

# Struggling for Consensus and Living Without It

## The Construction of a Common European Bioethics

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### I. INTRODUCTION

On Tuesday 19<sup>th</sup> December 2000, the British House of Commons passed a bill extending the grounds for research using early human embryos and allowing the creation of embryos by a new cell nuclear replacement technique ('therapeutic cloning') for a wider range of research purposes. One month later, on 23<sup>rd</sup> January 2001, the House of Lords agreed to this bill. – What might be seen as a domestic parliamentary decision caused excited reactions in some other European countries. In Summer 2000 the European Parliament had already passed a Resolution (advisory only) demanding that the British Government withdraw all plans to allow human embryos to be cloned for research. The European Parliament, as stated in the text,

considers that therapeutic cloning poses a profound ethical dilemma, irreversibly crosses a boundary in research norms and is contrary to public policy; calls on the United Kingdom Parliament members to reject the proposal to permit research using embryos created by cell nuclear transfer; repeats its call to each Member State to enact binding legislation prohibiting all research into any kind of human

cloning within its territory and to provide criminal penalties for any breach...  
(quoted from: House of Commons 2000, p. 32)

Two months after the British decision (but without mentioning it) the French President Jacques Chirac declared that he opposed the therapeutic cloning of human beings and warned against “a utilitarian conception of the human being which would call into question the very foundations of our civilisation”<sup>1</sup>. In Germany some Christian politicians even went further and demanded sanctions against Great Britain by the European institutions; for them, the British decision amounted to a revocation of membership in occidental culture or to a splitting of Europe and its moral identity.

These reactions illuminate two important things. On the one hand, there is a strong appeal to a specific European cultural and moral identity. “Europe” is not used as a mere geographical term, referring to the western appendage of the Asian continent, beginning with the Ural and ending with the Portuguese Atlantic coast, or to a number of states which are accidentally located in close neighbourhood. Instead, “Europe” is seen as a part of the world with a genuine historical and cultural identity, including a common set of values. Beyond its geographic meaning, the term “Europe”, therefore, refers to a historically grown model of society and civilisation, a way of life, different from other ways of life in other parts of the world. On the other hand, it is by no means clear which elements are included in this cultural and moral identity, how they are to be interpreted, or what their respective weight is. There are many disagreements and passionate debates about this. The Members of the British House of Commons presumably did not intend to violate European morality or to depart from the occidental culture, but were convinced that their decision was in accordance with this morality and culture. Since the British decision concerning therapeutic cloning is not the only example of such a disagreement, it is fair to state that there is a tension between the *supposition* that there is such a thing as a common European morality and the *fact* that this common morality is neither well defined nor undisputed.

The aim of this paper is to address this tension in the field of bioethical questions, as well as to explain its background and its implications. My aim, therefore, is mainly analytical, not evaluative. I will not ask ‘who is right’ or ‘what is right’, but ‘what is going on’ with bioethics in Europe and try to give some explanations. The premise of this approach is that bioethics is presently undergoing a change in function.<sup>2</sup> At least parts of it are extending beyond the academic world and beginning to play a public, a political or a legal role. Bioethics has become the ideological basis of *biopolitics*; some have spoken of a passage “from bioethics to biolaw”<sup>3</sup>. This means: in this paper I will refer by ‘bioethics’ not (at least not in the first instance) to the respective academic endeavours and debates, but to the ‘official’ decisions and documents which regulate professional action in the field of medicine, medical research and health care.

In the *first* section I will deal with how a European moral identity may be understood and what its major elements in the field of bioethics may be. *Then* I will discuss some of the limitations of this identity and show that there is a lot of difference and divergence among different European countries. And *finally* I will focus on the fact that the ‘official’ type of bioethics I am dealing with in this paper is the result of a political construction and venture some speculations about what the prospects of such constructions may be.

## I. STRUGGLING FOR CONSENSUS IN EUROPE

1. – There have been many attempts<sup>4</sup> to describe or define what the “European identity” might be; and, more specifically, what the cultural and moral elements of this identity might be. I would like to start with a rough distinction between two different approaches to this endeavour. This first is *positive* and *substantial*. It consists in identifying one crucial idea, principle or value, or several ideas, principles or values, which are constitutive for the European identity. There are three main candidates which have been mentioned again and again from antiquity to the present times: *freedom*, *individuality* and *rationality*. To

mention only one example of this positive, substantial approach I quote from Georg Wilhelm Friedrich Hegel's *Encyclopaedia*:

The principle of the European mind is, therefore, self-conscious Reason which is confident that for it there can be no insuperable barrier and which therefore takes an interest in everything in order to become present to itself therein. The European mind opposes the world to itself, makes itself free of it, but in turn annuls this opposition, takes its Other, the manifold, back into itself, into its unitary nature. In Europe, therefore, there prevails this infinite thirst for knowledge which is alien to other races. The European is interested in the world, he wants to know it, to make this Other confronting him his own, to bring to view the genus, law, universal, thought, the inner rationality, in the particular forms of the world. (Hegel 1845, § 393Z)

Usually, such ideas, principles or values like freedom, individuality, and rationality are traced back to one or more of the main epochs or traditions which have shaped European history. There are three of them which play an important role here: (a) Greek and Roman antiquity, with their emphasis on the rational approach to reality and on political liberty; (b) Christianity as the origin of the idea of an unalienable value of each human being and consequently of equality and dignity; and (c) the Enlightenment as the source of important moral and political values like toleration, human rights, and democracy. – This positive, substantial approach, irrespective of the merits it may have, faces two problems. The first is that each idea, principle or value which is declared as constitutive for the European identity has a broad variety of meanings; two people speaking of freedom, individuality or rationality can connect very different ideas with these concepts and draw very different conclusions from them. When, for example, Max Weber (1920, pp. 1-16) in the preface to his collected essays on the sociology of religion underlined “rationality” as the main feature of European culture, he had in mind something very different from Hegel’s concept of Reason. It is at least an open question if concepts like rationality have enough determinate content to provide the intellectual basis of a European identity. And,

moreover, what about the important theories and movements which have, in one way or another, criticised the ideas of freedom, individuality, and rationality? Are they not (or not truly) “European”? The second problem is that these ideas have spread all over the world and have developed deep roots in major parts of it. If freedom, individuality and rationality are constitutive for the European identity, then at least North America and Australia have long become “European”. It is hard to see how a distinctive European identity could be based on such ideas or values.

More promising, therefore, seems the second approach. It is *negative* in that it does not primarily try to identify some substantial content constitutive for the European identity, but draws a distinction between “Europe” and something else, preferably a threat or an enemy. And it is *functional* in that it does not only allude to an existing European identity but invokes and postulates such an identity as necessary. The advantage of this functional, i.e. programmatic and constructive approach lies in the fact that broad concepts like “freedom”, “individuality”, and “rationality” take shape and gain more content when they are used as means of demarcation from something which is (supposedly) not “free”, not “individual(istic)” and not “rational”. If we go back into history, we will see very easily that the idea of a European identity has mostly had this negative and functional character. It regularly came into play as a reaction to a threat and was intended as a means to overcome this threat. This should be no surprise because it is quite a common phenomenon that identities become more important and stronger, the more they are in danger. The idea of Europe has developed historically in demarcation from and in confrontation with other parts of the world: Especially “the East”. This began very early. In his *History* Herodotus starts with a report of the origins of the enmity between “Greeks” and “Barbarians” and gives a detailed description of the war with the Persians. (Herodotus, I, 3/4) The sharp line drawn here between the oriental and the occidental world continued to exist in a new form after the splitting of the Roman empire in 395 and became even deeper when in the following centuries Islam developed and became a strong political and military force, conquering Spain in the 8<sup>th</sup> century and besieging Vienna in the 17<sup>th</sup> century. At the

beginning of the 20<sup>th</sup> century, the dualism between “Europe” and “the East” changed again, when the Soviet Union originated and spread its influence over a third of the world.

