

WHO SHOULD WEIGH ETHICAL ISSUES IN MEDICINE?

Abstract. *The article tackles the common opinion that medical experts are the most qualified to resolve ethical questions that arise in medical practice. After analyzing three alternative answers to the question about the membership structure of ethical advisory boards (physicians, interdisciplinary, ethicists), the article builds an argument against exclusively medical boards and argues for the inclusion of moral philosophers, basing the proposition on an assumption of high value of personal autonomy and on a distinction between health and good.*

Keywords: *ethical advisory boards, experts, health, good, personal autonomy*

Introduction

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It is quite common to assume that physicians are the key experts on ethical questions that concern medical practices. After all they have had the privilege to deal with situations that require tough decisions on a daily basis for centuries. Throughout this time the medical profession acquired experiences and produced moral reflections that on the one hand are integrated into the daily practices of physicians, and on the other, constitute the ethical capital of principles, provisos, arguments and solutions to dilemmas and difficult cases. This capital can offer tools for a critical ethical assessment of these practices. Physicians are the first known professional group in the history of the West to impose on themselves an ethical code that survived for centuries and is, in a modernized version, still considered as offering the basic moral orientation for medical practitioners. In many countries the basic tenets of the so-called Hippocratic Oath are repeated by young medical graduates as an oath that they solemnly take before they begin to practice their profession. In the age of a ubiquitous proliferation of ethical codes and codes of conduct for various professions, when it is more and more a matter of prestige to be a member of a profession that has one, many see the medical profession as a groundbreaking role-model. And this is just one more reason to consider the medical profession as one of the most prestigious and praised.

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For many it is so uncontroversial and natural to maintain that physicians are by far in the best position to give advice or have the last word in cases of moral controversies in the medical domain that any plausible alternative that would challenge this assumption is hard to find. Who else could do it, if not they? Who would be a better candidate to weigh the usually quite complex set of possibilities, risks and outcomes of a proposed treatment or therapy and compare it with alternatives? A possible argument in support of this widely shared intuition about the preeminence of physicians in moral matters regarding their work, in fact one of the most favorable ones, begins by claiming that consequences in ethics matter and continues by saying that only expert physicians can assess and evaluate the probabilities of various outcomes that could be the consequence of a set of possible therapeutic interventions. If someone is to decide what to do in medical situations, that person should have medical knowledge and experience. It is impossible to assess the moral aspects of a specific medical situation without the knowledge to assess the health risks involved for the patient. In order to do that, it is necessary to have an in depth and accurate knowledge of what is happening with the patient from a strictly medical point of view. This ability of physicians seems to suffice for their designation as the only adequate group of persons to hold this role.

But are we truly certain that this is the right way to solve this problem? If we assume that physicians (or more generally, medically trained individuals) are the only competent persons to deliberate on the ethical dilemmas in the field of medicine, are we not merging two distinct values, health and good, which although very close to one another, should nonetheless be kept separate? Undisputedly, physicians are best equipped to detect the deep causes of medical problems that patients voice and propose ways for improvements in the condition of their health. However, it is simply impossible to attest that ethical problems and dilemmas tackle only the maximization and just distribution of health, as the conflation of the values of health and good would suggest. Be the disparity between health and good as minimal as possible, it nevertheless suffices to undermine the exclusivity of medical competence to deal with ethical matters in bio-medicine.

The article tackles the widespread opinion that medical experts are the most qualified to resolve ethical questions arising in medical practice. After proposing and analyzing three alternative answers to the question about the membership structure of advisory ethical boards (physicians, interdisciplinary, ethicists), the article builds an argument against exclusively medical boards and argues for an inclusion of moral philosophers, basing the proposition on an assumption of the high value of personal autonomy and on a distinction between health and good.

