 1980s, when a wider array of moral theories entered the scene and applied ethics became popular, few moral philosophers paid much attention to developments in biology and psychology.
>
> This isolation must end. Moral philosophers cannot continue to ignore developments in psychology, brain science, and biology. Of course, philosophers need to be careful when they draw lessons from empirical research. As Moore and his followers argued, we should not jump straight from

> descriptive premises in psychology or biology to positive moral conclusions or normative conclusions in moral epistemology. That would be a fallacy. Nonetheless, psychology can still affect moral philosophy in indirect ways (Sinnott-Armstrong 2006, 339).

Firstly, empirical findings and theoretical accounts can bear reciprocal influences. On the one hand, empirical findings can be considered relevant for setting the limits of what we can actually obtain as far as morality and normativity are concerned. Given the individuals that we are and our limits, a better knowledge of our natural endowment can help building a theoretical framework to which we can actually conform. In order for a thing to be something we ought to do, we need to have the capacity and the possibility to make that thing actual. In the economic debate, learning that individuals do not decide with perfect rationality, got a new line of inquiry on limited rationality off the ground. Something similar can happen within the relationship of empirical findings to our view of morality. Discovering that emotions are relevant for our moral judgments and for directing our behaviors, for instance, should be enough to consider any theoretical framework that denies the role of emotions as unnecessary – if any such framework really exists. This is not to argue for a reduction of the normative onto the psychological or biological level; rather, to subscribe to a liberal form of naturalism as setting possibility conditions.

> A convincing version of Liberal Naturalism would need to do justice to the range and diversity of the sciences, including the human and social sciences, and to the plurality of ways of understanding, including the possibility that some of these ways are non-scientific yet non-supernatural (De Caro, Macarthur 2010, 9).

Moreover, the influence of empirical findings on theoretical accounts should be indirect inasmuch as, as Sinnott-Armstrong says, we should not jump from them to draw conclusions for normative or moral accounts that rest on a different level of the analysis of the world; rather, we should first try to incorporate those findings into the vocabulary of the latter and see what aspects of our normative account can be confirmed or falsified by them.

On the other hand, as far as the influence of theoretical accounts on empirical findings is concerned, the former can certainly help in clarifying the concepts investigated empirically, in designing the experimental task, and in interpreting the outcomes and results.

Secondly, I think that there has been a misconception of Hume's divide and that several contemporary attempts to overcome it have done a bad service to their praiseworthy purpose, jumping too easily from description to prescription (e.g. Preston, de Waal 2002; Shamay-Tsoory 2011; Rifkin 2009; Baron-Cohen 2011). I believe Hume's concern was the absence of any explanation or justification for the passage from sentences containing "is" and "is not" to propositions connected with "ought" or "ought not" rather than a claim of impossibility of such passages.

> I cannot forbear adding to these reasonings an observation, which may, perhaps, be found of some importance. In every system of morality, which I have hitherto met with, I have

> always remark'd, that the author proceeds for some time in the ordinary way of reasoning, and establishes the being of a God, or makes observations concerning human affairs; when of a sudden I am surpriz'd to find, that instead of the usual copulations of propositions, *is*, and *is not*, I meet with no proposition that is not connected with an *ought* or an *ought not*. This change is imperceptible; but is, however, of the last consequence. For as this *ought*, or *ought not*, expresses some new relation or affirmation, 'tis necessary that it shou'd be observ'd and explain'd; and at the same time that a reason should be given, for what seems altogether inconceivable, how this new relation can be a deduction from others, which are entirely different from it. But as authors do not commonly use this precaution, I shall presume to recommend it to the readers; and am persuaded, that this small attention wou'd subvert all the vulgar systems of morality, and let us see, that the distinction of vice and virtue is not founded merely on the relations of objects, nor is perceiv'd by reason (Hume 2007, 302).

It is this sort of precaution that Hume recommends: if it is possible to move from a descriptive sentence to a prescriptive one, the change has to be justified (for an extremely detailed analysis of Hume's law, see Celano 1994). If justification is not at hand, an unwarranted jump, as Sinnott-Armstrong describes it, is in place. Interpreting Hume's quotation as claiming that it is impossible to go from empirical propositions to normative ones, neuroscience of ethics would be impossible. However, it seems an extreme interpretation of Hume's concern that is not grounded on what he actually claims. He just recommends precaution and that is what the neuroscience of ethics should conform to in order to avoid unwarranted jumps from prescription to normativity and yet to be able to use the most recent advances in the knowledge of our moral psychology to better define our range of possibilities as far as normative moral theories are concerned.

