Chapter I
FROM BIOETHICS TO BIOLAW

1. Ethical debate in bioethics

The current scientific and technological advances in the biomedical field opens up new possibilities of intervention on life (human and non-human) and, at the same time, it raises new moral questions. Anything that *can* be done, *must* be done anyway?

There is substantial theoretical agreement among scientists, moralists and jurists on the necessity of giving some sort of limits to technological research and applications. There are only a few people left (as far as the theory is concerned) who accept the illuministic conception of complete trust in scientific progress, asking for the absolute freedom of research and application. But, which limits? This is the specific question for moral philosophy. Contemporary philosophical thought is strongly marked by *pluralism*: moral positions differ as far as the choice of principles and values is concerned. There is no absolute unanimity in morality: different moral trends justify different principles and values that should set the boundary line between what is right and what is wrong in biomedical practice.

This is why the main question of the present philosophical debate is: which ethics for bioethics? And it is just at this level of meta-bioethics that the role of philosophy is clear. It deals with distinction between licit and illicit in the tecno-scientific field and biomedical practice. Because of the existing moral pluralism, the values and principles which are proposed in bioethics are extremely diversified.

The problem is in fact that different justifications of bioethics exist. The debate reflects the plurality, an emblematic feature of

today's complex society. It is important to know the main differing standpoints and arguments which appear in the bioethical debate, on a theoretical level.

1.1. Liberal-libertarian theory

The liberal-libertarian [1] perspective in bioethics starts with the assumption of the non-existence and the impossibility to know a common objective truth. The non-cognitive standpoint considers that every effort of unification of the plurality of values is theoretically improbable and not desirable, in so much that it is standardising, and consequently also repressive with respect to the peculiarities. Every subjective ethical view, according to such conception, must be accepted, tolerated and legitimated in its contents, in an equivalent way to any other.

In this perspective, if the sharing of substantial morals is not possible (that is, the common assent on what is good or bad), such sharing however remains possible and desirable within particular "moral communities" in which bonds among "moral friends" are established. In the awareness that the "moral communities" are friendly only inside and extraneous to each other ("moral strangers"), as they do not share the same moral contents. Only with "moral communities" is it possible to agree upon negotiation procedures, formal and extrinsic, in order to resolve bioethical controversies. The procedures consist in the stipulation of contracts or agreements between individuals who have differing substantial moral conceptions, based on "permission" and "informed consent".

These are the only possible sources of moral authority in the libertarian standpoint, in the free market of a neutral liberal society. Proceduralism, in this context, constitutes the only secular morals possible in pluralistic post-modern bioethics, where everyone can keep their own particular ethical private conception and at the same time negotiate publicly. Libertarian bioethics considers that public debate is possible only if the origin of mor-

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[1] H.T. Engelhardt jr., *Foundations of Bioethics*, Oxford University Press, New York 1996; Id., *Bioethics and Secular Humanism*, SCM Press, London Philadelphia 1991; M. Charlesworth, *Bioethics in a Liberal Society*, Cambridge University Press, Cambridge 1993.

al authority is sought not in substantial principles, but in the mere fact of agreeing between subjects or moral communities.

In this standpoint, the principles proposed in bioethics are: the principle of autonomy or permission and the principle of beneficence. The first guarantees the condition of the possibility of morals. The principle of autonomy sets insurmountable limits in the relationship between individuals and sets the boundaries of every moral community. The second one determines the contents of moral life in the identification of a particular sense of what is good. The first determines the moral subject of the individual that autonomously expresses consent. The second is a possible complement of a moral viewpoint that can only be determined within the moral community, encouraging (but not necessarily prescribing) a benevolent attitude among "moral strangers". Benevolence means a sympathetic attitude towards those who are not yet part of, or who are no longer part of, a moral community (in so much as not being able to express consent), introducing them into a "social role".

According to procedural libertarian bioethics only the "moral agent" is a person "in the strict sense" or "in the real sense". The moral agent is able to draw up a contract, to express consent and permission, or to actively participate in moral life, a self-conscious subject, capable of rationality and self-determination. The human beings that are not able to express consent are people in "a broad sense" and "in a social sense", or on the basis of what the moral agents decide or feel.

There are many objections to this perspective [2].

