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Moral Principles and Ethics Committees: A Case against Bioethical Theories

Anna C. Zielinska

This paper argues that the function of moral education in the biomedical context should be exactly the same as in a general, philosophical framework: it should not provide ready-to-use kits of moral principles; rather, it must show the history, epistemology and conceptual structure of moral theories that would enable those who have to make decisions to be as informed and as responsible as possible. If this complexity cannot be attained, an incomplete product—i.e. bioethics or bioethical principles—should not be seen as a viable substitute. This theoretical position is subsequently illustrated by a case study involving research ethics committees. It is argued that within these committees, that are carefully formed multidisciplinary bodies, what makes competent decision-making possible is not a bioethical theory, nor even a sound philosophical ethics, but the dynamics of the discussion of a number of experts coming from different disciplines. This multidisciplinary expertise is necessary and sufficient to undertake the challenges of complex decisions in the biomedical context.

Keywords: Bioethics; metaethics; ethics committees

We must not nail ourselves down so firmly to our humors and dispositions. Our principal talent is the ability to apply ourselves to various practices. It is existing, but not living, to keep ourselves bound and obliged by necessity to a single course. The fairest souls are those that have the most variety and adaptability.

Montaigne, *Essays*, III, 3, 621 B

After a long experience of Christianity in its both universalistic and dogmatic versions, moral thought since Montaigne became attentive to the difficulties of ethical universalism as a descriptive and normative project. However, a form of universalism persisted in the international philosophical scene—mainly due to ethicists who believed in the natural law—and a formal universalism was revived

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with Kant. This universalism assumes that there are some moral rules that admit no exceptions and those rules, or principles, are knowable in advance and then more or less easily applicable to particular cases. According to this model, moral knowledge is, first of all, a knowledge of principles and of their rules of application. In other words, particular people and circumstances involved should not be crucial in our decision-making. Certainly, this reading of Kant is not only sketchy but also not very generous, but what is interesting in this story is not Kant but the model of thinking about morality he left to posterity. This is the model that haunts most bioethics and contemporary medical ethics when these disciplines try to be directly inspired by moral philosophy. This very model can and should be contested. But if there are no principles to identify, how can one think of either moral education or medical ethics? When ethics is taught to philosophy students, teachers do not even pretend to know in advance the answer to any important practical questions; what they try to do is to convey a solid conceptual and historical framework and to force students to do the most important part of the work themselves. Can it be said that ‘the function of an ethics education in a professional context is fundamentally different to that which occurs in a philosophical context?’ (Emmerich 2013, 3).

Contrary to the usual assumption, I think that this function should be exactly the same: it should not provide ready-to-use kits of moral principles; rather, it must show the history, epistemology and conceptual structure of moral theories that would enable those who have to make decisions to be as informed and as responsible as possible. If this complexity cannot be attained, an incomplete product—i.e. bioethics or bioethical principles—should not be seen as a viable substitute.

In this paper I try to show that in carefully formed multidisciplinary contexts—i.e. within research ethics committees—what makes competent decision-making possible is not a bioethical theory, nor even a sound philosophical ethics, but the dynamics of the discussion of a number of experts coming from different disciplines. This multidisciplinary expertise is necessary and sufficient to undertake the challenges of complex decisions in the biomedical context. A few remarks on ethical education and on meta-ethics follow.

Ethics Committees without Bioethical Principles

From the very beginning of bioethics, the project was meant to provide several general principles of ethics that would guide particular moral decisions in the biomedical context. The *Principles of Biomedical Ethics* by Tom L. Beauchamp and James F. Childress became the reference book playing the quoted role and made the principles explicit. There are many reasons to think that the model proposed by this book, but also, more generally, by bioethics as such, is incorrect and makes of a complex and essentially indeterminate tissue of problems an almost formal discipline. Some of those reasons are made clear in the metaethical part of the present paper. Nevertheless, the most immediate

response to any criticism of strong moral theories is the following: if these principles were not constantly present in our minds, we would not know how to distinguish right from wrong, and this would make possible any kind of abuse. Bioethical principles, one might add, protect us from doctor Mengele and from the Tuskegee syphilis study.