2. Empirical findings and ethical theory

There are two ways in which one can think empirical findings have an influence on moral theory. The former concerns the support that certain knowledge of our moral psychology and functioning can provide for a specific metaethical theory. The latter regards a connection between the description of our endowment and normative[1] and substantive theories, telling us how we actually should behave.[2] As far as the latter is concerned, one can hold that there is no direct influence of empirical findings, but only an indirect one

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[1] In the following pages, I will use "normative theory" as indicating the domain of morality that concerns norms, rules, duties, or rights. At this level, the interest is on what we ought (or have right) to do. It refers to substantive and particular moral propositions, such as "stealing is wrong", "altruism is right", and the like.

[2] I will consider here metaethics and normative and substantive theories as two separate levels of moral reflection in order to investigate their relation to empirical findings and yet I will not enter into the debate about the relation between metaethics and substantive theories. The argument presented here is compatible both with the view that they have reciprocal influences and with the one that claims they do not.

based on the idea that what we ought to do (or have a right to do) has to be practically feasible. Moreover, a particular reading of reflective equilibrium[3] can help here understand to what extent one can derive normative conclusions from empirical data without properly deriving "ought" from "is".

As Greene underlines in his recent article (2014) – which replies to many of the objections his studies have raised (Greene 2007; 2005; Grene *et al.* 2009; 2004; 2001; Greene, Haidt 2002) – experiments, of the kind he himself conducted

> […] identify factors to which our moral judgments are sensitive. This information may be combined with independent normative assumptions concerning the kinds of things to which our judgments ought to be sensitive. This combination can lead us to new, substantive moral conclusions. In other words, scientific information can allow us to trade in difficult "ought" questions for easier "ought" questions, and thus advance ethics (Greene 2014, 711).

His subsequent example helps clarify this insight. If one wonders whether juries make good judgments, one can refer to several studies claiming for certain biases in their decisions – as, for instance, the fact that they are sensitive to race. Combining this insight coming from empirical studies with a normative assumption that juries should not be sensitive to race and several other biases, one can derive that at least sometimes juries make bad judgments. From this factual conclusion one can consequently derive that those biases that actually influence juries' decisions should be minimized by several strategies – for instance, including racial differences in the juries themselves. Three aspects of this way of solving normative questions that are still open are noteworthy. First, this kind of derivation does not represent properly an "is/ought" passage inasmuch as a normative assumption is present also in the premises. Second, the derivation represents

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[3] "In searching for the most favored description of this situation we work from both ends. We begin by describing it so that it represents generally shared and preferably weak conditions. We then see if these conditions are strong enough to yield a significant set of principles. If not, we look for further premises equally reasonable. But if so, and these principles match our considered convictions of justice, then so far well and good. But presumably there will be discrepancies. In this case we have a choice. We can either modify the account of the initial situation or we can revise our existing judgments, for even the judgments we take provisionally as fixed points are liable to revision. By going back and forth, sometimes altering the conditions of the contractual circumstances, at others withdrawing our judgments and conforming them to principle, I assume that eventually we shall find a description of the initial situation that both expresses reasonable conditions and yields principles which match our considered judgments duly pruned and adjusted. This state of affairs I refer to as reflective equilibrium. It is an equilibrium because at last our principles and judgments coincide; and it is reflective since we know to what principles our judgments conform and the premises of their derivation. At the moment everything is in order. But this equilibrium is not necessarily stable. It is liable to be upset by further examination of the conditions which should be imposed on the contractual situation and by particular cases which may lead us to revise our judgments" (Rawls 1971, 18). As far as moral theory is concerned, Rawls claims that: «we investigate the substantive moral conceptions that people hold, or would hold, under suitably defined conditions. In order to do this, one tries to find a scheme of principles that match people's considered judgments and general convictions in reflective equilibrium. This scheme of principles represents their moral conception and characterizes their moral sensibility» (Rawls 1999, 288). The kind of reflective equilibrium I am thinking of here is an equilibrium that takes people's principles and considered judgments into account, together with some facts about the world and about ourselves.

a simplification of the problem posed. Moreover, the conclusion itself refers to an empirical outcome – that is, they actually make bad judgments at least sometimes –, from which one can derive strategies to achieve what was included in the normative assumption – that is, juries should not be sensitive to racial biases. Balancing empirical findings and normative assumptions makes the derivation indirect and represents an application of reflective equilibrium.