Three basic positions

Here, another aspect has to be considered. It is not just the ethical competence of a person or a collective body, which is to make ethically difficult decisions, but also the type and scope of the appropriate ethical judgments that needs addressing. In fact, both aspects should be considered together. Relevant ethical problems that need to be addressed in the field of medicine are quite varied and often require multi-level ethical considerations. They range from decisions on ethically appropriate procedures in clinical practice to questions on how to reach ethical decisions, on statistical or future persons and health policies, or on the provisions of laws that should be enacted to preserve public health.¹ Shifting from cases involving a single patient to decisions about priorities in public health policies or to laws that regulate medical activities changes the framework of relevant moral circumstances. Consequently the solutions to the “same” problems also change. It is not morally inconsistent to propose one decision-making process for individual cases and another one for addressing the same problem on the level of a law (Beauchamp and Childress, 2001: 9).

It is obvious that reasons for conferring on physicians the leading role for making ethical decisions in the medical and general health area are of various strengths when it comes to different levels and kinds of problems. The prominence of medical expertise tends to fade as we focus on larger numbers of people who are subjected to laws and policies. Although decisions taken at the level of policies that affect societies at large are just as ethically relevant, they are such in a different regard. And there is a range of non-medical knowledge that is crucial if we want to get them right. Ethical deliberations on this level must account for “problems in feasibility, cultural

¹ *The institutional counterpart of these two different basic functions of ethical collective bodies is often marked by different denominations: “(clinical) committee” (weighing individual cases by already set deontological standards) vs. “ethics (advisory) board” (publicly weighing ethical standards on national and supranational level). Although the mentioned functional distinction is well established, the actual denomination of different collective bodies may vary from country to country. Ten Have exemplifies the different tasks and mandates of the two types of collective bodies, explaining the concurrent claims that Slovenia and France have expressed. Namely, both claim to have established the first national ethics committee, although the Slovenian was brought into life in 1965 while the French was not established until 1983. Yet, the goal of the French was to develop guidelines and legislation, while the goal of the Slovenian was merely to ethically review research protocols using pre-set standards (Ten Have et al., 2011: 383–384). In fact Slovenia, arguably, still does not have a bioethical advisory board by the standards of the UN Declaration. There is evidence that this kind of absence is part of a larger regional pattern. There are reports of similar deficiencies in Croatia (Borovečki et al., 2005) and Serbia (Raki and Bojani, 2011). Conducting a European inquiry on the functioning of national Ethics Advisory Boards, Mali et al. sent questionnaire to all of them, and “With one exception, no EAB from the new EU member states responded, which corroborates findings of earlier empirical studies [1, 28] that EAB in these countries are for various reasons less prepared to communicate with the outside world.” (Mali et al., 2012: 176)*

pluralism, political procedures” (Beauchamp and Childress, 2001: 9). It is evident that if we accept the suggested reasoning for the ethical preeminence of physicians, we have good reasons to affirm that specific expertise is needed to properly assess problems that imply the (inter)activity of large parts of society. And such expertise resides mostly in the domain of humanistic and social sciences.

In fact, in the growing corpus of literature dealing with moral justifications and the establishment of the proper role for ethical committees and counseling bodies in society,² the range of proposed answers about who should have an active role in giving directions and tackling open moral questions in medicine can be summed up in three basic positions:

1) The first one, as discussed above, states, that medical ethics is something to be established *intra medicos*. The Hippocratic tradition in this sense is a tradition of moral autonomy of the physician’s profession that takes moral lessons from no one else.

2) The second position acknowledges the importance of specific medical competences possessed by physicians in the process of addressing ethical challenges but highlights the complexity of relevant aspects in more abstract ethical decision making. Accordingly, it states that bioethical problems are interdisciplinary and involve, beside medics many other professions: humanistic, natural and social scientists, economists, theologians, psychologists and even laymen, who can provide the necessary knowledge given the specificities of the case under scrutiny. This position offers especially strong arguments about decisions pertaining to the realm of bioethics, which are taken by boards that give advice on health policies.