2. - What does this mean for the topic of this paper? When in recent times the cultural and moral European identity has increasingly been invoked and when there are intensive activities to formulate a common European bioethics, then we have to conclude from the previous considerations about the negative and functional character of this concept that there is (or is perceived) some kind of threat to it. But where could this threat come from? Obviously, it cannot be “the East”, because there is no Soviet imperium any more and it is hard to see how the Islamic world should be a threat in bioethical questions. The answer is that the threat for what is seen as the common European bioethical identity does not come any more from the outside; instead it comes from within. There are two main developments which form this threat.

The first is the rapidly increasing progress of biotechnology during the last decades. The permanent revolution of medical technology and biotechnology in general (especially of gene technology) and the new options for all subjects involved has for years been observed with suspicion by many people, including many politicians. Such concerns have not only led to public debates in several countries, but have triggered political activities at a transnational level, too. In the 1970s the *Council of Europe* already began to occupy itself with the new developments in biomedicine and biotechnology.<sup>5</sup> In 1982 the *Parliamentary Assembly of the Council of Europe* passed Recommendation 934 on genetic engineering, which in its first sentence alludes to “public concerns about the use of new scientific techniques for artificially recombining genetic material from living organisms” and then explicitly links some of the questions raised by this technology to the guarantee of human rights:

The rights to life and to human dignity protected by Articles 2 and 3 of the European Convention on Human Rights imply the right to inherit a genetic pattern which has not been artificially changed.

The text further recommends that the Committee of Ministers

provide for explicit recognition in the European Convention on Human Rights of a right to a genetic inheritance which has not been artificially interfered with, except in accordance with certain principles which are recognised as being fully compatible with respect for human rights (as, for example, in the field of therapeutic applications)

This line of argument was continued during the 1990s when the European “Bioethics Convention” was drafted, publicly discussed and then ratified.<sup>6</sup> The full title of this convention makes it explicit that the ethical and social problems of modern biomedicine are interpreted as human rights problems: *Convention for the Protection of Human Rights and Dignity of the Human Being With Regard to the Application of Biology and Medicine*. It is then only consistent that this Convention was issued by the *European Council* which – facing the splitting of Europe into two blocks – in 1950 had agreed upon the *Convention for the Protection of Human Rights and Fundamental Freedom*. Then the threat to human rights and dignity had been a political one; now, since the 1990s it is a scientific and technological one.

The second development is the ubiquitous process of *globalisation*. What is meant here is not a specific and narrowly conceived economic change, like the origin of transnational companies and the internationalisation of markets, but a pervasive social evolution which touches all parts of society and moulds all levels of human life. This is so because the economic changes coincide with strong neoliberal ideology, and with powerful scientific and technological achievements. ‘Globalisation’ will bring about a model of society which Jürgen Habermas (2001) has polemically characterised as having four features: (a) the anthropological image of the human being as a rationally deciding businessman who exploits his own labour power; (b) the political image of a post-egalitarian society which accepts the marginalisation and exclusion of certain individuals; (c) the economic image of

a democracy which reduces citizens to the status of members of a free-market society and redefines the state as a service enterprise for clients and customers; and (d) by the strategic thought that there is no better policy than that which runs by itself. According to Habermas, the neo-liberal world-view and the corresponding model of society does not fit the normative self-understanding of Europeans.<sup>7</sup>

But how and why may globalisation be seen as challenge to the European culture and morality and, more specifically, as a threat to the European *bioethical* identity? There are two different, but connected answers to this. (a) The economic development and the scientific-technological progress both lead to an erosion of traditional political and social *structures* and *institutions*. An important example in the biomedical field is the fact that medical actions increasingly take place outside the established medical system; the physician-patient relationship is going to be replaced by a provider-consumer relationship. This is important because the classical structures and institutions are not seen as mere social facts, but as embodiments of values. European medical ethics always focused on the physician-patient relationship as a special moral relationship; and the values inherent in this relationship cannot be upheld when medical action is increasingly determined by free market mechanisms and instrumental reasoning. The laws of supply and demand take the place of moral laws; scientific expertise and technological imperatives take the place of compassion and care. Nothing could be more misled, from this perspective, than the idea that the free market provides the appropriate model for dealing with moral problems of health care. For an influential group of bioethicists in the US, exactly this is the case. In Engelhardt's vision of the future, the general practice of moral stranger's resolving controversies will have a character illustrated by the free market:

Each participant can bring a quite different understanding of successful market transactions, the purposes of the market, and the goods it supports. However, each can also recognize a practice that all can understand as justified simply and barely through the permission of those who enter it. The authority of the endeavour depends not on any particular ranking of goods, moral narrative, or ordering of



right-making principles. Across moral communities the authority of the market can be regarded neutrally as drawn simply from the permission of those who engage it. (Engelhardt, 1996, pp. 114f)

The idea here is of a common European morality as a counter-design to this market-model; its premise being the conviction that there is nothing neutral with the market. That, quite the contrary, the market-model has to be seen as the epitome of a specific and particular moral vision – one which eliminates all cultural diversities and moral pluralism.

(b) It can be argued that the modern type of economy and the modern type of technology converge in their common tendency to erode the traditional, value-based *way of thinking*. What they foster is not a type of content-full reason, which Hegel had in mind, but an instrumental kind of rationality which has been analysed by Max Weber. But while Weber soberly tried to balance the gains and losses of the “Occidental rationality” many accounts today stress the losses and deplore the erosion of values. In former times, this mainly negative view of the rationalisation and modernisation of society was prominent on the right side of the political spectrum; during the last three decades of the 20<sup>th</sup> century it spread to the other parts, including the political left (the movement of the Greens is the most obvious, but not the only example). This holds especially with respect to the recent scientific and technological developments in the area of biology and medicine. Many religious believers, conservative politicians, Green or feminist activists, and remained socialists agree with the statement that some of the most fundamental European values are endangered by an increasing pressure (i) not only by the market imperatives of a globalised economy; but also (ii) by a naturalistic image of the human being, provided by the advances of biomedical science; and (iii) by the recent biotechnological achievements with their tendency to more or less subtle forms of instrumentalisation, and reification of human beings.

3. – But what are these fundamental European values? The most important one is *human dignity*. There can be not doubt that during the last decades human dignity has emerged as

the central and most important value or principle of the project of a common European bioethical framework. This concept can be traced back to the three main elements of European identity which have just been mentioned. We find this concept in parts of Greek and Roman philosophy, especially in Stoicism; it is a substantial element of Judeo-Christian anthropology, which views the human being as “*imago dei*”; and it has been philosophically elaborated by Enlightenment philosophers like Immanuel Kant. Moreover, this value plays a key role in the constitutional law of many European countries: Belgium, Czech Republic, Denmark, Finland, France, Germany, Greece, Ireland, Lithuania, Poland, Russia, Spain, Sweden and Switzerland. It is not by accident, therefore, that European international documents concerning bioethical questions rely heavily on this value. This is especially true for the important “Bioethics Convention” of the *Council of Europe*. The concept of human dignity not only appears in the official title of this convention but is at the center of its Article 1 which defines the purpose and object of the convention:

Parties to this Convention shall protect the dignity and identity of all human beings and guarantee everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the application of biology and medicine.

The *Explanatory Report* accompanying the convention underlines this central role by confirming that human dignity “constitutes the essential value to be upheld” and explaining that it “is at the basis of most of the values emphasised in the Convention”. – Unfortunately, the *Explanatory Report* does not say what the term “human dignity” means, nor what follows from the moral principle, which prescribes the protection of human dignity. There is a lot of debate about the correct interpretation of this key term and it is impossible to go into the details of this discussion here (cf. Bayertz, 1996; the bibliographies by Haferkamp, 1996; and Center for Ethics and Law, 1999). But there is a widespread inclination to a “substantialist” interpretation of this term, which includes a more or less fixed image of the human being. This results in a tension between the concept or principle of human dignity on the one hand, and the concept or principle of autonomy

on the other. Whereas the concept of autonomy did not play a central role in traditional European medical ethics, it has become fundamental during the last two decades, in part because of the strong reception which has greeted US American bioethics. The “Bioethics Convention” is very clear about this central role; the chapter on “consent” is the first after “general provisions” and Article 5 states as a general rule:

An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it.

This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks.

The person concerned may freely withdraw consent at any time.

