In Search of a European Approach to Bioethics: The Emergence of a Common Euro-Mediterranean Bioethical Culture

Rev Prof Emmanuel Agius

In his recent study on the birth of bioethics, Albert Jonsen claims that bioethics is an American phenomenon.[1] The fact that bioethics began as a movement and had its first development in the United States, led Jonsen as well as other authors to think that bioethics is a typical and specific product of the American culture. Some even reached the conclusion that, outside of the United States, this phenomenon can be spread out, applied, and particularized, but not enriched in its essence. This was the general belief expressed in the papers read by a number of American participants in the conference about *The Birth of Bioethics*, organised by Jonsen in the University of Washington, in Seattle, in 1992.[2]

Jonsen believes that American bioethics differs from all other bioethics because of the "American ethos". He describes the "American ethos" as, firstly, a destiny to make life better than it is and a conviction that it is possible to do so; secondly, a faith in the values of individuals and their capacity to reach consensual agreement; and, thirdly, a vague but genuine commitment to a conventional morality.[3] This contention is criticised by Diego Gracia who maintains that an accurate analysis of the history of bioethics leads us to conclude that Jonsen's interpretations are extremely parochial and ethnocentric. He disagrees with Jonsen's conclusion that bioethics is an American product, which other countries and cultures can import and assimilate, without the possibility of adding fundamental novelties.[4] In Charles Taylor's terminology, Jonsen's 'politics of nonrecognition or misrecognition' of the valid contribution

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[1] Jonsen, A, *The birth of bioethics*, Oxford University Press, New York/Oxford, 1998, p. viii and xv.

[2] Gracia, D., "History of Medical Ethics", in *Bioethics in a European Perspective* (H. ten Have and B. Gordijn, eds), Kluwer, Dordrecht, 2001, p.44.

[3] Jonsen, A., *op.cit.*, p 395

[4] Gracia, H., *op.cit*, p. 45

of other cultures to bioethics is a source of damage, distortion and oppression of the cultural identity of other regions or continents.[5]

Gracia defends the hypothesis that the success of bioethics is not directly related to the peculiarities of the American ethos, but to two general characteristics, namely, the secularization of Western culture and the emancipation of the decision-making process in the questions related to life and death issues.[6] This change in the socio-cultural context of medical practice diminished the influence of religious values in the resolution of moral problems in medicine, whereas a non-religiously, secularly grounded normative view of human life has become more influential. This view emphasizes personal autonomy and each patient's right to make his or her own health care decisions.

According to Gracia, the application of normative ethics in the field of moral problems related to life and death issues was traditionally entrusted to 'moralists', who were in general clerics of different religions. 'Ethicists' were only concerned with formal and abstract problems, like metaphysics and the nature of moral discourse. Until recently, 'ethics' was conceived of as the philosophical background to morality, and 'morals' as the discipline concerned with human behaviour. Ethics, which was conceived of as rational ethics, had no normative role. Only during the sixties has this word enriched its content by encompassing also the field of normative ethics. Whereas the word 'moralist' referred traditionally to someone engaged only in formative questions, the new word 'ethicist' began to denote a lay or secular person working in the field of moral norms and applied ethics. In this context, one can easily understand the reason why the word 'bioethicist' began to refer to someone who is engaged in normative questions and applied issues related to healthcare.

The handing over of normative ethics from the hands of 'moralists' to the hands of 'ethicists' between the sixties and seventies, which was

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[5] Taylor, Ch, *Philosophical Arguments*, Harvard University Press, Cambridge, Mass., 1997, pp 225-256.

[6] Gracia, D., *op.cit.*, pp.45-46.

described by Stephen Toulmin as the shift of philosophical ethics from meta-ethical questions to normative problems, was crucial in the establishment of bioethics as a movement. This revolution, which took place not only in America but also in Europe, led to the process of secularization of Western culture.

Gracia concludes that bioethics cropped up and developed as the natural consequence of this process of human emancipation from a certain kind of tutelage or paternalism that was traditional in Western culture. This explains the reason why bioethics stresses so strongly the principle of autonomy and the respect of the different value systems proper to each and every culture. This general phenomenon has manifested itself all through Western culture, and not only in North America. Bioethics was born in the U.S. not due to some particularities of the American ethos, but because it showed the first manifestations of this general phenomenon, namely the Civil Rights movement after the Second World War, and the development of biotechnology and medicine.

1. Attempts to identify a European Cultural Perspective

Though bioethics developed as a general phenomenon, it would be a mistake not to recognise the particular cultural articulation of bioethics. Bioethics is not the product of reason alone, independent of culture.[7] The fundamental ethos of applied ethics, its methodology and language, its concerns and emphases, and its very institutionalization have been shaped by beliefs, values, and modes of thinking grounded in specific social and cultural traditions. Moreover, bioethics literature reflects and articulates the socio-cultural value system within and through which it operates. It is, therefore, false to assume that bioethical theories and moral views are transcultural.[2]

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[7] Gbadegesin, S., "Bioethics and Cultural Diversity", in *A Companion to Bioethics* (Kuhse H & Singer P eds), Oxford, Blackwell, 2001, p. 24.