> As this example illustrates, we can reach interesting normative conclusions by combining interesting scientific facts with uninteresting normative assumptions. However obvious this may seem, some mistakenly assume that empirically based normative arguments are empty or question-begging if they rely on nonempirical normative assumptions. The above example suggests a more general principle: An empirically driven normative argument is non-question-begging if the normative assumptions it requires are less interesting (i.e., less controversial) than its normative conclusion. I am not claiming one can derive a moral "ought" from nothing but a scientific "is". Rather, my point is that moral psychology matters for ethics, that it is "normatively significant". Moral psychology matters, not because it can generate interesting normative conclusions all by itself, but because it can play an essential role in generating interesting normative conclusions. A natural objection to this example is that the work done by the science, while not insignificant, is *normatively* insignificant. The science does not challenge anyone's values. Instead, it simply alerts us to an application of the values we already have (Greene 2014, 711-712).

In order to answer this latest worry, Greene analyzes the example of consensual adult incest. In case we learn, from scientific data, that our disapproval of incest derives from a negative emotional response which aim is to avoid the risk of genetic diseases in the offspring, should we rely on this response in all possible contexts? He considers the example of Joe and Jane, two siblings separated in early childhood who grow apart and eventually fell in love. When Joe and Jane discover that they are siblings, they decide to remain together and take all possible precautions against the risk of producing a genetically ill offspring (i.e., vasectomy). According to Greene, with this example in mind and taken for granted that our disapproval of incest depends only on the emotional response against producing ill offspring, one should review the general condemnation against all possible cases of incest.

> Having made this assumption, and having learned something from science, we may now conclude that we ought not condemn all incestuous behavior – an interesting normative conclusion. This example – a classic *debunking* explanation – is notable because it genuinely challenges some people's moral values. Indeed, such arguments can change people's minds, if you give them enough time to think (Greene 2014, 712).

As controversial as the example may be, this still represents one possible way in which empirical findings have a role in shaping and changing our normative assumptions in specific cases. No proper "is/ought" passage is met because normative assumptions are also present in the premises of this kind of derivations.

As far as the role of neuroscience is concerned, Greene – contrary to what one may think based on his previous works – is explicit in claiming that findings from imaging studies do not play any special role in ethical thinking, but they are rather just one among many different sources of empirical research that might play the role depicted above (Greene 2014, 716). To this extent, the neuroscience of ethics does not differ radically from moral psychology. The neuroscience of ethics has been considered revolutionary, however, if Greene is right, it does not play any special role. Neuroscience can only provide a new tool to shed some light onto the moral domain.

Finally, as simple as it may seem, our normative account of morality should consider empirical findings inasmuch as they illuminate the basic capacities we are endowed with. If, as it seems likely from empirical studies (Greene *et al.* 2001), emotional responses are relevant for our production of moral judgments, one cannot think of morality as totally non-emotional without providing an account that is not viable for the kind of individuals we are. That is not to say that our epistemological access to morality is itself normative, but rather that, given the way in which we become acquainted with morality, we should prescribe behaviors that are at least possible. Knowledge of our implementational and representational endowment restricts possible theories to viable ones. If I ought to behave altruistically, I must be able to do so. This has to be regarded as a naturalistic attempt inasmuch as it restricts possibilities to what is naturally feasible for humans. A further problem might arise if one focuses only on what is actually praised or blamed, rather on what is praise-worthy or blame-worthy. A naturalistic account has to include something more than what we actually do if it claims to be normative and to be able to establish duties (or rights) as opposed to simply describing what we already do.

> The naturalist […] supposes that no duty can be established on grounds independent of what men do in fact do; and, when what men do in fact do shows a duty to make excessive demands, the duty is declared no duty at all (Brown 1950, 276).

If one focused only on what is actually praised or blamed in a certain society at a given time, then morality would be relativistic and no effort would be necessary for humans to judge and act morally. I think that is not the case. Naturalism can have different forms. The one provided by Brown is neither the kind I am interested in nor the primary interest of neuroethics in general. Among several other problems, if this naturalistic perspective were the only one possible, morality would be nothing more that a generalization over actual behavior. There would be nothing special about moral reasoning and moral disagreement – it would be only a disagreement about what we actually do or do not.