But according at least to some influential line of bioethical thought, informed consent is seen as a necessary rather than a sufficient condition for a medical intervention to be morally legitimate. If there is the above mentioned substantial image of the human being and its integrity, which must not be violated (human dignity), then there are limits to what a competent human subject is allowed to do, even if no other person is affected. There are certain limits to autonomous human self-determination, which becomes obvious when we look at the ‘appropriate’ reasons justifying medical or biotechnological interventions in human beings. Such interventions are legitimised mainly or even exclusively by their medical – i.e., in the last instance, by their therapeutic – goal. The French *Law Concerning the Human Body* of 1994 prohibits any intervention in the integrity of the human body unless there is a “therapeutic necessity for the person”<sup>8</sup>. Human reproductive technologies are a good example: Whereas in the US the use of such technologies is often justified by the right to a free choice of reproductive options, the justification in Europe is primarily medical: as a therapy for unwanted childlessness. It is only consistent, therefore, that in its Article 12 the “Bioethics Convention” confines predictive genetic tests to a medical framework:

Tests which are predictive of genetic diseases or which serve either to identify the subject as a carrier of a gene responsible for a disease or to detect a genetic predisposition or susceptibility to a disease may be performed only for health purposes or for scientific research linked to health purposes, and subject to appropriate genetic counselling.

In most cases of everyday medicine this special way of legitimising medical interventions makes only a philosophical but not a practical difference. But there are at least some areas where there are practical differences, too. Maybe most important is the question of commercialisation. Whereas many bioethicists in the US do not see major moral problems in the commercialisation of human organs and tissue, Article 21 of the Convention prohibits any financial gain from the human body or its parts. The same holds for the legal systems of many European states (like France and Great Britain), which do not consider individuals as ‘owners’ of their bodies; other countries (like Germany and the Netherlands) at least limit individuals severely in their free disposition over their bodies. This excludes the legal possibility of selling organs or tissues, including blood. (cf. ten Have and Welie, 1998) Likewise, contracts between parents and surrogate mothers would not be enforceable by law. Such limitations to the disposal of individuals over their own bodies are justified by the principle or value of human dignity, which is meant to exclude not only the instrumentalisation of other people, but self-instrumentalisation, too.

Another important element of European bioethics besides human dignity is the principle of *Equitable access to health care*. There is a widespread consensus in Europe that everyone who needs medical help should receive it, independent of individual financial background. From a US-American point of view, Europe is a “socialist” continent where each person is thought to have a legitimate claim to every treatment which is medically necessary. Although there are intense (and controversial) discussions about how this claim can be upheld in an era of rapidly increasing costs, only very few people dare principally to call into question what is stated in Article 3 of the “Bioethics Convention”:

Parties, taking into account health needs and available resources, shall take appropriate measure with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality.

This right to health care on the side of the recipient has its necessary counterpart in the principle of solidarity on the side of the community (or state), providing this help and paying for it. Solidarity implies the idea that there are certain social obligations human individuals have towards each other. In contrast to the US health care system, all European countries ensure (almost) universal health care coverage for their citizens.

### III. LIVING WITHOUT CONSENSUS IN EUROPE

4. – Thus far the *idea* of a common European bioethics. When we move from the theoretical programme to the practical reality we will soon notice that “European bioethics” is one thing, and bioethics in Europe quite another. It is one of the main theses of the present paper that the common European outlook in matters of medicine and health care is but narrow; and that all political attempts to construct and implement a common outlook will be of only very limited success. To lend this claim plausibility, let us step back from bioethics for a moment and take into consideration European culture on a more general level.

Any idea of Europe having a uniform tradition and monolithic culture is far from the historical as well as the contemporary reality. Why this is so becomes immediately clear on a closer look at the abovementioned roots and/or elements of European identity. These roots or elements are heterogeneous and in – sometimes latent, sometimes open – conflict with each other: In some respects the pagan world-view of Greek and Roman antiquity is hard to reconcile with Christian religion; and the Enlightenment has (in part) developed as a counter-movement to Christianity. If Europe has ever been a unity at all, it has always been a unity-in-diversity, or even a unity-in-controversy. Looking back, therefore, we do

not find only unity and agreement, but also divergence and controversy at different levels. What has been characteristic for Europe – at least during its history after the Middle Ages - is its ability to develop ways of living with dissensus rather than reaching consensus. One important example is the idea of toleration which emerged when the religious homogeneity of Europe collapsed after the Reformation. At first, this idea was by no means welcomed by everybody; and it took some hundred years to convince the Catholic church that there is no reasonable alternative to the freedom of religion. But finally this insight gained the upper hand, formulated impressively by John Locke in his *Letter on Toleration*:

It is not the diversity of opinions, which cannot be avoided; but the refusal of toleration to those that are of different opinions, which might have been granted, that has produced all the bustles and wars, that have been in the Christian world, upon account of religion. (Locke, 1667, p. 53)

As a second example one might add the recognition of political pluralism in the 19<sup>th</sup> century, when it had become clear after the French Revolution that the rival coexistence of different political parties was no temporary fact, but a structural feature of modern societies. Again, there was a lot of reluctance concerning this insight, but finally the idea of political pluralism and the implementation of democratic institutions were widely accepted. In both cases the ‘solution’ to the problem had not been to re-establish consensus, but to find *ways of living peacefully with dissensus*. And in both cases what was first allowed only reluctantly, was later increasingly welcomed as a value in its own right: toleration of pluralism.

With cultural pluralism things are somewhat different, in that this has always been regarded as an achievement. The assessment has always prevailed that the diversity of art styles and of ways of life in the different European countries – and the competition between them – has been one of the strengths of European culture. And exactly this diversity and competition seems to be threatened today to a degree previously unknown in history. Engelhardt has described this threat as follows:

[T]here is a global market ethos directed at the satisfaction of needs, inclinations, and drives that is powerfully refashioning tastes. To sell effectively to the largest market, one harnesses the most basic human concerns, passions, and interests. Mass marketing focuses drives that support mass culture. The result is a cultural homogenization: one encounters McDonald's, Coca-Cola, Kentucky Fried Chicken, and Microsoft from Buenos Aires to Cape town, Madrid to Kyoto. Fashions in music, clothes, and television are becoming global. All of us are invited to pursue self-satisfaction and self-realization, as this can be facilitated within a global market set within an evolving cluster of common global images of human well-being, satisfaction, and flourishing. (Engelhardt, 2003, p. 27)

Many artists, philosophers, intellectuals and politicians also believe that the specific humanistic culture which has developed in Europe over the many centuries since the end of the Middle Ages has to be defended against this threat of the global market, its economic imperatives and its instrumental way of thinking. The increased invocation of the European cultural and moral identity, the repeated appeals to be reminiscent of this identity and to strengthen it have to be interpreted as a reaction to the challenge of triumphant capitalism and its uniforming power.

The decisive point for the present context is that all this holds for morality, too. The cultural pluralism characteristic for Europe includes a plurality of moral convictions and ethical approaches. There is no monolithic "European morality" and there has never been one (or at least not during the last centuries). In cultural as well as in moral matters, Europe is and has been a unity-in-diversity, too. Any aspiration, therefore, to construct a European 'moral identity' as a homogeneous system of values, principles or ideals, which would (or at least could) function as the basis for a comprehensive moral consensus is without historical precedent and basis.

5. – If we return to the contemporary field of bioethics, we will have reason to expect considerable diversity within Europe in dealings with present problems raised by the new biotechnologies. And this is exactly what we find. Empirical studies on public perception, policy debates and the political regulations of modern biotechnology show great differences between the European states. On the basis of a vast amount of empirical data the authors of a comparative review on “biology in the public sphere” come to the conclusion:

that there is no unified public discourse about biotechnology in Europe. In terms of public policy, we have found different European countries dealing with modern biotechnology over very different timescales and in very different ways. In terms of media coverage, we have found that a commonly held discourse of progress and benefit is paralleled by rather different patterns of media reportage in the European countries. Last but not least, we have seen from the results of Eurobarometer 46.1 that the different European countries tend to have widely differing levels of engagement with, knowledge about and attitudes towards biotechnology. In light of these results, it is a brave person indeed who would hazard a general conclusion about ‘the European view of biotechnology’. (Bauer et. al 1998, p. 226.)