[8] Ten Have, H., "Principalism: A Western European Appraisal", in (E.R. DuBose, R. Hamel, L.J. O'Connell, eds), *A Matter of Principles. Ferment in U.S. Bioethics*, Trinity Press International, Pennsylvania, 1994, pp.106-7.

The dominant concepts of bioethics developed within particular cultural contexts. These concepts are not abstract but are always linked to the particularities of the practical setting. The idea that knowledge of normative theories and principles can be applied to medical practice simply ignores the fact that moral concerns tend to emerge from experience in medical settings themselves. Only recently we became aware of the importance of examining critically the socio-cultural context in order to understand better the strengths and weaknesses of dominant concepts of medical ethics. Charles Taylor raises a similar issue in his *Sources of the Self*, in which morality and identity are considered two sides of the same coin. To know who we are is to know to which moral sources we belong. The community, the particular group to which we belong, is usually at the center of our moral experience. Even the use of ethical language depends on a shared form of life. Wittgenstein's notion that our understanding of language is a matter of picking up practices and being inducted into a particular form of life is relevant here.[9]

Bioethics, as Daniel Callahan maintains, is always communitarian or cultural because particular decisions reflect not only individual responsibility but also the social dimension of moral life. Culture shapes individual choices by creating the context and limits of those choices.[10] The communitarian approach to bioethics pays more attention to the experiences of practitioners and to the particular context in which they operate. This particular perspective emphasizes the fact that the cultural context and the community are constitutive of the values and goals of individuals. The physician-patient relationship is neither a-historical and a-cultural, nor an abstract rational notion; persons are always persons-in-relation, are always members of communities, are immersed in a tradition, and participants in a particular culture. Morality is something we all participate in, and bioethics in particular is not the result of esoteric knowledge. Anyone involved in the medical setting

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[9] Ten Have, H., & Gordijn B., eds, *op.cit.* p. 59.

[10] Callahan, D., "Bioethics: Private Choice and Common Good", in *Hastings Centre Report*, (May-June) 1994, pp 28-31. Cf. Privitera, S. (ed), *Bioetica mediterranea e nordeuropea*, Istituto Siciliano di Bioetica, Armando, 1996.

is *ipso facto* a moral participant and "expert" at least with regard to moral experience and intuitive knowledge. It follows that all moral experiences inherent in health care practice must be taken into account.

Since it makes sense to reflect on the specific cultural dimension of bioethics, it is therefore worthwhile to examine the following questions: What is typically European about bioethics? Is it possible to identify typically European approaches in the area of bioethics? Is it possible to identify a common set of values that characterize the Euro-Mediterranean culture? It is important to raise these questions in order to determine what the European culture can contribute to the bioethical movement.

Before attempting to answer these questions, it is important to raise the issue whether there is a European culture. The concept of Europe refers to an area with a relative unity because of similar ways of life and thinking. Europe is not merely a distinct geographical entity, but rather a political and cultural concept. Although in Europe there are a number of traditions, together they constitute a coherent culture, a specific sphere. 'Europe' is manifested outwardly as a relative unity. It partly legitimizes itself by pointing to certain economic and political choices and achievements that are said to imply moral choices as well. More importantly, it tries to defend certain values, the results of a rich cultural tradition.[11]

This cultural sphere has been strongly influenced by the development of Christianity, and now by the presence of other religions, particularly Islam and Judaism. It was shaped by political changes, such as the French Revolution and the First and Second World Wars, by philosophical ideas about humanism and Enlightenment, by scientific and technological progress. Various catalogues of 'European' values have been proposed: freedom, tolerance, equal opportunity, social justice, human dignity, and solidarity.

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[11] Rietbergen, P., *Europe. A cultural history*, Routledge, London and New York, 1998 p. 461

Indeed, there seems to be a consensus in Europe that looks at man in society under a threefold aspect: each man is unique, each person has to make his own choices for good and evil but, first and foremost, being human means taking responsibility for others, that means, protection of others to preserve the quality of society at large.[12]

When did this search for a specifically European perspective in bioethics begin? Jos. V.M Weile and Henk ten Have claim that this search started not long ago.[13] A series of developments have motivated the attempt to articulate these perspectives. Political and economic issues led to the need to articulate the specific European identity vis-a-vis North America, Russia and Asian countries. This need intensified after 1989 when the political changes in Central and Eastern Europe started a period of transition and transformation all over the continent.