3) The third position claims that bioethics is just one of the many practical ethics or applied ethics that have evolved around a particular area of

² *In the mare magnum of bioethics and public ethics inquiries, the question of the membership structure of ethics advisory boards established itself as a recognizable special challenge that is addressed by many articles and book chapters. In a way the question was debated since the birth of modern bioethics in the seventies (ex. g. Singer, 1972), and since then its significance did not stop to grow. The approval of the Declaration on Bioethics in the UN (Universal Declaration on Bioethics and Human Rights, 2005) additionally boosted the public debate. Some approaches to the question are more philosophical in intent and are focused mainly on, broadly speaking, the relation between science and ethics (e. g. McCormick, 1983; Moreno, 1991; Singer, 1972; Benmakhlof, 2013; Resnik, 1998; Reichlin, 1994; Benmakhlof, 2012; Coehn, 1994; Kopelman, 1998; 2006). More recent contributions tend to include legal, sociological and political aspects in their argumentation. After the approval of the Declaration, more and more attention was devoted to the relation and accordance of the adopted bioethical standards and the concept of human rights (e. g. Ten Have et al., 2011; Evans, 2006; Engelhardt, 2011; Faunce, 2005; Hottos, 2012). The recent production is also typically characterized by the adoption of multiculturalism and legitimate moral pluralism as features of the relevant socio-cultural context. This point of research is at the crossroad with a more sociological approach (e. g. Mali et al., 2012). Some contributions are more modest in their scope: they just want e. g. to assess the bioethics structures of a specific country on the background of the standards set by the UN (e. g. Raki and Bojani, 2011; Borovečki et al., 2005).*

human activity with the purpose to deal with specific moral problems arising from a specific activity. Given that at the roots of any bioethical investigation there is an ethical approach, and since ethics is part of philosophy, philosophical competences are crucial.

One can see (3) as progression of (2): it accepts the argumentation of (2) and offers an ulterior distinction of non-medical expertise that should be used in the workings of ethical advisory boards and ethical committees. It states that all expert knowledge is not of equal importance and that different contributions of different kinds of knowledge are not just a result of different circumstances involved in specific cases. The role and contributions of specific experts can fluctuate depending on the matters discussed, however, there is one type of knowledge that is always needed in equal measure, independent of the level at which the decision is to be taken, or other particularities of the problem, and that is ethical knowledge. Its foundational role for the existence of bioethics is further recognized as so preeminently important that it openly challenges the until recently almost undisputed long-running and venerable assumption of the centrality of the medical knowledge. In this sense (3) is the alternative to (1).

To summarize, there are three possible answers to the question about expert knowledge that is at the base of bioethics: (1) bioethics as essentially based on medical knowledge and expertise, (2) bioethics as based on many kinds of (more or less) equally important types of knowledge (bioethics as interdisciplinary knowledge), (3) bioethics as an integral part of ethics and philosophy.³ Naturally, these analytic distinctions are not always evident; many intermediate positions are possible between these three clear-cut ones. It is also questionable if the irreducible positions are really three. An argument, as suggested above, could be construed for only two. It is possible to see (1) and (3) as the basic positions, and (2) as the outcome of the “softening” of the two basic positions, i. e. as a product of a symmetrical “tactical” step back of (1) and (3) from their respective maximalist ambition to represent the leading bioethical knowledge to embrace the interdisciplinary thesis to make allies.

Seen from this angle it is clear that the second position is a mediation between the two antagonistic views, offering the only in-between meeting point, allowing for an unbiased solution. The egalitarianism of competences promoted by (2) implies that (1) and (3) recognize to each other

³ Two examples of (3): “Bioethics, rather than being a multidisciplinary mode of inquiry, is in fact a branch of applied ethics which is characteristically informed by multidisciplinary expertise and findings. As Ronald Green puts it: ‘While ethics and moral philosophy may represent sometimes a relatively small part of the actual work of bioethics, they form in a sense the confluence to which all the larger and smaller tributaries lead, and, more than any other single approach, the methods of ethics and philosophy remain indispensable to this domain of inquiry.’” (Harris, 2001: 4)

equal status, therefore accepting the inclusion of a number of other expert competences.