What is stated here with regard to the public perception of biotechnology in general can also be confirmed with regard to the *ethical* aspects of biotechnology and biomedicine. There is impressive evidence from the available data that ethical appraisal by the public of important questions like the moral status of the human embryo encompasses enormous diversity (a) *within* the different European countries; and (b) *between* the different European countries; consequently, the opinions concerning biomedical options like stem cell research, embryo experimentation, IVF and PGD are very controversial. (Solter et. al.2003, pp. 157-203) The controversy concerning ‘therapeutic cloning’, reported in the introduction to this paper, may be seen as an illustration of the actual lack of consensus in important bioethical questions and as a warning against too much hope (or anxiety) regarding the possibility of a consensus. Official documents like the “Bioethics



Convention” are always programmatic and prospective in character, and therefore never offer a true picture of the given situation, stressing the reached agreements and leaving unmentioned all those questions on which agreement proved to be impossible. It becomes obvious that the realm of disagreement remains considerable if we focus on what is *not* regulated in the text of the Convention. Two especially important areas may be mentioned here.

The *moral status of the human embryo* is one of the key questions on which Europe remains far from any consensus. The “Bioethics Convention” states in Article 1 that the parties to this shall protect the dignity and integrity “of all human beings and guarantee everyone, without discrimination, respect for their integrity...”. Since the decisive terms “human being” and “everyone” are not defined, it remains an open question as to whether the human embryo is included.<sup>9</sup> This is not by accident, as the “Explanatory report” says explicitly:

“In the absence of a unanimous agreement on the definitions of these terms among member states of the Council of Europe, it was decided to allow domestic law to define them for the purposes of the application of the present Convention.” (§ 18)<sup>10</sup>

This makes it possible for very different regulations concerning several important medical options to continue to exist in different European states. (a) The first and most important of these options is *abortion*. There are states with strict prohibition of any kind of abortion, like Ireland, and others with very liberal regulations. (b) The same holds true for the question of *embryo experimentation*, where one finds three groups of countries. One group with very liberal regulation, explicitly allowing embryo research (UK); a second group with restrictive regulation, allowing research only if it directly benefits the embryo itself (Germany); and a third group which allows embryo research under certain specifically defined circumstances (Spain). (Solter et. al., 2003, pp. 111-155) (c) The third option to mention here is *preimplantation genetic diagnosis*, which is forbidden in Austria,

Switzerland and (de facto) Germany, but allowed in Great Britain, France, Sweden and Belgium.

A second important question to which there is no common European answer is that of *euthanasia*. The “Bioethics Convention” remains silent here, too. The deep divergences at the level of national regulations became obvious when on 14<sup>th</sup> April 2001 the first chamber of the Netherlands parliament decided to legalise (under carefully defined circumstances) assisted suicide and the killing of terminally ill persons; in Belgium a similar bill is currently in preparation. Reactions in other European countries were very similar to those some weeks earlier with regard to the British decision to extend the grounds for research using early embryos. The Prime Minister of the German State of Bavaria declared euthanasia to be “a break with our Christian and humanistic tradition”<sup>11</sup>. A group of (mainly Christian and Green) members of the European Parliament announced their intention to bring an action against legalised euthanasia to the European Court because of violation of Art. 2 of the *European Convention on Human Rights* (1950), which forbids the intentional killing of persons. These reactions appeal to “European values”, but they show at the same time how controversially these values are being interpreted. Many people think that these values have never been static and must be adapted to the contemporary conditions. Current intensive discussions in several European countries are intended to develop European values further in the direction of giving more weight to autonomous personal decisions. In some of these countries, including France and Switzerland<sup>12</sup>, a future liberalisation of the still existing restrictive regulations seems to be likely.

Moreover, it should not be overlooked that the “Bioethics Convention” is a product of political construction, drawn up by a small group of experts at the level of governmental agencies. It is the result of political bargaining and therefore formulates a compromise rather than a consensus. For two reasons it cannot and does not precisely express ‘the European bioethical point of view’. (a) There is, as we have seen, no consensus *between* the different states in important questions, and even in general attitudes, manifested in the fact that the Convention has yet to be signed by several countries, including Belgium

because it is too restrictive, and Germany because it is not restrictive enough. (b) There is no consensus *within* the different states. 'Europe' does not consist only of states, but also (or mainly) of many individual people. Among them we find a lot of partly converging, partly diverging opinions and convictions. 'Consensus' in the sense of 100% agreement by an entire population is a rare thing in all modern societies; and biomedical problems are no exception to this rule. (cf. the contributions in Bayertz, 1994) There are many and even fierce debates on bioethical problems in many European countries and it would be simply false to say that *the* British favour stem cell research and 'therapeutic cloning' while *the* Germans or French reject it. There are ongoing controversies in all these countries; and what we find at the end of the British parliamentary decision process is not consensus, but a majority decision: the House of Commons voted 366 to 174 and the House of Lords 212 to 92. Similarly, in the Netherlands the law concerning euthanasia was accepted by the first chamber of parliament by 46 to 28 votes.

6. – What are the reasons for and causes of these disagreements? At the most fundamental level it is the fact that, as explained above, the common cultural and moral identity of Europe has *never* been a homogenous and uniform system, but always more of a unity-in-diversity. If one looks more closely at the field of bioethics and concentrates on the differences *between* the countries, one will find some especially important factors of divergence:

(1) *Religious differences.* The general importance of religious differences should be clear; it is visible in the divergent opinions of Churches or confessions to specific biomedical options. The religious situations in the different European countries being very different, this can be expected to have a considerable effect on opinions and regulations. There are at least four groups of countries: (a) some predominantly Catholic: France, Italy, Ireland, Poland, (b) others predominantly Protestant: Great Britain, Scandinavia, (c) others mixed: Germany, Switzerland, Netherlands, (d) some predominantly Orthodox: Greece, Cyprus. Moreover, the influence of religious communities differs in degree from country to country: It can be very direct and strong (Poland, Italy, Germany), but there can be less

involvement elsewhere (France, Great Britain). As a matter of fact, the bioethical positions held by the various religious denominations differ gravely. One illustration of this is the opinions issued in the debate on the abovementioned revised edition of the British *Human Fertilisation and Embryology Act* by the Catholic Church, by the Church of England and by a Jewish Chief Rabbi: the first strictly negative, the second and the third cautiously positive regarding therapeutic cloning. (House of Commons 2000, p. 50-54) Empirical findings show clearly that the divergence of religious orientation is one of the most important factors explaining the divergence of opinions *within* and *between* the states on bioethical questions. (Solter et. al., 2003, pp. 183-186, 194-196).

(2) *Different legal systems.* In Europe the legal systems and legal cultures also differ from country to country. The contrast between the British and continental legal cultures immediately comes to mind. The following quotation pinpoints the British and French attitudes to biomedical legislation and regulation:

There is in human nature a scale of different possible reactions to the slogan: from ethics to law. At one extreme is the temperament which feels: if it's wrong, we must legislate at once. Let us forbid it in the Penal Code, or at least write it into the Civil Code, and if we can't do either of those, then let us outlaw it in some other code or body of law, such as the Public Health Code. The British think that is the French way.

At the other extreme is the temperament which feels: if it's wrong, let us educate everybody to know that it is wrong, and that will surely solve the problem. At the very most, let us hope the professionals will regulate it in their own codes of practice; medical nursing and so on. Above all, no new law. The French think that is the British way.<sup>13</sup>

This may be ironic exaggeration; but in fact we find very different legal situations in Europe. There is detailed legislation concerning biotechnology and medicine in countries

such as Austria, Germany, the Netherlands and Switzerland, whereas Italy has become noteworthy for its lack of regulation. Such differences can have far-reaching consequences for the public discussion:

The fact that Italy still has no law governing organ transplants or artificial insemination has meant that the philosophical, juridical, sociological and medical debate on these issues has become progressively harsher, with positions that are becoming increasingly radical and polarized. At the same time the arguments put forth by the different parties have become shallower and poorer. The result is that today the positions of the opposing factions are even further apart than they were a few years ago. (Mazzoni, 1998, p. 5)

(3) *Different mentalities.* The common European tradition and culture has not prevented the development of different mentalities in different peoples and countries. The British, for example, are said to be 'pragmatic', while Germans tend to be 'principled'. Of course, such differences and oppositions tend to be commonplaces or national(istic) stereotypes; and the analytic power of the concept of 'mentality' is doubtful. Nevertheless, at least some national differences in opinions about and regulation of bioethical matters can be explained by such diverging mentalities. Especially illuminating is the situation in multi-ethnic countries like Switzerland. In fact, we find here that the voting behaviour of the German population in referenda on bioethical questions differs gravely from that of the Roman (French and Italian) population, in being more restrictive.