The simple answer to this remark is: no, bioethical principles do not protect us from abuses neither in the Nazi death camps nor in poor districts. It is a notorious fact that Prussia did have, from the very beginning of the twentieth century, an impressive regulation on medical research founded on the principle of the autonomy of patients (Vollmann and Winau 1996). The Anglo-American world, on the other hand, had a long tradition of medical ethics that should have made the Tuskegee affair impossible (Thomas Percival's *Medical Ethics* from 1794 is one of its earliest examples). Principles were not enough because they do not grasp any salient feature of moral decision-making; they do not take into account (by definition) who makes the decision, in what context, and who should be accountable for its consequences. This is why before even thinking about the concrete content of future decisions we have to think about the institutional surrounding that will give them a sustainable setting.

The complex moral decisions concerning the biomedical sphere, either in research or in clinic, have to be made by multidisciplinary committees, members of which are ready to make the necessary effort to understand the particularities of each case. The discussion between those members is enriched by their individual expertise and from their epistemological proficiency in understanding their own role in this decision-making process. These two factors, as well as the necessary background of a healthy democratic society with a reasonable level of well-being and equality, are sufficient to assure the functioning of ethics committees and review boards. Thus, no bioethical theory that would frame this structure is needed. Moreover, if such a theory existed and had a binding value, decisions made by committees might be less relevant.

One might remark that the proposed background requirement is too vague and too difficult to manage to be presented as an ingredient of biomedical ethics. Yet if this fragile equilibrium between a healthy (metaphorically) democratic society and its medicine is not understood, this medicine will always be prone to abuses. When we talk about medical ethics, the accent should be made not on individually graspable principles in a perfectionist perspective, but on the society of which medicine is a constitutive part and on how a State is able to assure, via detailed legislation, its good functioning by education, by the transparency of its structures and by sufficient funding. It is only in this kind of framework that ethics committees have a *raison d'être* and may hope to prevent the dark history of medical abuse, both in research and in clinic, from repeating itself.

This is all theory. How do ethics committees work in practice? What if their practice shows that bioethics and moral principles are the necessary normative tools to make the right decisions? Observations and studies that I was able to make during the last two years within research ethics committees in France,

Germany and the UK make it obvious that this is not the case. Indeed, the arguments used by the members of those committees were always grounded in the particularities of the analysed case; they insisted on the design of the study, its relevance from the point of view of current medical knowledge, legal aspects (who can and who cannot take part in the study) and the quality of the information. When the problem posed by the study required engaging other, more general categories, they were not formulated in terms of conformity to general ethical standards but rather as a question: ‘What kind of practice do we, as an ethics committee, want to encourage?’ The institutional aspect seemed crucial in the way that the members of those committees see their work.

Usually¹, less than a dozen of new protocols are presented at every meeting of a committee; every protocol is given to two different members who read it integrally, others have only access to a short version. Protocols are then presented by relevant experts, who first describe the study and then, if applicable, express their worries concerning the proposed study. In France, worries are discussed with other members, and either resolved by the discussion or transmitted to investigators; in the UK, a representative of every investigator is invited to the meeting and questions can directly be asked in her presence. In both cases, if the decision is favourable, the investigator has to send a new version of the protocol that includes required or suggested amendments. If, after a discussion, members disagree about the outcome of the decision, they vote. In case of rejection of the protocol, other procedures are followed.

This quick presentation of practices shows that the decision is preceded by a throughout scrutiny of the protocol by two people with different backgrounds, and then discussed with even more people who might disagree on fundamental moral issues. What is valuable and efficient here is not a set of their moral convictions, but the capacity to understand complicated protocols, their scientific, psychological and social implications and to discuss those implications. Here, members of committees draw on their professional experience (scientific or social), on the capacity to understand and discuss arguments coming from different background, which constitutes the essence of this kind of committees, and (e.g. in France) on basic legal training received at the beginning of their involvement. The expertise of the committee as a whole is based on an encounter of different particular specialities, and not on a learned ‘bioethical knowledge’.