If bioethics is founded on procedures for the negotiation of controversies, only the free moral agent enjoys adequate protection. The individuals who are not able to exercise freedom are not protected, because they do not exercise it yet (embryos, foetuses, newborn babies, infants, but also minors) or no longer exercise it (the brain-damaged, the seriously disabled, the comatose), or those people who have never had and will never have freedom (the seriously congenitally handicapped with no hope of recovery). Prenatal, neonatal, terminal and marginal human life having no contractual ability has a problematic

[2] AA.VV., *Reading Engelhardt: Essays on the Thought of H. Tristram Engelhardt jr.*, Kluwer, Dordrecht-Boston 1997.

statute. The individuals that are unable to give their own consent would become "objects" of the beneficence of the "moral agents", who could decide to protect them, but could also decide to sacrifice them in view of the realisation of other things, such as progress in biomedical scientific knowledge, economic interest, or simply, subjective expectations and desires.

Furthermore, if bioethics is called upon to guarantee the agreement procedures between "moral strangers", without considering the moral content of the decision, how is it possible to resolve the case (far from being rare in bioethics) of decisions of opposing, but contextual and simultaneous, wills? If individuals want contrasting and incompatible things, at the same time and in the same place, bioethics can no longer manage the conflict neutrally, but would end up letting the strongest will prevail over the weaker one.

1.2. Utilitarian theory

Utilitarian bioethics is a consequentialist moral theory, as it justifies moral statements on the basis of the evaluation of the consequences which produce an action and not on the basis of the agent or the act in itself [3]. It is a welfarist theory in that it considers the action that produces the best consequences (with respect to other possible alternative actions) in terms of utility which coincides with welfare. Welfare is the best optimal balance, in comparative terms, of benefits over costs, of preferences/interests (in terms of pleasure/joy) over damage (pain/suffering). The calculation of the useful equally considers the interests of each individual (egalitarianism) maximising the interests of all the individuals involved considered as a whole. The centrality and exclusiveness of utility as an ethical category is considered a self-evident postulate, coming from common moral experience.

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[3] P. Singer, *Practical Ethics*, Cambridge University Press, Cambridge 1993; H. Kuhse, *The Sanctity of Life. Doctrine in Medicine: A Critique*, Oxford University Press, Oxford 1987; J. Harris, *Bioethics*, Oxford University Press, Oxford 2001; R.M. Hare, *Essays on Bioethics*, Clarendon Press, Oxford 1993; J. Harris, *The Value of Life*, Routledge, London 1985; J. Glover, *Causing Death and Saving Lives*, Penguin, Harmondsworth 1977; M. Tooley, *Abortion and Infanticide*, Oxford University Press, Oxford 1983.

In the context of such a theoretical approach there are different versions of utilitarianism. On the basis of the theory of value, the hedonistic utilitarianism of the "mental states" identifies the value with the pleasure produced by an action and the disvalue with the pain, measured according to the intensity, duration, certainty and proximity. The utilitarian theory of the "preferences" identifies the value with the satisfaction and realisation of a desire, autonomously decided by the rational agent. The utilitarianism of the "action" calculates the result of costs/benefits in reference to the single action.

Utilitarian theory in bioethics is rooted in an empirical conception which gives priority to sensation with respect to reason. What counts for utilitarianism, at an action level is, in the first place, the ability to feel pleasure and pain, that is, to have sensations and interests or immediate, instinctive and elementary desires. In the second place, what is important is the ability to prefer pleasure to pain, therefore to have preferences, which constitute the result of a comparison of mental states, in reference to the present but also projected into the future. Lastly, the ability to be autonomous is the preference that coincides with the self-determination of rationality and will.

In this sense, utilitarian theory in bioethics sets out different levels of subjectivity and personal statute on the basis of the different levels of conscience. The minimal level of conscience is the possession of the ability to have pleasant and unpleasant sensations in the immediacy of the present, and therefore possession of the central nervous system as a necessary neurophysiological condition. The intermediate level of conscience is the possession of the ability to carry out the complex elaboration of sensations, through comparison and preferential choice, in the present and future. The maximum level of conscience is the individual's autonomous decision.