(4) *Historical differences.* History plays an important role in current bioethical debates. This is especially true for Germany, where the burden of the past still casts a dark shadow on all contemporary discussions. Without knowledge of the crimes committed during the Nazi period it would be impossible to understand the often very restrictive legal regulation in Germany, as well as certain tendencies in the German discussion, which oppose any kind of pragmatism in bioethical questions and may therefore seem to be somewhat 'fundamentalist'. Many objections to the "Bioethics Convention" in Germany have their

roots in an intention to avoid the barbarities of the past. This is especially the case with respect to such questions as euthanasia, eugenics, or experiments with non-competent humans. Other countries which have a different history can deal with the bioethical problems of the present time more easily and more pragmatically.<sup>14</sup>

(5) *Ethical differences.* European countries differ in their philosophical traditions. Even if it would be an oversimplification to say that Great Britain is uniformly Utilitarian, Germany uniformly Kantian, and France uniformly Cartesian, it cannot be denied that these traditions have a strong influence and shape the philosophical and public debates in those countries. It has been pointed out that these differences in 'ethical culture' lead to different prevailing styles of ethical argumentation. One can roughly distinguish a consequentialist and need-oriented type of moral reasoning in countries like Great Britain, the Netherlands and Scandinavia from a deontological and value-oriented type of reasoning prevailing in France or Germany. The difference can easily be identified in recent statements concerning the cloning of human beings. Although all these statements agree in the rejection of this technology and in their plea for a prohibition of cloning, at least momentarily, they have significantly different justifications for this. The British opinions refer mainly to the risk of harm for human beings inherent to this method; the French and German opinions primarily argue the danger to values, especially to human dignity. (Birnbacher, 2000, p. 158) Another example of strong disagreement is the question of medical research on persons unable to consent. The "Bioethics Convention" allows for such research under certain conditions; in Germany this has caused strong protests from several groups, with the result that Germany has not signed the Convention.

The discussion of this issue in different European countries exhibits the difference between ethical cultures. In countries like Great Britain and the Netherlands without a collectivist past and perhaps with a stronger utilitarian tradition, the principle of 'group benefit' has met with much less opposition than in Germany. Part of this opposition stems from the Kantian tradition: In the case of experiments without consent and benefit for the person involved, the categorical imperative

never to use a human being merely as a means does seem to be violated [...] What the example shows is, in my view, the very relevance of diversity between cultures, both regarding their philosophical traditions and their moral-political experiences, for important questions of science-ethics. (Siep, 1997, p. 129)

#### IV. MORALITY AS A POLITICAL CONSTRUCTION

7. - Modern societies are essentially and increasingly self-observing and self-reflecting societies. They have developed special organs and institutionalised procedures for this self-observation and self-reflection; publicity and the media being the most important of these. It is trivial, but nevertheless important that this self-observation and self-reflection is not only descriptive, but always with a *normative* dimension: whatever becomes a topic of public concern will not only be reported but evaluated, too. It is obvious that matters of medicine and health care *are* a topic of public concern and it can be presumed that bioethics has assumed the role of a social institution of normative self-observation and self-reflection regarding the field of medicine and health care; and moreover, it has become a tool in the social problem-solving process and has thereby unavoidably been 'politicised'. Bioethicists are being appointed to committees and councils; they are expected to produce useful recommendations, directives or guidelines; their reasoning gains a practical impact not only occasionally or accidentally, but rather regularly and systematically. (cf. Bayertz, 2002) The possibly most important instrument of problem solving and, therefore, goal of bioethical activity is the construction of *consensus*. It seems to be self-evident today that consensus on moral questions and answers is a good thing. But this self-evidence is an illusion which decays rapidly if we look back at former times, where consensual agreements played only a minor role in politics. The attractiveness and necessity of moral consensus is a typical feature of modern societies which lack any authoritative and binding ideology, philosophy or religion. Under these circumstances it becomes difficult to legitimise political decisions (e.g. on biomedical problems) by appealing to unquestionable values and norms. Such decisions may then seem to be

arbitrary and lacking in moral foundation. A consensus suggests itself as a substitute for a moral foundation on such values and norms and is eagerly sought by political decision-makers whenever they have to provide answers to morally relevant questions. Modern societies seem to face a problem here, which may be called the *paradox of consensus*: The fewer unquestionable values and norms providing a legitimation basis for political decisions there are, the greater the need for consensus as a substitute for safe legitimation becomes; but at the same time the smaller the normative basis for such a consensus will be. What - instead of genuine consensus – will be feasible under these conditions, will be only more or less substantially contingent political compromises.

The increasing social institutionalisation and political involvement of bioethics, and its increasing attempts to achieve consensus, are not restricted to the national level, but extend to the supranational level, too. The *Universal Declaration on the Human Genome and Human Rights*, which was adopted unanimously by the General Conference of UNESCO in 1997, is one example of this tendency; the efforts of the European Council and the European Union to develop a common bioethical framework are another. There are a number of reasons given for this need for supranational agreements and regulations:

- (a) Most important is a widespread perception in major parts of the public and the political class that the progress of modern biotechnology and the biomedical sciences on the one hand, and globalisation on the other, imply serious ethical risks; and that these risks not only touch peripheral problems but the very core of what morality is all about. It has become a widespread assumption that at least some bioethical problems (e.g. germ-line intervention and reproductive cloning) are *human rights* problems,<sup>15</sup> the solution of which cannot be left to individual nation states. As far as Europe is concerned, the European Council then seems to be the appropriate institution for developing and implementing such regulations because it was founded during the Cold War to defend human rights.
- (b) Some major health care problems (AIDS, SARS) are supranational in their dimensions and, therefore, have to be met at a supranational level. Moreover, the progress of modern biomedical sciences and technology is essentially a supranational



development; the ethical problems arising from this development cannot be sufficiently solved at a national level alone. This is especially true for Europe, where geographical distances are very short and where the borders between different states – especially within the EU – have lost their former importance dramatically during the last decades; traffic and tourism are increasing. This implies that medical services which do not exist or are forbidden in one country can easily be obtained by going to a neighbouring country. During the 1960s many German women went to the Netherlands to have an abortion; today they go to Belgium for preimplantation diagnosis. Many, especially politicians, see this as a problem which has to be solved; and the solution can consist only in a harmonisation of national legal regulation, which presupposes common ethical standards

- (c) The member states of the European Union are cooperating more and more closely in certain political fields, including science and technology. In fact, the European Union has increasingly established its own supranational policy in this field. An important example is provided by biomedical research and development, which has become a major beneficiary of funding by the central institutions of the European Union. This presupposes a certain amount of agreement on the ethical permissibility of this research. In most cases this will not be difficult to obtain; in other cases, however, strong disagreements exist: embryo research is certainly one of the most important research options for which no ethical agreement exists. There are many inter-European consultations and negotiations to develop a common ethical framework, within which the EU may continue to extend its biomedical policy. In addition the European Commission, as the executive organ of the EU, decided in 1991 to set up a “European Group on Ethics in Science and Technology” with the following terms of reference: (i) identification and definition of ethical issues raised by biotechnology; (ii) appraisal of the ethical aspects of Community activities in the field of biotechnology and their potential impact on society and the individual; (iii) advising the Commission in the exercise of its powers as regards the ethical aspects of biotechnology.<sup>16</sup>

The reasons given for the need for a common European bioethical framework range from practical-political reasons, resulting from a closer cooperation within the European Community, to very fundamental considerations concerning the character of challenge posed by modern biomedicine. Especially these latter considerations make it impossible – for the political class as well as for major parts of the public – to treat the challenges of biomedical progress in a merely pragmatic way. These challenges are perceived as genuine and deep *ethical* problems; and they are perceived as ethical problems whose solution cannot be left to a spontaneous moral discourse, which may have a contingent or arbitrary outcome. Instead, the solution must be pushed ahead institutionally and controlled by legitimised political organs. The “Bioethics Convention” is by no means the only, but maybe the most significant attempt to *construct* a common European morality for dealing with matters of medicine and health care policy. – This at least is the bioethical agenda of the political authorities and of major parts of the general public<sup>1</sup>. And this agenda fits very neatly into what we have already seen above: the identity of Europe in general, and its moral identity in particular exist mainly in the form of an idea or a postulate. This can easily be detected from the fact that talk about “European bioethics” is in most cases counterfactual: It does not refer to a given reality but to something which we either have lost or forgotten (and, therefore, should recall); or which would be good to have or which may even be necessary in order to solve threatening problems.