One of the studies I conducted included an analysis of several dozen notices of rejection of research protocols submitted to French Research Ethics Committees (*Comités de protection des personnes*) in the period from November 2010 to October 2013. I have studied documents concerning refusal of 61 new studies, 24 substantial amendments and three simple amendments, and observed that the words ‘ethics’ and ‘moral’ (in expressions like ‘moral reason’ or ‘unethical’) were used only six times. All these uses were, as a more detailed analysis shows,² only short slogans subsequently developed in detailed argumentation about why

¹ This applies to committees in France and in the UK.

² For more details, cf. Zielinska (2015).

a study cannot be accepted. These specified reasons conformed perfectly with either the Declaration of Helsinki or the local legislation (unjustified placebo use, poor design of the trial, unfavourable benefit-risk balance) and quoted neither moral principles nor theories that would justify the decisions.

An interesting example from the point of view of the use of principles comes from a committee which refused a new protocol testing a new drug on healthy volunteers. The argumentation of this refusal seems to blatantly contest a well-accepted moral principle of patient's autonomy.³ The study was proposed by a private pharmaceutical company, included a placebo, and aimed at evaluating the safety of a new drug in healthy males. The information given to the patients was clear: they would be given a product over a few weeks, they would be paid several thousand euros [sic!] for their participation in the trial, and the risk of death with this product is estimated at 1 per cent. The committee justified their refusal by noting that the potential benefits are 'massively inferior to the risks'. But at the same time, the patients' information was complete and the subjects of the study were not vulnerable in any classical sense. In consequence, one may think that the situation they were in was one of perfect autonomy; they thus could have decided for themselves whether they wanted to take part in the study. And yet, the committee went against the purported principle and, from the context, it seems that this decision was correct. That means that not only bioethical principles are not necessary to guide those decisions, but also to go against principles recognised by standard American bioethics, for example, can lead to a much better decision than when the principle is applied.

If Not Bioethics, Then What?

The fact that bioethics presents itself as an applied discipline has already been carefully criticised, and a more critical interpretation of its specifics and methods, deeply imbedded in the cultural and historical context of its origins, has been postulated (Baker 2002). Is it then sufficient to maintain a critical perspective if we understand bioethics with its principles and its contradictions as 'inherently controversial', and to keep in mind that 'teaching the view that there are settled truths that should be accepted by students could be seen as an illicit boundary crossing and therefore an abuse of professorial authority in the liberal arts classroom'? (McCullough 2002, 399). This is probably a good starting point, but even here, two concerns remain valid: (1) In what sense does this collection of controversial stances still constitute a discipline? (i.e. bioethics); (2) Is it helpful to think of these controversies as solvable in advance (not by the teacher, but by the students) and as constituting a field of investigation in its own right?

Baker and McCullough show a justified defiance towards the conception of philosophical ethics that would be applied to medical practice, as suggested by

³ Autonomy is the first of the four principles advanced by Beauchamp and Childress (2001).

the notion of ‘applied ethics’. They also suggest that moral philosophy is more often used as a starting point for discussions about necessary modifications in existing practices or legislations when they need theoretical resources to convince other parties. This is also the use, they continue, that bioethics has of philosophy: it ‘involve[s] the appropriation of philosophical concepts or theory fragments to create new ethical paradigms that justify moral norms that conflict with conventionally accepted moral concepts and norms’ (Baker and McCullough 2007, 6). Thus it would be rather useless to remark that the creators of the Belmont Report in 1978 (Tom Beauchamp, James Childress, Albert Jonsen, Karen Lebacqz, Robert Levine, Stephen Toulmin, and LeRoy Walters, among others) used the notion of autonomy imperfectly; it was not Kantian in a scholarly satisfying way, but it remained a relevant appropriation of it in the field they applied it to (this is not the only example given in this very interesting paper).

If this idea is true, philosophical ideas are an ornament to the decision-making processes, and to the writing of legislations and regulations. Philosophical arguments are instruments in the discussions—they may change the minds of proponents or of the general audience, but as far as public debate is concerned, they are never self-standing; they are tools to promote certain positions. It is crucial to understand this feature also to avoid being a victim of an argument from authority. Quite trivially, one should never accept an idea only because a philosopher stated it.