Personal subjectivity expresses itself or it disappears suddenly or gradually, grows or decreases according to the level of conscience (sensitivity, self-consciousness as the awareness of oneself in time or subjectivity as the ability to appreciate life, rationality and autonomy). This is a functionalistic conception which reduces personal subjectivity to the presence of functions, defining the level of moral significance of the personal subjectivity according to the intensity and duration of the mani-

festation of the functions (measured, at a quantitative level), irrespective of qualitative considerations (belonging to the species or nature). Whoever has a greater level of conscience has more value, regardless of the nature it has. It follows that personal subjectivity is disassociated from human nature.

In this sense, utilitarian theory accuses the anthropocentric theory of "specism", as it places human beings at the centre of the moral debate in an unjustified arbitrary way. Ethical utilitarianism places sensitive consciousness at the centre of the ethical debate, at a minimal level, and rationality or self-consciousness, at a maximal level. It follows that, on the one hand, human embryos, insofar as not being sentient, are not subjects or persons. On the other hand, however, animals, or rather some animals, are subjects as they are able to feel pleasure and pain. Self-conscious individuals (animals or humans) are subjects or persons in a strong sense, or those who are able to be aware of themselves as continuous subjects in time and to express their own preferences and desires (in reference to the appreciation or non appreciation of their own existence), and are able to elaborate them rationally as well as deciding autonomously. In this sense, the human embryo is not a subject (having not yet developed sensitive ability) but a dolphin or a pig can be a subject (in so much that they have a certain level of conscience).

In the logic of the calculation of the maximisation of pleasure and minimisation of pain, life has value only when it has a certain level of "quality of life", measured in terms of welfare. A life (human and non-human) in which suffering prevails is considered "not worth living". The "right not to suffer unnecessarily" becomes a "duty" to suppress suffering life or life that can suffer, or which causes or can cause too much suffering to others, in the present and in the future. The only limit to the killing of sentient beings can be the presence and the expression of a "preference to live" (that is, being a subject of a life that appreciates its own existence), as long as it is not in contrast with the preference of others. In any case, if self-conscious individuals, irrespective of their existential conditions, evaluate their own life negatively and consider it preferable to die, their desires should be respected. A serious right to life is attributable only to rational and self-conscious persons who prefer to live.

There are many objections to utilitarianism [4].

The arguments proposed are counter-intuitive, and are often in contrast with common sense morals and the generally widespread convictions of society. The reduction of the evaluation of actions only on the basis of the consequences or effects [5] does not explain the moral significance of the intentions of the act. With the result that the subject is responsible for what his or her actions produce, even if they cause only indirectly a certain state of things or has a negative responsibility for not having given rise to a number of states of things. The close connection between actions and consequences produced does not adequately explain the moral experience, in which the subject sometimes makes choices that are not based on the calculation of the usefulness, but on moral sentiment or on one's own projects in life.

Furthermore, it is necessary to stress the difficult compatibility of subjectivity of the maximisation of pleasure and preferences with the demand for common objective social rules. How is it possible to protect, contextually and simultaneously, irreconcilable interests and preferences? And there is always the possibility that an individual may make choices that are in contrast with interests and subjective preferences out of a mere sense of duty. The maximisation of preferences, which may imply the frustration of interests even only for a minority group, justifies a moral duty that is incompatible with equity. The utilitarian collective theory, in view of the achievement of the greatest welfare possible, risks penalising some individual interests even seriously, potentially leading to iniquity, unacceptable for common morals.

For these reasons it is problematic to accept the legitimisation of suppressive actions on human beings. The elimination of a life can never be "painless" (it is one thing to take away pain, and another thing to take away life). Furthermore, a pain

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[4] A. MacLean, *The Elimination of Morality. Reflections on Utilitarianism and Bioethics*, Routledge, London 1993; D.S. Oderberg, J.A. Laing (eds.), *Critical Essays in Consequentialist Bioethics*, MacMillan Press, London 1997.

[5] In the consequentialist standpoint, an action has no intrinsic value or disvalue, but it is bad if it has harmful consequences, approvable if it has acceptable or desirable consequences.

that seems to be unbearable for someone can be for another person or for others (but also for the individuals themselves, at different existential moments) not only bearable but even a reason to live. And, even admitting that a certain existential situation of illness could make others suffer, the indirect effect with respect to others cannot prevail over the direct effect concerning the individual.