8. – But what about the prospects of all these attempts to construct a common European bioethics? Will they be successful? Will Europe within the foreseeable future be dominated by one comprehensive bioethical outlook? – It is obvious that there *is* a process of Europeanisation in biopolitics, a tendency towards the “harmonisation” of regulations. And this process is accompanied and legitimated by a broad range of bioethical activities and arguments, which will certainly not remain without its effects on public opinion. Biopolitics thereby seems to fit a general pattern of cultural development within Europe: a development towards less diversity and more homogeneity.<sup>17</sup> Recent empirical studies in

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<sup>1</sup> It is **worth noting** that **the** vast **majority** of the general public in EU **member** states prefers **regulation** on embryo experimentation by EU authorities to regulation on the level of nation states. (Solter et. al, 2003, p. 198-200)

different, but similar fields show that specific attitudes and policies in different European countries (such as the liberal Dutch drug policy, the restrictive Nordic alcohol control policy, and the conservative Irish policy towards sexual morality) are under pressure originating from the expansion of European governance; they come to the conclusion “that national peculiarities are shrinking and that a modest rate of cultural convergence has occurred” (Kurzer, 2001, p. 2). The increasing amount of activities in the field of bioethics at a European level seems to point in the same direction and intentionally aims at this direction.

Nevertheless, it would be hasty to expect this process to be overwhelmingly successful within a short time-span. There are several reasons not to be either too optimistic (or, if one prefers, too pessimistic) with respect to the Europeanisation of bioethics, biolaw and biopolitics. I wish to mention three of them. The *first* emerges from what has been said about the counterfactual character of the idea of a European identity and about the diversity of European culture during most of its history. It seems very unlikely that the efforts of one (or even a few) generation of politicians, bureaucrats and bioethicists to harmonise opinions and regulations will be able to sweep away what has grown over centuries. To be sure, laws and regulations can be made easily and changed easily; but mentalities and traditions certainly cannot. We have to expect, therefore, that there will be a considerable amount of obstinacy with respect to deeply rooted mentalities and traditions, preventing a straightforward bioethical homogenisation of Europe. There will be agreement and consensus; but there will be disagreement and dissensus, too. *Second*: This is exactly what we find if we look carefully at what has actually been achieved in matters of a common “European bioethics”. Especially instructive is the most important of these achievements: the “Bioethics Convention”. It has already been mentioned that this document does not provide any complete and consistent regulation of bioethical matters, but leaves important questions open (especially, but not only the questions of the moral status of the human embryo and of euthanasia). In practice, this means that these questions are being answered in very different ways by national law. Moreover, even where the Convention provides regulations, considerable scope for national differences remains. The

Convention provides only *minimal* standards of protection and allows explicitly for national regulations going beyond what is prescribed by the Convention. *Third*: We must bear in mind the simple fact that regulation does not guarantee homogeneity. We know from many contexts that the same rule can be interpreted and implemented very differently and that the *setting* of standards is one thing, the *enacting* of standards quite another.<sup>18</sup> Empirical findings show that regulations may not be as universalisable as one might expect:

Rothstein et. al. have recently reviewed the issues of regulatory convergence and Europeanisation, taking the agrochemicals sector as their case study. They concluded that Europeanisation goes along with difference and that moves towards standardisation can serve to re-emphasise the significance of local mechanisms for interpretation and implementation. Their empirical finding was that a distinction of considerable importance exists between standard setting and standard enactment. In the context of agrochemicals regulation, they found that a subtle and diverse series of negotiations goes on within the process of regulation concerning ‘what regulatory requirements really mean’. (Wilkie, 2000, p. 120; – the author summarises the findings of Rothstein et. al., 1999)

There is no reason to expect that the gap between regulation and implementation will suddenly disappear when it comes to bioethics and biolaw. Even if European supranational regulations will be comprehensive and pervasive one day (which is not likely), this would not necessarily mean the end of all national or regional diversities.

All this seems to indicate that we do not have to expect a thorough process of ethical homogenisation of European bioethical thinking and regulation. The supposition that bioethical diversities will continue to exist is supported by other empirical studies which deal with similar problems. In her abovementioned book on the evolution of national attitudes and policies in several European countries, Kurzer comes to the conclusion that her findings:

do not point to an end to Europe's famous *mélange* of cultural diversity and lend support to the contention that not much will fundamentally change in the foreseeable future. Changes are taking place and the direction of adaptation is towards mainstream EU thinking, but the pace is slow and change is piecemeal. Whether this is good or bad depends on one's vision for Europe and one's hope for the future. One thing is sure, however. Genuine political union will take a long time to emerge. For the reasons sketched out in this study, on morality norms and national culture member governments face a loss of national sovereignty and are required to make adjustments that they do not necessarily desire. But national institutions package reforms in such a fashion that adjustments are ultimately modest and perhaps inconsistent with what prevails in the rest of Europe. Furthermore, the main pressure for change comes from the abolition of borders and the desire of consumers to enjoy goods and services not easily available at home (Kurzer, 2001, pp. 184f)

9. – Moving from the empirical to the normative level, we finally have to come to an overall assessment of the present European situation, of its (likely) development in the future and, especially, of the struggle for a common European bioethics. The starting point for such a normative assessment should be the insight that ethics basically has to do with the freedom and well-being of human individuals. This means, with regard to the problems we are dealing with in this paper, that the central question we have to ask is *not* whether bioethical regulations come from national political authorities or from supranational institutions; instead, the central questions are:

- (a) Are these regulations simply politically imposed, or do people agree with them, do they accept them?
- (b) What is the content, the aim and the effect of the regulations; especially, do they restrict the freedom of individuals and infringe their well-being or do they enlarge their freedom and foster their well-being?

The first question pertains to political legitimation, not only in a narrow or formal sense. It is realistic to say that there is a certain suspicion among the public in all European countries concerning EU regulations *in general*. The EU institutions seem to exist and to decide far removed from the citizens who are subject to their regulation. Moreover, these citizens are accustomed to national parliaments passing laws and national governments enforcing them. However, this aversion against supranational institutions and law should not be overestimated; it equally exists with regard to national governments. It is often forgotten that national law is a recent achievement and its ‘naturalness’ an illusion stemming from a deficient historical memory.<sup>19</sup> What seems to be ‘natural’ may change within a few decades and people may soon become accustomed to EU-law just as they have become accustomed to national law. Whether this will happen depends on several factors which can hardly be anticipated, one of them certainly being the content of EU-law and its appreciation by the citizens. Remarkably, some (very few) available data show that just with respect to *bioethical* questions there is a widespread opinion that regulation at a EU level is necessary; at least with respect to embryo experimentation in eight of nine European countries a majority among the population prefers common regulations for the whole EU to national regulation. (Solter et. al., 2003, pp. 198-200) It is hard to judge if this finding can be generalised; it indicates, however, that common EU regulations of bioethical matters have at least a good chance of being accepted by a majority of the population.

Ethically more important is the second question. If we take seriously the insight that the central ethical question pertains to the freedom and well-being of individuals, we shall immediately see that there is nothing inherently moral in any kind of national diversity and/or supranational homogeneity. Diversity and homogeneity *become* morally relevant if they satisfy human needs and individual preferences, if they provide opportunities for human beings to decide their own destiny and live their own life. – If we look at European bioethics and biolaw from this perspective, we have to establish that there certainly has been no general tendency to narrow individual freedom. Quite the contrary: Any sober recapitulation of the history of the last three or four decades shows clearly that the overall

tendency during this period has been a continuous extension of room for autonomous decisions concerning individual bodies, sexuality and health. The proliferation of biotechnological options on the one hand, and a step-by-step retreat of the state<sup>20</sup> on the other have created an increase in individual liberty which would have been inconceivable half a century ago.