This is not to say that philosophers have no substantial contribution to make to the field of general moral education of medical practitioners. Indeed, the fact that members of ethics committees, who are already mature in virtue of their professional background and years of practice, do not seem to need a specific education in ethics does not mean that no education is to be given to students. What is needed here is a thorough reflexion on the methodology of discussion, argumentation, truth and validity, justification and acceptability of arguments. These features compose an epistemology of discourse (of moral discourse, in our case), and should form, along with an education in metaethics⁴ and history of medical ethics, a basis of moral education for medical practitioners. These disciplines provide tools enabling to consciously and responsibly prepare for future decision-making, to understand language and methods of ethics and avoid the blind application of purported ethical rules.

The fact that professionals other than physicians are to contribute to the teaching of biomedical ethics has been acknowledged a few decades ago and does not seem to be controversial. Ernlé Young (1977) insists on the necessity of formal rationality and meta-ethics in the curriculum, while admitting that the competence of the medically trained teachers is insufficient, given the limited amount of time they have (125–126). This knowledge must be transmitted along

⁴ By metaethics, I mean a study of meaning of moral terms and of ontology of the referents of those terms. Typical metaethical questions would be: ‘Does “good” mean “pleasant”?’ or ‘Does an evaluative proposition describe something real or nothing at all?’

the knowledge of facts, awareness of the diversity of fundamental human values, and of the diversity of obligations, both towards society and the patient. What would then be the aim of this kind of education is the 'questioning of long held assumptions and convictions' (Young 1977, 130).

The case-based method seems to have gained a consensus among a large part of the medical community. Cases usually come from medical practice, but some authors argue that since medical students are not yet able to grasp the complexity of dilemmas that are usually proposed to them during their pedagogical curriculum, their moral education should rather go through the analysis of the problems they could actually encounter in their own lives as medical students. This should help them to go beyond abstract moral theory and be able to perform 'an analysis of the powerful social forces that shape the behaviour and guide the ethical development of medical students, for better and worse' (Christakis and Feudtner 1993, 251). Christakis and Feudtner suggest that while engaging in unethical behaviour, students know that they are doing something wrong, but do it nevertheless: 'It is not clear that learning about ethical principles or legal standards, an objective of many existing ethics curricula, will alter this phenomenon' (1993, 251). An enlargement of the scope of ethics to social issues that give rise to individual moral problems, a 'macroethics', has also been advocated, along with the necessity to engage into the educational process a range of experts coming from different disciplines to show its necessary complexity (Fox, Arnold, and Brody 1995, 766).

In 1994, two authors argued that moral education in medicine should be guided by a 'hidden curriculum' rather than by a formal education (Hafferty and Franks 1994, 861). They distinguished between 'a pedagogical approach that highlights ethical principles as residing squarely within the physician's professional *identity*' and 'a view of ethics that frames ethical principles as tools to be employed in the course of clinical work' (Hafferty and Franks 1994, 862), which is dependent on circumstance and where the principles can be discarded if necessary. Given this distinction, the authors insisted on the necessity of identity-formation, rather than a possible instrumentalisation of principles as tools.

These proposals seem to offer a plausible and sufficient project of medical ethics education for students of medicine-related disciplines. Now, I shall present a meta-ethical and historical case against moral principles in general that will go beyond questions of applied ethics. The refusal of principles is neither a new nor a rebellious proposal in moral philosophy. Its roots are to be found in Aristotle's contextual query for the 'golden mean', but it has to be understood against the backdrop of more contemporary debates. It shows not only that one can think of a strong position in ethics that goes without moral principles, but it also gives a number of indications about how such a position can provide a space for discussions and for expertise, on a case-by-case basis.

Do We Need Moral Principles?—A Metaethical Perspective

Moral emotivism of the 1930s and 1940s in British and American philosophy—which argued that our moral judgements do not aim at describing the world or saying something true, but only express our emotions about what we perceive—was quite often understood as a strong form of moral scepticism. Among many reactions to emotivism, one of the most popular positions was called ‘moral prescriptivism’, and it was mostly defended by Richard M. Hare. Prescriptivism is interesting since it acknowledged the impossibility of attaining any realist or universalist consensus about what is right, yet it insisted that even if this is impossible, it remains important to keep in mind the idea of moral principles, imperfect as they are. Hare (1952) thinks that principles (moral principles included) are essential to understand any knowledge: ‘Without principles, most kinds of teaching are impossible, for what is taught is in most cases a principle’. If they were not there, ‘every generation would have to start from scratch and teach itself’ (61), and even then it would need to pass through principles, because to proceed case by case would be utterly time-consuming. A person would ‘spend his whole time deciding matters like whether to step off with the right or the left foot, and would never reach what we should call the more important decisions’, if the principles were not there.