As a result of the collapse of ideological barriers, the map of Europe has changed with the emergence of new nations. The Council of Europe has almost doubled in size. Though nationalism became widespread, there were many efforts in Europe to reassert the common cultural values and to stress human rights and fundamental freedoms. Since 1989, the European Union started an intensified cooperation programme with other countries in Europe, not only to support transition in economic and scientific terms, but also to support the protection of human rights and democracy, as well as to endorse particular values.

2. **European Approaches to Medical Ethics**

What are the specific characteristics of a European approach to moral problems in health care? Is it possible to identify a European approach in the area of bioethics?

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[12] Ibid., p. 465

[13] Weile,Jos V.M. & Ten Have H., "Bioethics in a Supranational European Context: 1989-1991" in (Lusting, A. et al. eds.) *Bioethics Yearbook*, Dordrecht, Kluwer Academic Publishers, 1992.

Henk ten Have claims that it is problematic to identify typically European perspectives. He believes that continental philosophy is typified by an amazing variety of philosophical theories and methods without any major and dominating school. The same is true for bioethics. Many schools and approaches flourish in practice and literature: applied ethics, phenomenology, hermeneutic ethics, casuistry, post-modernism, clinical ethics, and narrative ethics. These different approaches play an important role in enriching the analysis of concrete facts. But this situation seems not too different from North America. There also a variety of approaches exist. He maintains that, although there are many similarities, there is, nonetheless, truth in the proposition that American bioethics has predominately been developed around a common methodological structure and a particular set of ethical principles.

Moreover, ten Have claims that in Europe the philosophical perspectives in medical ethics seem broader than in the United States. In Europe, the bioethical debate is enriched by a number of philosophical approaches which all contribute valid insights. He disagrees with those who believe that the Anglo-American philosophy is generally classified as empiricist, while European philosophy is more influenced by rationalism. On the contrary, he contends that Anglo-American ethics is generally more teleological and consequentialist, while European ethics more deontological.[14]

Furthermore, ten Have explains that, on the one hand, in many European countries, ethics is very much under the influence of philosophical and theological traditions, and multifaceted in philosophical substance – not dominated by analytic philosophy. In Central and Eastern European countries, bioethics emerged only recently from the former departments of marxist-leninist philosophy or social sciences. On the other hand, only in a very few countries, such as the United Kingdom, the Netherlands and the Nordic countries, medical ethics in particular is the specialized enterprise of a new profession. Most often it is the

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[14] Idem.

recognised business of medical practitioners or lawyers, who therefore dominate public debate. This is presumably also one of the reasons why the term 'bioethics' is not as frequently used as 'medical ethics' or 'health care ethics'.[15]

During the late seventies, Dietrich von Engelhart and Sando Spinsanti have already defended ten Have's position. They claimed that, though bioethics flourished in most European countries during the late-twentieth century, however, as a field of ethical reflection and an instrument of public policy, bioethics is hardly uniform across the continent. Medical science and technology, as in many countries throughout the world, stimulated an interest in medical ethics in many European countries. Yet they maintained that the way various countries have experienced that development differ, as has their ethical response. Although influenced by social and political events, and by philosophical, literary, religious, and cultural ideas common to the European milieu, various countries and cultures have contributed in unique ways to the formulation of bioethical ideas.[16]

Diego Gracia's views on the identity of European bioethics are analogous to Henk ten Have's perspective. He claims that the Western world harbors three different ethical traditions, each with its own characteristics: the Anglo-Saxon, the Central European and the Mediterranean. Because modern bioethics is a product of the Anglo-American culture, Mediterranean countries have not attempted simply to import or "translate" bioethics but rather, to 're-create" or "re-make" the discipline to their own cultural and ethical traditions.[17]

Diego Gracia focuses on the particular characteristics of bioethics in the Mediterranean region. All European countries surrounding the Mediterranean basin, in addition to geographical and climatological

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[15] Ten Have H. & Gordijn B., eds. *European Perspectives in Bioethics*, p.63.

[16] von Engelhart D., & Spinsanti S., "History of Medial Ethics in Europe: the Contemporary Period", in *Encyclopaedia of Bioethics*, vol. iii, p. 1554-6.

[17] Gracia, D. & Gracia Th., "History of Medial Ethics in Europe: Southern European", in *Encyclopaedia of Bioethics*, vol. iii, p. 1557

affinities, have for many centuries shared a common history centered on the Mediterranean Sea. Although they maintain local peculiarities and differences, the nations of southern Europe can be said to have a common identity. He claims that this common identity is particularly evident in ethical issues. Western ethics had its origin in the Mediterranean Greco-Latin culture, and since the days of the Greek philosophers, this ethics has centered on the concepts of virtue and vice. Only with the Enlightenment did a new ethical tradition, with right and duty as its main concepts, begin to take shape in central Europe. Since then, the two approaches have widely been considered opposite, although they are in fact complementary. The ethics of virtue has persisted in those countries in which the Enlightenment had less influence, such as the Catholic and Orthodox southern European countries, while the ethics of duty has prevailed in the Protestant central European and Anglo-Saxon countries.[18]

Salvino Leone, following Elio Sgreccia, contributes also to the idea of a Mediterranean approach to bioethics. He claims that Southern European countries elaborated a "Latin" model of bioethics.[19] While the Anglo-American model is structured around the four classical principles of autonomy, nonmaleficence, beneficence and justice, he bases the so-called Latin model on the four foundational values of life; liberty and responsibility; totality (or therapeutic wholeness); and social subsidiarity (the idea that smaller units are always preferred to larger ones when it comes to addressing social problems).