However, (2) is much more a politically correct stance than an ethically sound one. It can be a suitable and a viable solution to establish the member-structures of boards and committees, but it is inadequate in explanatory terms and does not give justice to the peculiarities of claims (1) and (3). The proposed equalization of their contributions leaves unanswered what precisely is equalized if the multi-faced analysis implicit in the interdisciplinary position is accepted.

It appears evident that, even if they could be considered equal, the contributions of medicine and moral philosophy in solving ethical problems concerning medical activities are quite different in kind. While the biomedical expertise provides the relevant findings to determine the actual medical status and, based on that, predicts the medical consequences if this or that treatment is (not) applied, it is not entirely clear what could in such cases be the specific contribution of moral philosophy.

Some might claim that there is no such thing as ethical expertise, since ethics does not have a specific realm like sciences (cf. Moreno, 1991). Accepting this argument opens the way to minimize or banish moral philosophers from collective bodies of experts deciding on bioethical matters. It tends to minimize the contribution of moral philosophy in the process of making moral medical and health-care decisions. Of course, it is a zero sum game between positions (1) and (3): diminishing the role of ethical expertise amounts to the reinforcement of the preeminence of bio-medical knowledge. Undoubtedly, biomedical experts can provide pertinent insights to be considered in deliberations of the moral aspects of healthcare provider activities, the latter also being predominantly biomedical professionals. Other experts would therefore be relegated to the margins.⁴

However, this is the outcome only if the question is perceived strictly as a power-relation question, renouncing any justification for the inclusion (or exclusion) of different kinds of expertise among the members of the ethics advisory boards. But such a renunciation is untenable from the point of view of public reason and public deliberation (cf. Gutman and Thompson, 1997; Mali et al., 2012). The contrary holds: we should strive to find an answer to the question of public interest that will be backed by the informed consent of a large section of the population, hopefully everyone. What follows is an attempt to present the arguments for moral philosophy to have a constitutive role in bioethics committees and advisory boards.

⁴ *The intuitive attractiveness of (1) is bound to be tempered when confronted with its generalization. Exactly the same reasons that support physicians in the role of privileged sectorial ethicists, give support also to economist or even businessmen in the role of key experts in matters of business ethics, bakers in bakers' ethics etc.*

Some remarks on science and ethics

To begin with, we can acknowledge that critics of moral philosophy are right when they say that ethics radically differs from science, as does, to a certain point, ethical knowledge from scientific knowledge. This is not due to the lack of a specific ethical realm of investigation, but due to the specificities of this realm. The realm of ethical inquiry includes all human acts (personal, collective, institutional), which are then analyzed in relation to (existing or proposed) moral norms and principles. The irreducible parts of moral discourse are moral evaluation, moral prescription and moral justification. None of these elements is constitutive in a scientific discourse. The evaluations made in science are not moral, its prescriptions and justifications are strictly cognitive. The different purposes of sciences and moral philosophy were outlined already by Aristotle: science explains what there is, giving descriptive accounts of (specific segments of) reality, while ethics gives answers to the question of what is the right thing to do and explains the reasons for having chosen one option and not the others. Ethical reasoning of this kind is in fact an injunction to align one's behavior with the proposed ethical norm. In short, ethics is not so much about explaining why somebody sometimes acts in a certain way nor why somebody acted so in the past, nor about predicting when he will do it in the future, but about how any one person should act and why they should act precisely in that way.

Moral evaluations, prescriptions and justifications form not only the backbone of moral arguments but can be characterized as irreducible. All attempts to show the Entity, the category of Being or Fact from which the moral categories supposedly originated that have been proposed until now, have failed to gain general support. Therefore, these answers remain controversial and are not exempt from the fierce opposition and noncompliance of many. Therefore, if moral values, norms, duties and prescriptions cannot be adequately thought of as rooted in facts or categories of Being, moral investigation cannot be adequately thought of as rooted in a scientific or metaphysical discourse as both are descriptive and typically form sentences containing the words "is" or "is not". Practical ethics, on the other hand, typically deals with sentences marked by the use of the words "should" or "ought", which are virtually absent in descriptions (be it as analytical as it can be).