Moreover, several accounts can avoid the denial of a role to personal engagement and deliberation in a reductionist manner. It is not the case that, given certain basic abilities, one is *determined* to behave in a specific way. Referring to empirical findings in this context is only a way to test which theories are more viable and to clarify the set of possibility conditions for an account.

As to the connection between empirical findings and metaethical theories, there is no proper passage from factual premises to normative conclusions inasmuch as metaethics does not deal with ethical substantive "ought". In Joyce's words:

> Even if there were an *a priori* prohibition on deriving evaluative conclusions from factual premises, this need not stand in the way of *meta*ethical implications being drawn from factual premises, for a metaethical claim is not an ethical "ought" claim; it is more likely to be a claim about how we use the word "ought" in ethical discourse – which is a perfectly empirical matter (Joyce 2008, 371).

If any sense of "ought" must be applied to metaethics, it is a linguistic one, a second-order reflection concerning how we should apply moral concepts, under what conditions those concepts are properly used.

> In so far as some metaethicists offer prescriptions about how the word "ought" *ought* to be used, metaethics sometimes steps beyond the descriptive. Even in such cases, however, metaethicists are still not pushing *ethical* "ought" claims (Joyce 2008, 371).

As for normative conclusions, there is a sort of balance between empirical findings and linguistic normative assumptions that rest on the premises' level before any conclusion about how we should apply the word "ought" can be made. So, in this respect, there is no illicit passage from empirical premises to normative conclusion, even when the normative concept is a linguistic one.

A further role empirical findings might play in choosing a metaethical account resembles one of the roles identified earlier. If empirical data support a role for emotions, as well as for higher order rationalization, in our moral judgment, then a hybrid account of ethics can better explain the way in which we actually learn about morality, they can illuminate our epistemological access to moral properties. If data from neuroimaging studies underline that both emotions and rational engagement are simultaneously present when a moral deliberation occurs, then the metaethical theory that has to be favored is one among those that recognize both an emotional and a rational component to moral deliberation. Any theory that advocates moral deliberation to be uniquely emotional or uniquely rational should be considered unfeasible. It is not the case that a single experiment, or even a set of significant ones, can prove a thesis on the metaethical level, however it can reduce the spectrum of theories that can be considered feasible by falsifying other theoretical options – for instance, those that deny completely a role for either emotions or reasoning.

3. The power of empirical findings

Another noteworthy consideration regards the power of empirical finding *per se*. As Sinnott-Armstrong said, we should not jump from empirical evidence to normative conclusions, not only because of a certain philosophical caution relative to Hume's law, but also for independent reasons. Firstly, empirical data are most of the times correlational studies – with some exceptions like behavioral genetics –, so that interpreting their conclusions as providing a comprehensive explanation of our behavior is an overestimation of their powers. As Hume rightly pointed out, precaution is the key. On the one hand, correlational studies do not identify causes; and, on the other, different theoretical approaches can be used to interpret and make sense of exactly the same set of data. Secondly, given the different vocabularies that science and philosophy adopt, it is not always easy to understand exactly what empirical findings can actually contribute to. If one is not a reductionist and, thus, if one does not believe that there are correspondence rules between philosophical and scientific statements (Nagel 1961), then some reflection is needed before claiming that certain data support – they do not demonstrate in any case – any philosophical thesis. These two further difficulties explain why, on the one hand, several findings are taken to support antithetic perspectives and, on the other, why, even though we have gained some further knowledge about how we judge, there is still room for philosophical enquiry and debate. Philosophical and empirical enquiry should cooperate to pursue a better understanding of human ethics.

4. A non-reductionist naturalism

Subscribing to a naturalistic account of ethics does not amount to committing oneself to reductionism or to the impossibility of finding a place for normativity (Prinz 2007, 2). There are four understandings of naturalism according to which one can advocate for it without incurring these two risks (Prinz 2007, 2-3). As far as naturalism is concerned, one can be interested in metaphysical, explanatory, methodological, or transformation naturalism. All these forms of naturalism have several different versions. I will not deal with them here specifically, in particular I will not discuss transformation naturalism. My aim is just to show that one can advocate a non-reductionist naturalistic account.

As far as metaphysical naturalism is concerned, one can simply claim that no supernatural entities exist.