According to Diego Gracia, Mediterranean countries have created a "realistic" and "personalist" model of biomedical ethics, based on the classical Aristotelian-Scholastic philosophy and complemented with more modern European philosophical traditions such as phenomenology, axiology and hermeneutics.[20] In this perspective, the

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[18] McIntyre A., *After Virtue*, 1984, pp.

[19] Lenoe S., "Il problema del 'valori comuni' nelle deliberazioni dei comitati", in *I comitati di bioetica: Storia, analisi, proposte*, , Rome, Edizioni Orizzonte Medico, 1990, pp.143-158.

[20] Gracia, D. & Gracia Th., "History of Medial Ethics in Europe: Southern European", in *Encyclopaedia of Bioethics*, vol. iii, p. 1558.

idea of virtue acquired much more significance than any other Western tradition, a fact that has important consequences in the medical field. For example, trustworthiness is considered more crucial than the right to information. Patients in southern European countries are generally less concerned with receiving detailed information or having their autonomy respected than with finding a doctor in whom they can place their full confidence. One virtue is particularly important in establishing a satisfactory doctor-patient relationship, namely friendship.

Another distinctive characteristic of Mediterranean bioethics is its overwhelming concern with health-care justice. In southern European countries, the State takes the responsibility for what in other countries is considered the realm of private enterprise. In fact, the health systems of these countries are mainly state-run. While autonomy plays an important role in North-American bioethics, justice plays a decisive role in European biomedical ethics. In fact, France, Italy, Greece, Portugal, Spain and Malta have similar national health insurance systems.

The way patients' rights were established marks another distinctive feature of the Mediterranean countries. In the United States these rights, particularly the right to informed consent, took shape in the field of common law, while in Mediterranean countries their entry was directly through statutory laws and codes. In these countries, protecting patients' rights is a duty of the State more than the duty of individuals. For instance, in Spain, patients' rights were first established legally and then socially.

3. **Towards European Harmonisation**

In several fields, the European Union is developing binding policies for its Member States. This is particularly true in economic matters, such as trade and antitrust rules, and in agriculture. In contrast, matters of morals or ethics are areas of "national competence" – each Member State establishes its own policy. General principles such as civil liberties, political freedom, legal equality, and social justice are endorsed as the basis of European democracy. However, on specific issues, including abortion, embryo research, protection of animals, environmental protection, patenting of living organisms, or surrogate motherhood, national differences are still appalling.

As a result of these divergences in bioethical policies at the European level, the issue of harmonisation has emerged as an urgent matter. As former EU-Commissioner, Karl Heinz Narjes put it, "We cannot have a situation in which the same research might lead to a Nobel Prize in some Member States of the EEC and to prison in others". Consequently, an important question is raised: should ethical matters be left to individual member states, or should they be dealt with at a supranational European level?

As a reaction to the differences in public policies in health care issues, many ethical bodies have come into existence at a supranational level to find a consensus and to achieve harmonisation. A significant development has been the gradual expansion of the European Union that is now promoting co-operation in health protection. In fact, during the last few decades, initiatives in bioethics emanated from several EU institutions.[21] In 1991, the Commission of the European Union set up a Group of Advisers on the Ethical Implications of Biotechnology (GAEIB). The EU has had a number of meetings and conferences on bioethical problems and established a number of directives on biomedical problems.[22]

Moreover, bioethics has become a focus of the Council of Europe that has taken upon itself the responsibility of harmonising European rules and regulations in healthcare issues.[23] It is logical for the Council of

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[21] Elizalde, J., "Bioethics as a New Human Rights Emphasis in European Research Policy", in *Kennedy Institute of Ethics Journal*, vol 2, no 2, (1992) 159-170. Se also Weile, Jos V.M. & Ten Have H., "Bioethics in a Supranational European Context: 1989-1991" in (Lusting, A. et al. eds.) *Bioethics Yearbook*, Dordrecht, Kluwer Academic Publishers, 1992, pp. 97-126, and Riis, P., "Medical Ethics in the European Community" in *Journal of Medical Ethics*, 19 (1993) 7-12.

[22] "The basic Ethical Principles in the EU and the Council of Europe", in *Basic Ethical Principles in European Bioethics and Biolaw*, Vol i., pp 281-287.