But the acceptance of the anti-foundationalist assumption just illustrated does not produce any kind of solution to open moral problems. On the contrary, its acceptance presents a shift and changes the domain of meaningful moral argumentation. While it is true that the recognition of cultural and moral pluralism does not depend on the anti-foundationalist assumption, anti-foundationalism certainly reinforces the idea that there is a plurality of

plausible moral theories, which all have serious difficulties to provide satisfactory answers to a variety of objections with which they are targeted, they also have difficulties with convincing other participants in the debate that the discussed theory is the best moral theory available. In this sense, the assumption supports the necessity for a discussion between the representatives of various moral traditions and proponents of specific moral arguments, with the aim of reaching an agreement, with which more or less all in a morally and culturally pluralistic society can live with. The process of consensus-building, including debates, confrontations and drafting of regulatory documents is an integral part in gaining the needed level of social cohesion in pluralistic societies, in which any fundament of morals outside of moral reasoning itself is proven to yield unsatisfactory results.

Some remarks on medicine

To summarize: the scientific discourse is in its kind different from the ethical one and following the Humean argument of “the naturalistic fallacy” the inference from scientific assertions to ethical ones is invalid. This, however, implies important and irremovable restrictions regarding the scope of applying biomedical knowledge at the ethical level. The biological discourse cannot yield a valid justification of a specific ethics, and neither, I argue, can medicine.

In the relation between biology and medicine one point should be made clear. It would be an oversimplification to include the medical discourse straight into the family of natural sciences. In fact, the activity of a physician is, strictly speaking, scientific only as long as he investigates the nature of the patient’s sickness and ends up with a correct diagnosis for their illness. However, when he proposes a therapy aiming to restore health or to maximize it, the physician is no longer studying the physiology of a particular human being. Rather, he proposes a kind of intervention into a detected state of health, aiming to change it for the better or stop its deterioration. This feature puts medicine into a position closer to a technical profession: medicine is not so much a collection of scientific knowledge about one’s nature, but more of an art about how to maximize one’s health, using the knowledge provided by natural sciences regarding man’s nature. An accurate diagnosis is a precondition for any therapeutic success, but is as such void without an effective therapy that tops it. The therapeutic activity is crucial in defining medicine. Since the goal of medicine is not just to research the health status of patients, but to restore, improve or maintain it – in short to intervene into it – medicine cannot be reduced to a descriptive scientific discourse, but is in its own way prescriptive: a treatment is suggested to the patient and, if accepted, “prescribed” to him.

This prescriptive or therapeutic side constitutes the difference between biology and medicine, and places medicine in the proximity of moral philosophy. Both, medicine and practical ethics want to change the “natural” course of things, intervene in it for the better of the person involved. The main difference between them is in the ultimate goals they pursue: health and good. It might be that these two goals are seen very close to each other, so close that their differences can be overlooked. Health is a quite peculiar quality. To a vast majority of people it is very valuable, many would not hesitate to declare health the most important value in their personal lives, the one for which they are prepared to use a great deal of their resources. This stance can grow even stronger among those who have had the opportunity to see that a sudden drastic deterioration of health is possible. For them caring for their health may slip from valuing life quality to valuing life itself. In these cases health no longer presents just care for the quality of one’s life but is reconnected to the preservation of life.

Health as a universal value

All of the above seems to qualify health as the supreme universal individual value, around which the largest possible consensus can be build; a consensus that can transcend cultures, civilizations and unite various religious people with agnostics and atheists. This quality of health could be easily pushed even further and be made, intentionally or unintentionally, into a universal human truth, upon which institutions and their activities could be designed.