> It is the view that our world is limited by the postulates and laws of the natural sciences. Nothing can exist that violates these laws, and all entities that exist must, in some sense, be composed of the entities that our best scientific theories require. This is a metaphysical thesis; it concerns the fundamental nature of reality (Prinz 2007, 2).

One may wonder how metaphysical naturalism can avoid being reductionist, on the one hand, and maintain the existence of moral properties, on the other. As the latter worry is concerned, our epistemic difficulties in accessing moral properties – as opposed to other real entities – should not matter when dealing with metaphysics, with their existence. Moreover, if one considers what entities actually exist from a scientific perspective – say, atoms and electrons – the epistemological issue reveals itself trickier than expected also as far as scientific entities are concerned.

> The naturalist offers to save realism but eliminate the mystery: the domain of moral value is to be seen as simply a part of the familiar natural world, known about in just the familiar, broadly empirical ways we know about the natural world. While for other views there is a gulf to bridge between the domain of prosaic natural facts and the domain of values, the moral naturalist seeks to collapse this distinction and reveal value to us as straightforwardly part of the domain of natural fact (Lenman 2014).

Collapsing such a distinction does not, however, necessarily commit to reductionism. Moral properties can emerge or supervene onto natural facts and they can be analogous to natural facts in many relevant respects. Moral properties are properties of the world we live in, the natural one. We access them as we access other secondary qualities. They emerge or supervene on natural properties similarly to the way in which any other secondary property – as colors or emotions – supervene or emerge on them.

A minimal version of metaphysical naturalism refers simply to the fact that we live in a natural world and the experiences we have are all in a sense natural (Lecaldano 2010, 25). From such a perspective there is no need to postulate supernatural entities to account for a version of moral realism. Moreover, avoiding reductionism is possible through the concepts of emergence or supervenience.

> Metaphysical naturalism entails a kind of explanatory naturalism. If everything that exists is composed of natural stuff and constrained by natural law, then everything that is not described in the language of a natural science must ultimately be describable in such terms. This is not equivalent to reductionism in the strong sense of that word. Strong reductionists say that the relation between natural science and "higher-level" domains is deductive. We should be able to deduce higher-level facts from their lower-level substrates. Antireductionists deny this. They think, for example, that there are higher-level laws or generalizations that could be implemented in an open-ended range of ways. Regularities captured at a low level would miss out on generalizations of that kind. […] The explanatory naturalist does not need to claim that low-level explanations are the only explanations (Prinz 2007, 2).

One can, thus, endorse explanatory naturalism without being committed to reductionism.

To this extent, it will be useful to consider Marr's distinction of different levels of explanation (Marr 1982, 24-25). Marr distinguishes between a computational, an algorithmic, and an implementational level. In order to introduce these levels, he uses the example of a cash register. The first and more abstract level of explanation is that of a computational theory, which aims at understanding *what* the device does and *why*. Following Marr's example, the cash register sums. The *what*-question is answered by a theory of addition. The *why*-question is answer by considering the reason for choosing that particular operation – addition – instead of other possible options. It is answered by a series of constraints.

> In order that a process shall actually run, however, one has to realize it in some way and therefore choose a representation for the entities that the process manipulates. The second level of the analysis of a process, therefore, involves choosing two things: (1) a *representation* for the input and for the output of the process and (2) an *algorithm* by which the transformation may actually be accomplished. For addition, of course, the input and output representations can both be the same, because they both consist of numbers. […] If the first of our levels specifies what and why, this second level specifies *how*. For addition, we might choose Arabic numerals for the representations, and for the algorithm we could follow the usual rules about adding the least significant digits first and "carrying" if the sum exceeds 9. Cash registers, whether mechanical or electronic, usually use this type of representation and algorithm (Marr 1982, 23).

The last level is the implementational one; in the case of the cash register it is the specific machine that embodies physically the algorithm. As Marr underlines, the algorithm that a child uses to add two numbers might well be the same used by the cash register, but obviously the implementation is rather different. Some devices might be more apt for certain algorithms. So that when *designing* a program, it might be that the choice of either the implementation we want to use or the algorithm that best suits our purposes commits to certain choices at the other level. This, obviously, holds only when the aim is creating a device and not when the aim is *explaining* an existent device that was not produced by us – like in the case of vision, Marr's concern, or any other cerebral device.