Not only was the position advanced by Hare influential in the 1950s, but he also seems to have set the agenda for how a moral theory should look—independently of various meta-ethical stances taken by moral philosophers, with the result providing a set of principles. This idea was naturally challenged by a number of moral philosophers, first from the area of virtue ethics (Anscombe 1958), and then by moral particularism—the idea that moral decisions are only made in particular cases and do not involve a foregoing calculus on abstract moral principles.⁵ In meta-ethics, the question of whether we need some general principles in ethics and whether they have any chance to be true remains open, since the positions that assume the necessity of principles, like Kantianism or consequentialism, are still very lively.⁶ Yet in applied ethics, or more generally in the practical sphere, a shared conviction that right actions need to be guided either by principles or at least by a coherent moral theory remains unchallenged, even among recent writers (Garrard and Wilkinson 2003). This is very peculiar; the field that needs the best possible tools, i.e. applied ethics, often uses only caricatures of these tools.

The position *de facto* defended in this paper is moral particularism (or neointuitionism), one of the major strands of contemporary metaethics. In biomedical context, it does not propose a new applicable theory, but rather invites to take the circumstances seriously. According to particularism, ‘the possibility of moral thought and judgment does not depend on the provision of a suitable supply of moral principles’. This definition is accompanied and made

⁵ Cf. McDowell (1981), Dancy (2004).

⁶ For a straightforward criticism of particularism, cf. McKeever and Ridge (2006).

possible by the idea of holism concerning reasons: 'a feature that is a reason in one case may be no reason at all, or an opposite reason, in another' (Dancy 2004, 73). In other words, the only way to know what to do in a given situation is to evaluate the details of this particular situation. These details are only relevant and meaningful in the context in which they appear. This is probably not an entirely reassuring conception of morality; some would prefer to obtain a number of univocal moral rules that we would be able to apply in problematic situations. Yet this search for reassurance should be resisted. Moral principles are not only false when they claim, as most of them do, to apply universally to all possible cases. They are also not particularly relevant: our crucial moral decisions are probably not made in virtue of application of moral universals. And if, on the contrary, they are made by simple application of general rules, they are probably going to miss some important features of the evaluated situation.

There might still be some reasons to do or not to do something that would look like principles, such as: 'one should not provoke useless suffering to the innocent'. Yet from the fact that one is able to formulate phrases of this kind does not follow either that we have understood what they imply by learning principles, or that when we abstain from certain actions we do it by recalling these reasons and by founding the legitimacy of our decisions on them. The decision-making must be understood as including all available and relevant features of the situation. '[T]he question whether reasons are atomistic or holistic is a very basic question about the nature of rationality' (Dancy 2004, 77), adds Jonathan Dancy, the most prominent representative of moral particularism. This statement shows how far this position is from the atomistic conception of reasoning promoted by principlism: moral judgements or decisions are part of our ordinary cognitive activities; they have to take into account the complexity of contexts and are intimately linked with all other decisions and judgements.

Conclusion

In what precedes, I tried to show how, in the concrete context of research ethics committees, bioethics as a normative discipline is not only unessential but it also should better be avoided while analysing concrete protocols. Then, I gave an alternative account of teaching medical ethics that do not insist on rules ready to use. Finally, it gave a few hints concerning metaethical presuppositions of principled ethics and proposed an alternative theoretical position that is coherent with the presented reflexions on teaching. Indeed, this paper refuses the idea that professional ethics does not need to have strong metaethical basis as long as it works in practice: on the contrary, formal and theoretical requirements should be the same independently of the kind of application one has in mind.

In a recent book, Nathan Emmerich insists on the role of acculturation, reflexion and metacognition in moral decision-making in the biomedical context.