[23] Quintana, O., "International bioethics? The Role of the Council of Europe", in *Journal of Medical Ethics*, 19 (1993) p.5

Europe, which has blazed a trail in the protection of individuals and human rights since 1949, also to commit itself to guaranteeing harmonious progress for the benefit of the individual and society, while reiterating the primacy of the human being in relation to science and denouncing any subordination of the former to the latter. In 1985, the Committee of Ministers of the Council of Europe decided that bioethical issues should be dealt with by a single specialised committee. This committee obtained a permanent status in 1992 as the Steering Committee on Bioethics.

A landmark in this process of harmonisation and in articulating a European perspective in bioethics is the *Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine*, developed by the Council of Europe and signed in 1997 by 21 members in Oviedo, Spain. The objective of the Convention is to set future ethical standards for all European nations by establishing a number of general principles that will protect human rights in the changing context of medical practice.[24] The Convention identifies basic ethical principles necessary for the application of medicine and life sciences in all European countries. As a general framework of reference for public policy and international cooperation, the Convention is a milestone in the harmonisation of health care ethics and law.

The European Convention on Human Rights and Biomedicine is a well-intended and a carefully prepared document that may stand as a landmark in the evolution of bioethics in Europe. It builds on the earlier foundations of the Universal Declaration of Human Rights as well as on the European Treaty for the Protection of Human Rights and Fundamental Freedoms. The Bioethics Convention can be considered as the result of a number of important previous resolutions and recommendations by the Council of Europe on medical experiments with human beings, reproductive technologies, genetic manipulations, prenatal diagnosis and genetic testing, experiments and trade with

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[24] Rogers A. & Durand de Bousingen D., *Bioethics in Europe*, Council of Europe Press, 1995, pp13-4.

embryos, organ transplantation, and euthanasia and life prolonging treatment (including protection of terminally ill patients).[25]

Although the Convention provides a common framework of minimum norms there is still a lot to be done to harmonise national and international regulations. A number of problems of the Convention, concerning the protection of incapable people, the protection of the human body, the status of the embryo, etc, need to be continuously evaluated in order to reach a consensus.

4. Emerging Common Bioethical Values in Europe

Diego Gracia claims that, because of the plurality of traditions that make up contemporary European bioethics, it is not possible to isolate a single path of development.[26] An emerging core of bioethical values common to all European countries proves this statement wrong. Current efforts in Europe do not only aim to forge an economic and political identity, but also a common cultural identity. Nowadays, Europe is characterised by a widespread sensibility and effort to build common values that will enhance the European identity. In fact, European institutions are striving to establish above all a community of values. The aim of the European unification is to realise, test, develop and safeguard these values.

European identity is rooted in national identity, and emerges at the point where countries realise that they share a common future. Fundamental rights and parliamentary democracy are unquestionably the basis of this identity today. But they, though indispensable, are not enough to make every individual feel fully as part of a country and of Europe too. European identity will achieve its full potential through a freely accepted "community of values". Moreover, the need of a common European ethical approach can also partly be explained by the fact that many citizens in Europe feel that they have a common

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[25] Ibid., pp. 287-308.

[26] Gracia, D. & Gracia Th., "History of Medial Ethics in Europe: Southern European", in *Encyclopaedia of Bioethics*, vol. iii, p. 1555.

history and a common destiny. Indeed, the Treaty of Maastricht in 1992 (Article 17) introduced for the first time the notion of a citizenship of the Union that compliments national citizenship.

The promotion of a Europe characterised by common values was reflected back in 1992 in the establishment of the first European Union bioethics committee, an independent, multidisciplinary, advisory body, set up to examine comprehensively applications of biotechnology in research, medicine, and agriculture. The work of the European Group on Ethics in Science and New Technologies, combined with the growing influence of public opinion, has done much to ensure the prominence of ethical principles in the European biotechnology debate. These principles, such as the respect for human dignity, the right to confidentiality of medical data, the principle of non-discrimination and the right to safety and transparency have all been enshrined in European law. The upshot of these concerns is that they are helping to clarify what a common European political identity really means. More precisely, bioethical principles developing out of such concerns are increasingly coming to represent the building of a Europe which is no longer just a single market, but also a family of nations based on common values, which includes freedom, as well as human dignity and safety.