If we assume that health is universally the supreme individual value, two dividing lines are crossed and this should not go unnoticed. The first is the line between many and all: the universalization of the vast majority of people’s wills and occasions when these wills are expressed totalizes an empirical picture with verifiable exceptions: there are individuals who voluntarily dissent, sometimes drastically. However, the really important, second crossing is enabled by the first one, that is, when the great divide between the descriptive and the normative-prescriptive discourse is crossed. Universal praise of health imposes health as the paramount value also to the minority of those who have made a legitimate and informed decision to subordinate it to other values, sometimes even to the point of seriously jeopardizing their life, or have decided to stop valuing health. Shifting from a generalization based on a vast majority to a universalization that implies the absence of any single exception makes sense only if it is followed by a shift from a descriptive to a normative-prescriptive discourse. This shift has major consequences. The priority of health and preservation of life is no longer something that should be empirically verified, something subject to

changes, but is a universal desideratum or value that needs no verification. Personal health, defined as a state of affairs that is valuable in itself, independently of the opinion formed on that matter by the person in question, in fact imposes obligations on this person and requires action in its support also from other persons who may not see health as the ultimate value. After such a shift the individual person, the previous bearer of rights, acquires duties towards himself.

Medical paternalism

Besides individuals, the imposition of duties to maximize health can also to a certain degree affect the design and purpose of the whole construction of social institutions, especially public health institutions. Injunctions in the name of Health are voiced by a number of representatives of these institutions, from the Minister of Health to our trusted physician. They all take the side of “our best health interests”. After all they are the ones best qualified to present and explain these to us. The ways in which they address us are based on the presumption that health is the good we want and want it most. There is nothing wrong with this position until it is imposed on someone against his or her will. However, this is precisely what can easily happen since the position of physicians in relation to their patients is “naturally” a paternalistic one. If we presume that a physician endeavors to give patients as much health as possible, he becomes comparable to a father who wants for his children what’s best for them. In fact, he also defines what’s good for them and, most importantly, enjoys a position of superiority over the other that enables the imposition of his will. The child and the patient simply lack the knowledge and experience to have a say. Both situations imply a strong cognitive and, as a consequence, power asymmetry.

The relevant difference is that we consider paternalism of parents toward their children as a morally required attitude of a person who wills good towards someone who is not yet fully capable of autonomous decisions; on the contrary, medical paternalism towards a grown up patient is considered an infringement of his or her autonomy and human dignity. While there are divergences about the extent of the moral obligation to respect autonomy, there is nonetheless a wide agreement that such an obligation exists and is strong enough to be included into the legal system.

Conclusion

Assuming that personal autonomy is a strong value (Universal Declaration on Bioethics and Human Rights: Art. 3, 5, 6, 7, 8, 9; Beechum and Childress, 2001: 57-112; Engelhardt, 2011; Andorno, 2009) we can safely

conclude that since medical competence covers only questions regarding health and since health is not always synonymous with the value of good, affirmations about how to attain greater health are not as such moral ones and there is no moral obligation for individuals to follow them. That brings us to a conclusion that a) rules out 1) as an acceptable starting point for a suitable membership structure of ethical advisory bodies, and b) strongly argues for the inclusion of ethicists in ethical advisory bodies of any kind where their expertise should be seen as essential or just useful.

A further extension of the same argument for the inclusion of ethicists in bioethical advisory bodies is possible. If their usefulness is, as has been pointed out, in their guardianship of the moral difference between health and good and of the personal autonomy that can be endangered if these are conflated, one can further argue that they can best perform their job if they represent the range of different ways of moral arguing and defining the good legitimately present in a morally pluralistic society as ours. This line of argumentation opens the way for the inclusion of distinguished members of important cultural and moral communities, present in society, in the work of advisory boards.