If this is the case, which role has the EU played in this process and which will it presumably play in the future? It would be a grave exaggeration to pretend that European unification has played a dominant role in this process; this is elucidated by the fact that EU regulations of bioethical matters began when this process had not only already begun, but had also already reached a considerable momentum. The main factors have been the technological development and a general and pervasive cultural change not only in Europe but in other developed countries of the world, too. But the European institutions and their activities have promoted this tendency (a) by weakening the importance of national boundaries between the European states, intensifying traffic and commerce, and by guaranteeing free movement for patients and professionals. It is hard so see how the prohibition of PID in some countries (e.g. Germany) will continue to exist in the long run, while it is available in surrounding countries. And (b) by a constant pressure on the individual nation states to make possible and facilitate access to biotechnological options and health care services. The admission and availability of abortion in almost all European states is probably the most striking, but not the only example. With regard to the few European countries in which abortion is still forbidden or severely restricted, in 2002 the European Parliament accepted a Report which recommended “that, in order to safeguard women’s reproductive health and rights, abortion should be made legal, safe and accessible to all” and called upon governments of the Member States and the Accession Countries “to refrain in any case from prosecuting women who have undergone illegal abortions”. (European Parliament, 2002, p. 9/17) If this (very controversial, of course) Report is successful one day, there will be less national diversity in Europe; and there will be more individual freedom for pregnant women in Ireland, Poland or Portugal.

There is one final objection to this analysis. We have seen in this paper that the common European bioethics and biolaw which has been constructed and implemented during the recent past includes at least some substantive moral values, 'human dignity' being the most prominent among them. These values build a (rough scaffold of a) particular moral vision, a vision of what human beings essentially are and how they have to behave in the biomedical world. As a corollary of this vision and of its legal implementation, the freedom of choice in some fields is confined. The prohibition of a commercialisation of the human body and its parts, of surrogate motherhood, and of predictive genetic testing outside the established health-care system show that 'human dignity' not only guarantees the protection of individuals from unwanted third-party interventions, but restricts their freedom even where no infringement upon the interests of others occurs. From a liberal or libertarian point of view it seem obvious that a common European bioethics of this kind will impose a particular substantive morality on autonomous persons and thereby not widen, but narrow the range of individual liberty. It is undeniable that there is a tendency in this direction and that there are influential groups (mentioned above) who favour and push for a common European bioethics exactly because they take this to be morally necessary.

If we look at the entire struggle for a common European bioethics from a distant perspective and try to put it in its proper place we will have to come to the conclusion that its effects are not only limited, but – more importantly – are essentially ambivalent. Many of the possibilities and opportunities offered by technologically advanced biomedicine amount to a provocation for the historically grown moral convictions of major parts of the population. The substantive moral values of a common European bioethics are robust remnants of these convictions and form a barrier to certain forms of use of these possibilities and opportunities. But it would be hasty to conclude that this barrier is impermeable or insurmountable. German constitutional lawyers, trained in dealing with the value or principle of human dignity, like to say that while the *violation* of human dignity is *not* allowed, its *interpretation is*. And via interpretation the strong substantive content of 'human dignity' can be gradually changed into flexible procedural norms. Values can be



preserved by thinning them out; and this is what happens to many of them. The prohibition of predictive genetic testing unrelated to any health-purposes certainly restricts the free choice of individuals by preventing them from using this technology. The term “health purposes”, however, can be interpreted in a way which will minimise the number of occasions on which people will be refused the availability of this kind of diagnostics. The requirement of therapeutic legitimation for all kinds of biomedical interventions restricts only marginally the free choice of individuals; it can be argued that its factual effect is to make available (almost) everything, provided that some kind of justification in medical terms can be given.<sup>2</sup> Apart from some exceptions, such as the sale of organs or surrogate motherhood, the European way of regulating biomedical action may in the long run prove to be an effective device for paving the way for a widespread use of modern biotechnology by autonomous individuals.

## V. SUMMARY AND CONCLUSION

(1) During the recent past there have been many intensive efforts to construct and implement a common European bioethics. Among the reasons why this has been judged necessary are immediate political and pragmatic ones, which have to do with the fact that a growing part of research and development in biotechnology and medicine has been shifted from the individual states to the European Union. More importantly from an ethical point of view, however, is a certain assessment by many opinion leaders, ideological groups and

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<sup>2</sup> My analysis converges neatly with the findings of Dominique Memmi, who in her analysis of “statal administration of the human body” comes to the – seemingly paradoxical – conclusion that individual autonomy concerning the human body has been *encouraged* and *made possible* by activities and regulations of the modern state. “Ce qu’on voit apparaître ici au total, c’est la coexistence de trois phénomènes qui sont qu’apparemment contradictoires entre eux: la montée des l’autocontrôle comme idéal, son encouragement mais aussi son encadrement par les instances représentatives de l’État, enfin l’avènement d’un *sujet triomphant*, curieusement encouragé *par les dispositifs de contrôle eux-mêmes...* E’étape contemporaine du processus d’individuation apparaît alors comme un produit de l’État moderne: c’est un processus par lequel les agents sociaux intériorisent les discours del’État plutôt que de les subir sous forme de sanctions juridiques imposées à des pratiques déviantes. Ils peuvent d’ailleurs se contenter d’une adhésion minimale, purement discursive, leur permettant d’être capables des les produire au moment voulu (il suffit d’assister à une demande d’avortement ou und procédure de conciliation de divorce, pour s’en convaincre). Le seul contrôle qui importe alors, c’est celui par lequel sont encadrés les discours que le ,je‘ produisent sur eux-mêmes.” (Memmi, 2000, pp. 14f)

politicians that there are two pervasive developments which form a deep threat to human rights and dignity on the field of bioethics: (a) the revolutionary progress of bioscience and biotechnology and (b) the economic, social and cultural changes epitomized as 'globalisation'. The "Bioethics Convention" of the European Council is the most important document reflecting this struggle for a common European bioethics which is intended to form a bulwark against this threat.

(2) When we look at the agents of these efforts, we find a variety of groups and their (partly harmonising, partly diverging) ethical world-views. This is what should have been expected in a part of the world which consists of modern pluralist societies. And it should come as no surprise when we find that these groups are trying to take advantage of these efforts to construct and implement a common European bioethics, to bring their respective ethical world-views into play, and to take this opportunity to enforce their world-view through the authority of the state(s). What is going on, therefore, may well be described as a battle about the should-be European bioethical identity. An especially strong and influential party in this battle consists of a big coalition of otherwise competing groups which are unified (negatively) by a certain sceptical appraisal of modern science and technology as well as of globalisation; and (positively) by a certain substantial image of the human essence and a content-rich conception of the good. They tend to identify "Europe" with one of its ideological and moral traditions (preferably with the Christian one) and to marginalise the other traditions and moral world-views.

(3) One of the main theses of the present paper has been that it is crucial to make a clear distinction between what the moral aspirations of people or groups are on the one hand, and the European reality on the other. If we look at the latter we will find that attempts to homogenise European bioethics have not been very successful so far. The plurality of standpoints, judgements and traditions has proved to be rather resistant to efforts to construct and implement one common bioethical identity. Although there is considerable pressure in the direction of homogenization, there are also robust factors which have

guaranteed European bioethical diversity so far. And there is no evidence that there ever will be such a thing as a common European bioethics.

(4) This does not preclude that a certain harmonisation of the different European *legal systems* will take place; and that in this context a (more or less) common *biolaw* will originate. It is still an open question how far this process of mutual assimilation of the national legal systems will go. Even if it will go – in the long run – very far, we have every reason to remain sober in this respect. The diversity of the national legal systems is a historically very recent fact and should not be furnished with any intrinsic moral worth. National differences have no value of their own. Morally valuable are not differences between states, but the possibility of *individuals* to decide their own destiny and thereby become different from each other.