The report on the BIO-MED II-project, *Basic Principles in Bioethics and Biolaw,* which was written on the basis of collaboration between 22 partners, presents an analysis of the ethical principles prevalent in Europe. The idea of this analysis of European bioethics is to show the limitations of an approach to bioethics that is built solely on the concept of autonomy, a concept that has been widely influential in American inspired bioethics.[27] Among the four principles, it is autonomy that has been the most widely mentioned in the international debate on bioethics. It is a standard reference point in the Anglo-American bioethical debate, where the philosophies of Tom Beauchamp and James Childress in

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[27] Cf. Wulff, H., "Against the Four Principles: a Nordic View", in *Principles of Health Care Ethics*, (Gillon, R., ed), John Wiley & Sons, Chichester, 1994, pp. 277-286.

their influential book *Principles of Biomedical Ethics* (1979) have become the foundation of much research. This book refers to the principles of autonomy, non-maleficence, beneficence and justice. Respect for patient autonomy has largely been accepted in American, and to some extent, in European countries. But this acceptance is marked by a tendency to consider autonomy as the only guiding principle concerning the protection of the human person. Consequently, it ignores other dimensions of the protection of human beings.

Consequently, the researchers in this project claim that other supplementary principles must be taken into account when dealing with personal autonomy and the protection of human beings in bioethics.[28] In contrast to the scheme elaborated by Beauchamp and Childress, the new European bioethics takes dignity, integrity, and vulnerability to be the guiding values. By showing the limitations of autonomy and viewing this concept in relation to the principles of dignity, integrity and vulnerability, the BIO-MED II-project aimed to provide a more secure foundation for the protection of the human person in bioethics. In this light, the project integrated the principles in the framework of solidarity, responsibility and justice.

In contrast with the basic ethical principles proposed by the researchers of the BIO-MED II-project, the following paragraphs elaborate an analogous common set of values that are emerging in supranational institutions as general guidelines for the future direction of European bioethics and biolaw. They may be interpreted as providing a normative framework for the protection of the human person in biomedical development. Moreover, they indicate the political morality that will shape the medical and legal system of the European Union in the decades to come.

a) **Human Dignity and Fundamental Rights**

The foundation of the culture of human rights that was to develop throughout the second half of the twentieth century was laid by the

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[28] *Basic Ethics Principles in European Bioethics and Biolaw* vol 1. Pp. 18-19.

post-Second World War international instruments. The concept of human dignity is a seminal idea that acts as the background for the recognition of human rights and as the source of the fundamental freedoms to which all humans (*qua* human) are entitled. The idea of human dignity has its roots in the three monotheistic traditions, namely Christianity, Judaism and Islam, which all profess that every human being is created in God's image. Philosophers then radicalized it in the Renaissance and the Enlightenment, particularly Kant who maintained that every rational moral being has intrinsic value.[29] Dignity is the property by virtue of which human beings possess moral status.

What exactly does the concept of human dignity mean? There are two interpretations of human dignity: a) on the one hand, 'human dignity as empowerment' treats human rights as founded on the intrinsic dignity of humans; b) on the other hand, 'human dignity as constraint' on free choice is more concerned with human duties than with human rights.[30] This distinction correlates broadly with the contrast between the background role typically assigned to human dignity in the founding international instruments of human rights as against the foreground role assigned to it in the recent instruments that set the framework for modern bioscience. Where human dignity plays a background role, the governing conception is human dignity as empowerment; where it plays a foreground role, the distinctive conception is human dignity as constraint.

According to the BIOMED research project, dignity cannot be reduced to autonomy. Rather, dignity is defined both as an intrinsic value and as a matter for constructive morality in human relationships. It expresses the outstanding position of human beings in the universe. It refers to the inviolability of individual human life. It further expresses the moral responsibility of the human person. On this basis, human dignity can be interpreted to include the following meanings as an intersubjective

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[29] "Human Dignity, Human Rights, and the Human Genome", *in Basic Ethical Principles in European Bioethics and Biolaw* (Rendtorff J.D., $ Kemp P., eds), vol. II, pp. 15-44.

[30] Beyleveld. D., & Brownsword. R., *Human Dignity in Bioethics and Biolaw*, Oxford University Press, 2001, p. 1.

concept: 1) It expresses the intrinsic value of the human being in a community or society. 2) It includes respect for the moral agency of the human subject. 3) It means that every human being must be considered as being without price and unable to be commercialised. 4) This includes that human dignity refers to the indeterminant position of human beings in the universe – as they are able to create their own future. 5) Self-esteem, to be proud, shame, feeling of inferiority and degradation are essential matters of human dignity expressed in the intersubjective relations between individuals. 6) Dignity can establish restrictions on interventions in human beings in taboo-situations, because of the necessity of human civilised behaviour. 7) Finally, dignity relates to metaphysical experiences of human beings in existential limit by degrading treatment. But the relation between rights and dignity is also essential. In that context, human dignity expresses the intrinsic worth and fundamental equality of all human beings.[31]

The discourse on human rights and human dignity in bioscience is being interpreted as a new horizon of human rights in Europe. The 'first generation' of human rights – political freedom and civil liberties – are reaching the whole of the European people for the first time in history. 'Second generation' rights – the social charter – are still awaiting general recognition. The 'third generation' or 'solidarity rights' are accepted in principle by all European countries. But now, the institutions of the EU and the Council of Europe are rightly leading the way toward the 'fourth generation of human rights' or 'bio-rights' that imply a universal protection of the human person with intrinsic value as an end-in-itself. This 'new generation of human rights' is accepted internationally as an adequate development that is urgently needed to guide today's accelerated progress in life sciences.