BIBLIOGRAPHY

- Andorno, Roberto (2009): Human Dignity and Human Rights as a Common Ground for a Global Bioethics. *Journal for Medicine and Philosophy* 34 (3): 223–240.
- Benmakhlouf, Ali (2013): Une éthique intégrative de la science. In Comité consultatif national d'éthique, *La bioéthique, pour quoi faire?*, 143–146. Paris: Puf, Paris.
- Beauchamp, Tom L. and James F. Childress (2001): *Principles of Biomedical Ethics*. London: Oxford Press.
- Borovečki, Ana; Henk Ten Have and Stjepan Orešković (2005): Ethics And The Structures Of Health Care In The European Countries In Transition: Hospital Ethics Committees In Croatia. *British Medical Journal* 331 (7510): 227–229.
- Brock, Dan W. (1999): Truth or Consequences: The Role Of Philosophers in Policy-Making. In Helga Kuhse and Peter Singer (eds.), *Bioethics. An Anthology*, 587–590. London: Blackwell Publishers.
- Coehn, Daryl (1994): *The Ground of Professional Ethics*. London: Routledge.
- Engelhardt, H. Tristram, Jr. (2011): Confronting Moral Pluralism in Posttraditional Western Societies: Bioethics Critically Reassessed. *Journal for Medicine and Philosophy* 36 (3): 243–260.
- Evans, John H. (2006): Between Technocracy and Democratic Legitimation: A proposed Compromise Position for Common Morality Public Bioethics. *Journal for Medicine and Philosophy* 31 (3): 213–234.
- Fauce, T. A. (2005): Will International Human Right Subsume Medical Ethics? Intersections in the UNESCO Universal Bioethics Declaration. *Journal of Medical Ethics* 31 (3): 173–178.

- Gutman, Amy and Dennis Thompson (1997): Deliberating about Bioethics. *The Hastings Centre Report* 27 (3): 38–41.
- Harris, John (2001): Introduction: The importance of Bioethics. In John Harris (ed.), *Bioethics*, 1–22. London: Oxford University Press.
- Hottois, Gilbert (2012): *Qu'est-ce que la bioéthique?* Paris: Vrin.
- Kopelman, Loretta M. (1998): Bioethics and Humanities: What Makes Us One Field. *Journal of Medicine and Philosophy* 23 (4): 356–368.
- Kopelman, Loretta M. (2006): Bioethics as a Second-Order Discipline: Who Is Not a Bioethicist? *Journal for Medicine and Philosophy* 31 (6): 601–628.
- Kuhnse, Helga and Peter Singer (2001): What is bioethics? A historical introduction. In Helga Kuhnse and Peter Singer (eds.), *A Companion to Bioethics*, 3–11. London: Blackwell Publishers.
- Mali, Franc, Toni Pustovrh, Blanka Groboljšek and Christopher Coenen (2012): National Ethics Advisory Bodies in the Emerging Landscape of Responsible Research and Innovation. *Nanoethics* 6 (3): 167–184.
- McCormick, Richard A. (1983): Bioethics in the Public Forum. *The Milbank Memorial Fund Quarterly. Health and Society* 61 (1): 113–126.
- Moreno, Johnatan D. (1991): Ethics Consultation as Moral Engagement. *Bioethics* 5 (1): 44–56.
- Raki, Vojin and Petar Bojani (2011): Bioethics in Serbia: Institutions in Need of Philosophical Debate. *Cambridge Quarterly of Healthcare Ethics* 20 (3): 440–448.
- Reichlin, Massimo (1994): Observations on the Epistemological Status of Bioethics. *The Journal of Medicine and Philosophy* 19 (1): 79–102.
- Resnik, David B. (1998): *The Ethics of Science. An Introduction*. London: Routledge.
- Singer, Peter (1972): Moral experts. *Analysis* 32 (4): 115–117.
- Ten Have, Henk, Christophe Dikenou and Dafna Feinholz (2011): Assisting countries in Establishing National Bioethics Committees: UNESCO's Assisting Bioethics Committees Project. *Cambridge Quarterly of Healthcare Ethics* 20 (3): 380–388.
- Universal Declaration on Bioethics and Human Rights (2005). Available on http://portal.unesco.org/en/ev.php-URL_ID=31058&URL_DO=DO_TOPIC&URL_SECTION=201.html, 29th April 2014.