Once a distinction between different explanatory levels has been proposed, though, a question concerning the relations between them may arise. Marr explains how he believes the three levels relate to each other as follows:

> […] there is a wide choice available at each level, and the explication of each level involves issues that are rather independent of the other two.
>
> Each of the three levels of description will have its place in the eventual understanding of perceptual information processing, and of course they are logically and causally related. But an important point to note is that since the three levels are only rather loosely related, some phenomena may be explained at only one or two of them. This means, for example, that a correct explanation of some psychophysical observation must be formulated at the appropriate level. In attempts to relate psychophysical problems to physiology, too often there is confusion about the level at which problems should be addressed (Marr 1982, 25).

The three levels are logically and causally related – as mentioned above, when designing a device some constraints from the implementational level might guide the choice for a certain algorithm to be implemented, or it might be the other way around – yet, they are to some extent independent from one another. One can advocate a computational theory of vision without entering details about how it is represented or implemented.

Distinguishing between different levels of explanation and maintaining explanatory naturalism, one can account for he fact that generalization on higher levels – representational or computational levels – can provide explanatory elements that would be missed if one focuses only on the low-level description. Moreover, maintaining different explanatory levels can also account for multiple realizability at the implementational level. For instance, if the description of the way we judge morally rests on a representational level of analysis, one can claim that there might be different possible implementations for it to occur. Neuroimaging studies can enlighten humans' activations when they face moral dilemmas. However, in case computers or cyborgs became possible, the implementational level of explanation would differ, while the representational one could remain identical. The same can be said of inhabitants of other planets who might be wired differently from us. Keeping representational and implementational explanations apart can account for different possible implementations of the same representation: just as much as, in Marr's case, the algorithm "addition" can be implemented by certain operations of a person's mind, but also by some operations of a cash register. These two different devices constitute differences in the implementation, but not in superior levels of explanation – say, representational and computational.

Methodological naturalism claims that:

> If all facts are, in some sense, natural facts (according to metaphysical naturalism), then the methods by which we investigate facts must be suitable to the investigation of natural facts. Philosophers sometimes claim to have a distinctive method for making discoveries: the method of conceptual analysis. If metaphysical naturalism is true, this cannot be a supernatural method of discovering supernatural truths. [...] Conceptual analysis is, like all legitimate investigatory tools, an empirical method (Prinz 2007, 3).

Finally,

> Each form of naturalism has implications for normativity. Metaphysical naturalism entails that moral norms, if they exist, do not require postulating anything that goes beyond what the natural sciences allow. Explanatory naturalism entails that we can ultimately describe how any moral norm is realized by natural entities. Methodological naturalism entails that we should investigate norms using all available empirical resources tools. Transformation naturalism entails that we must investigate norms from within our current belief systems, and, as a result, the norms we currently accept will influence our intuitions about what norms we ought to uphold. If we choose to change our norms, we cannot do so by adopting a transcendental stance that brackets off the norms we currently accept (Prinz 2007, 3).

If these non-reductionist naturalisms are correct, then:

> If the world includes facts about what ought to be, those facts must be explicable in terms of how things are. Every ought must supervene on an is (Prinz 2007, 4).

According to Prinz, naturalism does allow to infer an "ought" from an "is".

The debate on Hume's law, as well as the one concerning naturalism, should be analyzed in much more detail that it has been done here. However, the intention was just to show that naturalism is not necessarily committed to reductionism and to point at possible interactions between different research fields that can – and should, in my opinion – cooperate to achieve a better understanding of moral behavior and moral conscience, resting on different explanatory levels. I believe the representation of these problems provided here could guide further investigations and represent a way to achieve such cooperation.

5. Conclusion

One concrete example of an over-interpretation of data coming from empirical research is the role that has been attributed to empathy in the moral domain. Several authors have considered it as the basis for our moral capacity jumping too easily from the description of a neural device we are endowed with to normative conclusions (e.g. Preston, de Waal 2002; Shamay-Tsoory 2011; Rifkin 2009; Baron-Cohen 2011). They have claimed that since we are to some extend endowed with empathic abilities all that is necessary in order to act and judge morally is that empathy is activated. However, being empathy simply a device that enables the resonance of others' emotions, there is nothing intrinsically moral about it. Empathy can provide the natural and embedded basis for our ability to understand those who are similar to us, but it will not be moral until we somehow decide that we are going to take the emotions of others as relevant for our moral judgment and decision-making and to give a precise direction to this consideration. As long as empathy is just an unreflective affective reaction, it is far from being morally relevant, and tells us little on how we should behave towards others. Before adopting and endorsing a more impartial and detached consideration, empathy is simply amoral (Carrasco 2011; Bloom 2014).