Thus, it is now widely accepted that scientific and medical progress must be compatible with due regard for human dignity and human rights. Such a view represents the wisdom of the Bioethics Convention.

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[53] Rendtorff, J. "Basic ethical principles in European bioethics and biolaw: Autonomy, dignity, integrity and vulnerability – Towards a foundation of bioethics and biolaw", in *Medicine, Health Care and Philosophy. A European Journal*, vol. 5, no 2 (2002) 237.

The concept of human dignity is central to the Bioethics Convention. In fact, the main objective of the Convention is to protect human dignity for present and future generations. The Preamble to the Council of Europe's Convention on Human Rights and Biomedicine recites that the signatories resolve "to take such measures as are necessary to safeguard human dignity and the fundamental rights and freedoms of the individual with regard to the application of biology and medicine." And in Article 1, it is provided that the purpose of the Convention is to "protect the dignity and identity of all human beings and guarantees everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the application of biology and medicine".

Similarly, the Preamble to UNESCO's *Universal Declaration on the Human Genome and Human Rights*, whilst recognising "that research on the human genome and the resulting application open up vast prospects for progress", emphasises "that such research should fully respect human dignity and individual rights"; and Article 5 underlines the legitimate limits of such research by providing that "No research application should be allowed to prevail over the respect for human dignity and human rights, in particular in the fields of biology and genetics". Even in the Directive on the Legal Protection of Biotechnological Inventions, the need for patent law to respect dignity is emphasised. Recital 16, for example, proclaims that "patent law must be applied so as to respect the fundamental principles safeguarding the dignity and integrity of the person". Furthermore, the Preamble to the Protocol to the Convention dealing with the cloning of human beings states that the Protocol is guided by the consideration that "the instrumentalisation of human beings through the deliberate creation of genetically identical human beings is contrary to human dignity and thus constitutes a misuse of biology and medicine."

The proclamation of the Charter of Fundamental Rights of the European Union in December 2000 is a remarkable achievement. The Charter starts from the concept of human dignity and places the human person at the centre of the Union's action. Human dignity is a value that gives a community its particular identity. Seen from a communitarian perspective, human dignity speaks less to what is special about human beings *qua* human beings and more to what is special about a particular community's idea of civilized life and the concomitant commitments of its members. The new bioethics aspires to represent Europe as a community that stands for a certain vision of human dignity; and, what is more, it is this particular vision of human dignity that identifies Europe as the particular community that it is. In principle, a particular community might conceive of human dignity in terms that give priority to the exercise of free choice, such that individual autonomy is seen as the highest expression of human dignity. However, the European project takes a different turn by conceiving of human dignity as setting limits to individual autonomy.[32]

b) **Justice, Solidarity and the Common Good**

The medical sociologist R. Fox has shown how the political norms of liberalism and individualism are very much characteristics of North American bioethics. By stressing autonomy and rights of individuals, other significant considerations (e.g., community and the common good, duties and shared responsibilities) have been neglected, such as critical philosophical questions concerning the value of medical progress and personal and public health in communal life.[33] Although interest in the philosophy of medicine in Europe in general seems to emphasis the social aspects of medicine and the common good, rather than individual autonomy, the dominating conception of medical ethics in some countries seems in many respects not significantly different from that in the US, where liberalism and personal autonomy are stressed.[34]

Daniel Callahan also shares the view that North-American bioethics lacks a communitarian dimension. He maintains that bioethics

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[32] *Human Dignity in Biethics and Biolaw*, p. 65.

[33] Meulen ter R, *et al*, (eds), *Solidarity in Health and Social Care in Europe*, Kluwer Academic Publishers, Dordrecht, 2001, pp. 1-39.

[34] Ten Have H. & Gordijn B., eds, *European perspectives in bioethics*, pp 58.

gravitated almost from the start towards an ethics of autonomy.[35] The field of bioethics was from the first pushed towards an assertion of individual rights. Moreover, Diego Gracia believes that autonomy plays in European bioethics a less prominent role than in America, maybe due to the Latin sense of community, virtue and shared values.[36] The North-American one-sided emphasis on individual autonomy implies an underdevelopment of beneficence and justice that are concepts more characteristic of the European approach.[37] European authors criticise the individualistic focus of dominant bioethical discourse and the relative negligence of community values, interpersonal relationships and solidarity. Individual ethics in their view should be complimented with social ethics.