It is clear that all these features are essential, yet the question is the following: do they enrich the conception that we have of ethics (while ethics remains, fundamentally, a set of principles), or is ethics as a set of principles an artificial construction that emerges, for various historical reasons, from our social and cultural context? Emmerich (2013) claims that the metacognitive capacities develop in the process of ‘mutual co-construction’ of medical capacities, where the medicine is and should be seen as an ‘ethical enterprise’ (13). This idea must be taken seriously on the normative level. If medicine-related moral education is essentially holistic—i.e. it shows how to take into account all the relevant challenges of each case (social, psychological, legal and moral)—then learning through principles can impede its progression and should be definitely abandoned.

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References

- Anscombe, G. E. M. 1958. “Modern Moral Philosophy.” *Philosophy* 33 (124): 1–19. doi:10.1076/jmep.27.4.447.8606.
- Baker, Robert. 2002. “Bioethics and History.” *The Journal of Medicine and Philosophy* 27 (4): 447–474. doi:10.1076/jmep.27.4.447.8606.
- Baker, Robert, and Laurence McCullough. 2007. “Medical Ethics’ Appropriation of Moral Philosophy: The Case of the Sympathetic and the Unsympathetic Physician.” *Kennedy Institute of Ethics Journal* 17 (1): 3–22. doi:10.1353/ken.2007.0000.
- Beauchamp, Tom L., and James F. Childress. 2001. *Principles of Biomedical Ethics*. New York: Oxford University Press.
- Christakis, Dimitri A., and Chris Feudtner. 1993. “Ethics in a Short White Coat: The Ethical Dilemmas That Medical Students Confront.” *Academic Medicine* 68 (4): 249–54. doi:10.1097/00001888-199304000-00003.
- Dancy, Jonathan. 2004. *Ethics without Principles*. Oxford: Oxford University Press.
- Emmerich, Nathan. 2013. *Medical Ethics Education: An Interdisciplinary and Social Theoretical Perspective*. SpringerBriefs in Ethics. London: Springer.

- Fox, E., R. M. Arnold, and B. Brody. 1995. "Medical Ethics Education: Past, Present, and Future." *Academic Medicine* 70 (9): 761–769. doi:[10.1097/00001888-199509000-00011](https://doi.org/10.1097/00001888-199509000-00011).
- Garrard, Eve, and Stephen Wilkinson. 2003. "Does Bioethics Need Moral Theory?" In *Scratching the Surface of Bioethics*, edited by Matti Häyry and Tuija Takala, 35–45. Amsterdam: Rodopi.
- Hafferty, Frederic W., and Ronald Franks. 1994. "The Hidden Curriculum, Ethics Teaching, and the Structure of Medical Education." *Academic Medicine* 69 (11): 861–871. doi:[10.1097/00001888-199411000-00001](https://doi.org/10.1097/00001888-199411000-00001).
- Hare, Richard M. 1952. *The Language of Morals*, 14. Oxford: Clarendon Press.
- McCullough, Laurence B. 2002. "Philosophical Challenges in Teaching Bioethics: The Importance of Professional Medical Ethics and Its History for Bioethics." *The Journal of Medicine and Philosophy* 27 (4): 395–402. doi:[10.1076/jmep.27.4.395.8610](https://doi.org/10.1076/jmep.27.4.395.8610).
- McDowell, John. 1981. "Non-Cognitivism and Rule-Following." In *Wittgenstein: To Follow a Rule*, edited by Steven H. Holtzman and Christopher M. Leich, 141–162. London: Routledge.
- McKeever, Sean D., and Michael Ridge. 2006. *Principled Ethics: Generalism as a Regulative Ideal*. Oxford: Oxford University Press.
- Vollmann, Jochen, and Rolf Winau. 1996. "The Prussian Regulation of 1900: Early Ethical Standards for Human Experimentation in Germany." *IRB: Ethics & Human Research* 18 (4): 9–11. doi:[10.2307/3564006](https://doi.org/10.2307/3564006).
- Young, Ernlé W. D. 1977. "An Approach to the Teaching of Biomedical Ethics." *The Monist* 60 (1): 121–135.
- Zielinska, Anna C. 2015. "Is Bioethics Really Necessary? Expertise within Research Review Boards without Ethical Theory." *submitted to Journal of Medicine and Philosophy*.