The innate capacity is, thus, necessary for the sympathetic consideration of other people – or compassion, as Paul Bloom (2014) calls it –, but it is not a sufficient condition to make that relationship moral: having such a mechanism is totally compatible with making immoral decisions and judgments – it is, for example, totally compatible with some degree of *Schadenfreude*.

> *Schadenfreude* – derived from the German from *Schaden* (adversity, harm) and *Freude* (joy) – means taking enjoyment in another's pain or misfortune Schadenfreude is the flip side of empathy: similar cognitive abilities are used (e.g., perspective taking, awareness of others' emotions), but the result is not sympathy or a desire to help another person but rather a sense of pleasure when another person experiences pain or distress. […] Schadenfreude is related to envy; brain imaging studies show that when a person feels envy, brain regions associated with physical pain (i.e., the anterior cingulate cortex) are activated. When a person one envies

> experiences a misfortune, triggering feelings of Schadenfreude, the ventral striatum (a brain region associated with pleasure and reward) is activated [Takahashi *et al.*, 2009] (Reevy *et al.* 2010, 237, italics in original).

If we lack such a automatic mechanism for sharing other people's emotions, it is much more complicated to understand them, though it is not impossible by means of a more complex and mentalizing mechanism that cannot provide an immediate and emotional sharing, but an intellectual comprehension through the attribution of mental states to others. There are other ways to perform pro-social behavior that do not entail empathy (Slote 2010, Prinz 2007). Similarly, there are other more mentalizing ways to understand others that do not entail empathy. And yet, even when the mechanism is in place, it does not necessarily follow that the behavior or decision taken upon it would be morally good. *Schadenfreude* represents the counterexample of this inference: empathy – that is, the capacity to resonate others' emotions is in place and yet the behavior or decision that follows is an immoral one.

The neural circuits give us a possibility. The fact of having such a circuit does not mean that it is necessary to develop it in a desirable way: the realization of oneself as a sympathetic, compassionate, and caring being is totally open. Empirical findings about our empathic abilities only illuminate the set of possibility's conditions of the emergence of a moral conscience and moral capacities (Boella 2008, 43). Empathy has here been used only as an example of what inferences can and cannot be drawn from empirical findings. The existence of a certain mechanism requires our theoretical approaches to take it into consideration, that is to grant some room to it, and yet it cannot determine, by its existence *per se*, moral decisions or moral behaviors.

The neuroscience of ethics has, thus, to face a serious methodological challenge when trying to derive normative, substantive conclusions from empirical findings. As it has been shown, in particular with the example of empathy, it is not the case that empirical research cannot illuminate our understanding of the moral domain, yet, as Hume claims, anytime one goes from an "is" to an "ought" such passage has to be explained and justified. Data coming from neuroscience, as much as from any other empirical domain, can play an indirect role in modifying our theoretical understanding of morality. What they cannot do is prove one specific theory, their role is simply that of limiting possible theories to feasible ones. In the case of the research on empathy, for instance, what the huge amount of data collected can tell us is that empathy plays a role in our understanding of others, so that a theoretical approach that denies completely such a component in morality does not count as a feasible one. However, it is not by data alone that we can decide among several theoretical options that recognize a role to empathy.

Understood in this way – that is, as a combination of empirical research and philosophical insight to enlighten our actual possibilities in the moral domain –, the neuroscience of ethics can avoid being reductionist without committing to non-naturalism. Our ethical questions will not find a definite answer in empirical data, but simply another set of information to be interpreted and used to better understand the constraints we are subject to. This account of the interaction of empirical findings with theoretical enquiry and of the role data can actually play should restrict the fear and criticism to neuroethics that have come from those who fear a reductionist move.