Henk ten Have claims that bioethics must develop between freedom and solidarity. To sacrifice one of these to the other is to contradict the meaning of human dignity. The challenge to find a balance is accentuated by the developments of biomedical technology which have brought into conflict the individualistic one-to-one doctor-patient relationship and the social aspects of health care decision-making, based on the physician's obligations to a group of patients or even to a broader community. The discrepancy between individualistic and social aspects of heath care decision-making is not an easy one to solve. There is in Europe a widespread endeavour to find the right mixture of these two values.[38] In fact, the prevalent health policy in Western as well as Central and Eastern European countries has been based on the principle of solidarity and the right to equal access to health care in the sense that everybody is entitled to every health care intervention available for other.

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[35] Callahan, D., "Bioethics: Private Choice and Common Good", in *Hastings Center Report,* (May-June 1994) 28-9.

[36] Gracia, D. "History of Medical Ethics", in *Bioethics in a European perspective*, p. 47.

[37] Holm, S., "Socialized Medicine, Resource Allocation and two-tier health care – The Danish Experience", in *The Journal of Medicine and Philosophy*, 20: 631-637.

[38] Ten Have, H., eds,, *Bioethics in a European Perspective,* p 200.

The application of social justice in a health care system and the just distribution of health care resources are two fundamental issues in bioethics. The model of the health care system, which a particular country aims to establish, depends on its perception of social justice. By and large, one can conclude that in Europe there is a solid basis for the common denominator in debates on social justice. Despite their cultural and socio-economic differences most European countries still base their health care policies on the principle of equality and solidarity. In many European countries, the health care resource allocation debate is characterised by a social context in which two values are generally accepted as fundamental, i.e. solidarity and equity. The guiding principles of most post-war governments, conservative and progressive, have been those of equality of access to health care and solidarity in sharing the financial burden proportionate to income. These two principles are reflected in the health care system of many European countries. Moreover, the Bioethics Convention explicitly refers to "equitable access to health care". The explanatory report to the Convention states, however, that "equitable means first and foremost the absence of unjustified discrimination" and is "not synonymous with absolute equality" but "implies effectively obtaining a satisfactory degree of care".

On the issue of the just allocation of health care resources, the waiting list as a rationing instrument is morally problematic, although it is organised on the basis of ethical selective principles. Henk ten Have claims that a different approach to the allocation problem is needed. This approach should take seriously the social dimension of human beings. As long as the focus is on individual needs and wants, it will be impossible to adequately resolve the issue of fair allocation of resources. The focus should shift towards the following question: What from the perspective of the community of individuals is it necessary to provide?

Ten Have proposes a communitiarian approach in order to safeguard the basic notions of equal accessibility and solidarity in health care. A priority setting process focused on patient categories and community needs rather than individual patients and individual needs is necessary to determine what are essential services that must be provided without restrictions to all citizens.[39] According to this community-oriented approach, health is regarded as the ability of every member of the society to participate in social life. Health care is necessary when it enables an individual to share, maintain and if possible, to improve his/her life together with other members of the community. However, it is the community to specify what is necessary care.[40]

c) **Subsidiarity and Participation**

One objective of the EU policy is the creation of a health system in Europe that ensures the best health care possible for all citizens and to shift responsibility as close as possible to the individual citizen, based on the principle of subsidiarity.

It is neither the role nor the intention of the Council of Europe and other European institutions to impose a standardisation of "ethical thought" on its member states. On the one hand, the emerging bioethical standards have great importance as general guidelines for a harmonisation of European policy in bioethics and biolaw. On the other hand, these standards do not abolish cultural variations in Europe, but demand subsidiarity, i.e. that each European society applies these standards according to the particularity of their specific convictions. European institutions believe in the philosophy of persuasion rather than that of coercion.

In fact, the EU does not enforce any policy in bioethics in member states or candidate countries. On a national level each country must establish a balance between harmonisation on a European level and subsidiarity on a national level. Although an increasing number of EC activities give impulses for national health-promoting schemes, they do not solve the problems on implementation on a national level.

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[39] Ten Have, H, "Choices in Health Care", in *Bioethics in a European Perspective,* p 233-237

[40] Ten Have, H., eds,, *Bioethics in a European Perspective*, p 196-7..

Though there are attempts to harmonisation, in most countries these matters are regarded as domestic matters. No country, up to now, has accepted supranational interference in the way its national health care system is organised.

As a conclusion, one may remark that the emerging ethical principles discussed in the final section offer a conceptual framework within which European countries are in fact debating issues of bioethics and biolaw. It should not be thought, however, that a common language implies an easy resolution of the matters to be discussed. Facilitating debate is one thing, resolving value differences is another matter altogether. Each of the regulative values should be regarded as a guiding idea for debate and decision-making. However, these values are open to competing interpretations.

The more these basic ethical principles are realised in future European domestic policies on biomedicine in order to protect all citizens confronted with biomedical technology, the more a new generation of human rights would be developed in European bioethics and biolaw. This would be a great achievement for the benefit of both present and future generations!