(5) While unlikely, it is certainly conceivable that there will some day be one common European or even global bioethics without forming any threat to moral diversity and ethical pluralism. The condition is that this common European bioethics reduces to some essential but thin procedural norms which leave it to the individual moral subjects to make their own medical decisions and to use (or not to use) modern biotechnology according to their own values as long as others are not affected. The beginnings of a European bioethics of today are far from this. But if one considers the developments during the last decades one can hardly overlook the fact that some important steps in this direction have been taken.

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<sup>1</sup> “Les perspectives très sérieuses qu’ouvrent aujourd’hui les thérapies cellulaires en matière notamment de lutte contre les maladies dégénératives méritent un débat approfondi. Il faut l’aborder avec une grande prudence. Ce débat ne doit pas faire prévaloir une conception utilitariste de l’être humain, qui mettrait en cause les fondements mêmes de notre civilisation et porterait atteinte à la dignité de l’homme. Mais il ne peut pas non plus priver l’humanité de la possibilité de faire reculer ses souffrances.” And concerning therapeutic cloning: “Par ailleurs, je ne suis pas pour ma part favorable à l’autorisation du clonage thérapeutique. Il conduit à créer des embryons à des fins de recherche et de production des cellules, et, malgré l’interdit, il rend matériellement possible le clonage reproductif et il risque de conduire à des trafics d’ovocytes.”

<sup>2</sup> For a more general analysis of this change **in** ethical thinking cf. Bayertz, 2002. Within the present volume the contributions **by** David Solomon **give** an analysis of the origin and the prospects of applied ethics, while the paper **by** Kevin Wildes deals more specifically with bioethics.

<sup>3</sup> Cf. the papers under this heading in Mazzoni, 1998.

<sup>4</sup> As a substitute for many other references **I** only mention the essays collected **by** Anthony Pagden, 2002.

<sup>5</sup> The *Council of Europe* must not be identified **d** with the *European Union*. The *Council of Europe* **was** founded during the Cold War in 1949 to foster the idea and the implementation of human rights in Europe, and in 1950 it issued the *European Convention on Human Rights*. Today, it has more than 40 member states, among them all **m**embers of the EU, **as well as** most East-European countries including Russia, and Turkey and **Cyprus**. – For a short history of the activities of the Council of Europe see (Council of Europe, 1995); the appendix of this report lists many documents related to bioethics adopted by the Council of Europe.

<sup>6</sup> Valuable information concerning the background and history of this convention **is offered by** de Wachter, 1997. – The process of globalisation as an important background of the “Bioethics **C**onvention” **is** stressed by Honnefelder, 1999.

<sup>7</sup> It should be emphasised that this impression is not restricted to intellectuals like Habermas. The (former) French Prime Minister Lionel Jospin **formulated** a concept of Europe as a specific way of living, based on a common history and on common values, which **is clearly invoked as** a counter-model to the effects of globalisation: “Il existe un ‘*art de vivre*’ à l’européenne, une façon propre d’agir, de défendre les libertés, de lutter contre les inégalités et les discriminations, de penser et d’organiser les relations de travail, d’accéder à l’instruction et aux soins, d’aménager le temps. Chacun des nos pays a ses traditions et ses règles mais celles-ci composent un univers commun.” (Jospin, 2001)

<sup>8</sup> “Il ne peut être porté atteinte à l’intégrité du corps humain qu’en cas de nécessité thérapeutique pour la personne.” The next sentence requires the consent of the person. (Loi No. 94-653, Art. 16-3) – The German

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penal code in its § 228 regards interventions in bodily intactness as punishable bodily harm if they “offend public decency”, even if the person affected freely agrees.

<sup>9</sup> A detailed analysis of the notion of the human being as depicted in the “Bioethics Convention” is provided by Reuter 2000. – The European Court of Human Rights judged in 2004 “that the issue of when the right to life begins comes within the margin of appreciation which the Court generally considers that States should enjoy in this sphere” and “that there is no consensus on the nature and status of the embryo and/or foetus”. European Court of Human Rights, 2004, §§ 82 and 84.

<sup>10</sup> Even more explicit is the “Report giving an Opinion on the Draft Bioethics Convention”: “The interpretation which the European Commission of Human Rights places on the terms – such as ‘human life’, ‘person’, ‘everyone’, etc. – should facilitate the acceptance of the text of the bioethics convention which does not include a definition of these terms. Otherwise, given the philosophical, scientific, ethical and religious implications, we might become involved in an interminable debate, which would reveal our inability to address rationally and respond adequately to a dynamic situation in which science and technology increasingly enter into the activities of everyday life.” (European Council, 1995, p. 9f)

<sup>11</sup> Frankfurter Allgemeine Zeitung, March 8, 2001. p. 8.

<sup>12</sup> In Switzerland active euthanasia is forbidden; assistance to suicide is legal only when it is not egoistically motivated. There have been two initiatives in the Parliament in 1994 and in 2000 for a liberalisation of the law but a consensus has not yet been reached.

<sup>13</sup> Lord Kennet in an unpublished paper, quoted from: Fluss, 1998. p.13.

<sup>14</sup> An impressive analysis of the historical roots of differences in the debate on euthanasia in the Netherlands and in Germany is provided by Gordijn, 2000.

<sup>15</sup> This assumption has been disputed. In his critical analysis of the “Bioethics-Convention” Gilbert Hottois comes to the conclusion that some of the underlying assumptions of the Convention are not in accordance with, but conflict with the human rights tradition: “...the presence in the convention of some items – for example, technoscientophobia focused on research and development in genetics; the ‘right not to know’; the subtle influence of the ‘slippery slope’ argument raising doubts about the value of knowledge, information, education, ethics of responsibility and the individual capability of judging freely; the poor explanation of a progressivist and ethical policy – all run counter to the human rights philosophical tradition.” (Hottois, 2000, p. 145)

<sup>16</sup> Cf. the detailed overview by Hottois, 1998.

<sup>17</sup> It is an open question whether this general process of a decline in specific regional or national cultures is restricted to Europe and caused by the process of European unification. There are arguments and theories which state similar processes in many areas of the world and predict an end to national cultures. The Europeanisation of culture and morality described in this paper would then be nothing but an element of a worldwide comprehensive tendency of cultural development in general.

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<sup>18</sup> The reader will find a possible philosophical interpretation of this often overlooked fact in the paper of Joseph Boyle. According to him, Thomas Aquinas makes a distinction between self-evident moral principles on the one hand, and judgments based on reasoning that must take into account a variety of moral circumstances on the other. “It certainly seems that bioethical judgments generally fall along a continuum between the immediate implications of moral principles and the detailed casuistical judgments that require the analytical expertise of trained casuists... Consequently, recognising general moral standards should not be expected to remove controversy. When the full details of the circumstances of troubling decisions come to light, controversy must be expected as a matter of the structure of moral reasoning, and any bioethics, global or other, will not remove that.” (p. 14f)

<sup>19</sup> “Present-day Europeans live under their national systems of law, which are almost invariably codified... European courts of justice, the European Commission, the European Parliament and European laws have not yet altered the basic fact that people live under national laws which were produced by the sovereign national states. And most people, no doubt, find this a natural state of affairs, as natural as their various languages. What they do not realise and would be surprised to find out, is that this ‘natural state of affairs’ is, on the time scale of European history, quite recent (going back only one or two centuries) and that the rise of the European Union may turn into a brief and transient phase.” (van Caenegem 2002, p.1)

<sup>20</sup> My assessment differs from Angelo Petroni’s diagnosis on this point, who writes: “In all European countries health care is monopolised or heavily regulated by the state. While in past years the state has rolled back from the control of the economy, there is no sign that the same is happening as far as health care is concerned. One could be tempted to say that the contrary holds. The more the states are losing control over the economy as a result of the common European market and globalisation, *the more they have the tendency to extend their control over other aspects of human life.*” (p. 26f) A possible explanation for this disagreement may be that my analysis focusses mainly on the question of how strongly individual choice concerning the use of biomedical options is infringed upon by state regulations. My thesis here is that in many cases state regulation is a *form* through which autonomous individuals gain more freedom in biomedical matters: Voluntary euthanasia has become a real option for people in the Netherlands *by state regulation.*