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Summaries

Marco Annoni

Exceptional Lies: The Ethics of Deceptive Placebos in Clinical Settings

In this article I explore the ethics of using deceptive placebos in clinical contexts. The view that I will defend is that there is no reason to regard the moral case for or against the use of deceptive placebo as different from other cases in which doctors confront moral dilemmas about the use of "paternalistic", "therapeutic", or "benevolent" deception. In particular, I will criticize two influential positions within the current placebo debate. The first position is the one according to which deceptive placebos do not raise substantial moral concerns because they can be administered in ways that are "not transparent" and yet "not deceptive". The second position, then, is the one endorsed by the American Medical Association (AMA) according to which the use of deceptive placebos without patients' consent must be categorically prohibited. In this article I argue that both views are flawed because they equally misrepresent key aspects of the morality of benevolent deception in clinical settings.

Marianna Nobile

L'autonomia "irrazionale": interventi sul corpo e integrità fisica nel dibattito multiculturale

In order to understand the limits and the liberties entailed in the right to health in the multicultural society, it is necessary to pay attention to the different ideas of health belonging to minority ethnic groups. In particular, the essay focuses on bodily interventions and on the limits of self-determination, determined by the partially conflicting value of bodily integrity. The aim is to evaluate whether the bodily integrity argument, adopted to motivate the opposition to female genital mutilation, can be considered a valid argument, especially in reason of the common and legal acceptance of other bodily interventions, such as genital plastic surgery, that damage the bodily integrity of the individual as well. Recognizing the principle of self-determination as the prerequisite of the fundamental right to health, considered as the

protection not only of the biological body, but also of the psychological well-being, it has to be ascertained if the concept of bodily integrity can be universally accepted or if, on the contrary, it is a culturally oriented body construction.

Virginia Sanchini

Bioethical Expertise: mapping the field

In a specialized world, where knowledge has increasingly become a collective enterprise, nobody can master all the fields. This has led to the generation of a myriad of experts, each of whom is specialized in a precise domain or subdomain. Given this picture, it is not surprising that people with training in bioethics are often referred to as "bioethics experts" and/or "bioethical experts". However, the question "who is the bioethical expert?" does not appear so easy to answer. This paper locates precisely within this debate and aims to provide a picture of the contemporary debate over the issue of bioethical expertise, analysing and reshaping the main objections present in the literature both against the concept of bioethical expertise and the existence of bioethical experts. It will be then shown that, if properly considered, there is some space for bioethical expertise and bioethical experts within contemporary democratic societies.

Sarah Songhorian

Neuroethics: The Relation Between Philosophical Reflection and Empirical Research

The aim of this paper is to focus on the most relevant methodological challenge that neuroethicists have to face when dealing with the neuroscience of ethics, that is with the contribution empirical research in general and neuroscience in particular can make to our knowledge of moral issues. Before considering any substantial thesis in the debate, those who are interested in neuroethics have to try to answer a tricky question: how, and to what extent, can empirical analysis modify philosophical theories? That is, how can the way things *are* influence they way the *should* or *ought to be*?

A worry can arise concerning the relation between empirical findings and theoretical analysis and it has deep routes into the philosophical debate. The interpretation of Hume's is/ought passage, the division between fact and values, and Moore's argument against the naturalistic fallacy have made any attempt to consider scientific discoveries into the philosophical debate hard. I will conclude that data coming from neuroscience, as much as from any other empirical domain, can play an indirect role in modifying our theoretical understanding of morality. What they cannot do is prove one specific theory, their role is simply that of limiting possible theories to feasible ones.

Notizie sugli autori

Marco Annoni, Ph.D., is research fellow at the National Research Council (Cnr), Institute of Biomedical Technologies (Itb). He is part of the scientific secretariat of the Cnr Research Ethics and Bioethics Advisory Committee, and of the Ethics Committee of Fondazione Umberto Veronesi (Fuv). His main research interests concern biomedical ethics and American Philosophy. Among his main publications: "Placebos in clinical practice: An ethical overview" (with F.G. Miller, 2014), "Principali questioni etiche della sperimentazione con soggetti umani" (with C. Nardini, 2014), "Words that matter: Peirce and the ethics of scientific terminology" (2014), "Alle Origini del Pragmatismo. Corrispondenza tra C.S. Peirce e W. James" (co-edited and translated with G. Maddalena 2011).

Marianna Nobile studied at the Vita-Salute San Raffaele University in Milan where she gained both a Bachelor and a Master's degree in Philosophy, majoring Bioethics and Moral Philosophy. She completed her Ph.D. in Law at the University of Milano-Bicocca, specializing in the Philosophy of Law and Bioethics. Her research interests are focused on ethical and political issues related to health in the multicultural society and she is author of numerous publications on these matters.

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