1.3. Principlism

The so-called "principlism" is an approach to moral issues that has arisen in the context of the American bioethics reflection [6], and become considerably widespread, to the point of being called the "mantra" of Anglo-American bioethics.

In the sphere of the distinction between the different levels of ethics (theories, principles, norms or rules, judgements and actions), "principlism" considers it possible to elaborate a bioethics at the level of principles. This is a "medium" level, despite the divergence or dissent at the theory level, with respect to which the possibility of reaching a theoretical assent is excluded. It is possible to find a practical agreement on the thematisation of a number of principles of reference without giving a foundationalist theoretical justification. Principles have the function of elaborating an interpretative scheme of reference for the purposes of analysing concrete bioethical *issues*.

The principle of autonomy defines the freedom of the individual understood as non-interference and self-determination, when dealing with intentional, informed/conscious actions without external conditionings. The principle of beneficence refers to the choice of the action that produces the best positive balance between benefits and harm. The principle of non-maleficence derives from the Hippocratic 'do not harm' or do not cause intentional damage. The principle of justice is based on the criterion of distributive equity.

The four principles aim at providing a strategy for a bioethical decision making process and constitute the basis of mediation whereby to stipulate pragmatic agreements on problems.

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[6] T.L. Beauchamp, J.F. Childress, *Principles of Biomedical Ethics*, Oxford University Press, Oxford 2012[7].

They have a non-absolute statute, even though *prima facie*. They are always binding principles, unless they are in conflict with other obligations, making a balancing necessary. They are not hierarchiable and irrevocable, but always reviewable according to the diversity of the particular situations and the specificity of the actual circumstances.

This approach attempts to achieve a mediation between the opposing tendencies of deductivism and inductivism, proposing a "reflexive equilibrium" inspired by the theory of J. Rawls. Principlism seeks a justification in the overall coherence of principles, in the dialectic relationship between common morals (which are born from experience) and systematisation (which is elaborated at theoretical level). Principles are generalisations of pondered judgements, and thus come from experience, but such judgments are subject to correction if incompatible with other principles, according to the logic of harmonisation.

Principles are subject to a dual strategy, one of "balancing" and one of "specification". The balancing consists in the moving of the weight of obligatoriness from one principle to the other in the evaluation of the single circumstances, and thus in the modification of the hierarchy of principles in the case of conflict. Specification indicates the progressive adherence and adaptation of principles to the concrete situation in which they are applied. Principlism is not a systematic, logical and compact system, but nor can it be reduced to case study. It is rather a variable procedural modality, that is referred to principles whose meaning and importance are verified in the single circumstances.

Several criticisms have been made against principlism [7].

Principles risk becoming mere nominal empty references, that can be filled with any content according to different ethical theories and different concrete situations. The lack of a criterion for the definition of the priority of principles means that each principle tends to become the privileged instrument of different theories: autonomy for liberalism, non-maleficence for deontologism, beneficence for utilitarianism, justice for con-

[7] In the context of the critical debate, see in particular: S. Toulmin, *The Tyranny of Principles*, in "Hastings Center Report", 11, 1981, pp. 31-39.

tractualism. Should one not know which principle to privilege, there is the risk of falling into a situationist relativism or into a moral eclecticism. The principle is changed according to the theory that is deemed to be applied to that specific case at that moment. The accusation made against principlism lies in the very lack of a solid theoretical framework of reference that guarantees constant meanings [8].

Furthermore, the model of principles has an intrinsic weakness insofar that on the one hand it acknowledges common morality uncritically and on the other it claims to subject it to a critical examination. But in the absence of a theoretical reference framework the basis is lacking for a criterion that might express a criticism on common morality, making a distinction between acceptable pondered judgments and unacceptable pondered judgements.

Principlism is moreover criticised for the abstractness and rigidity of the interpretative de-personalised scheme that it proposes.

1.4. Virtue ethics

Virtue bioethics [9] contrasts with principlism in its impersonality, abstractness and rigidity and with bioethics based on systematic theories, both of a deontological (founding the moral rules on duty) and consequentialist configuration (justifying moral rules on consequences). The theoreticians of virtue bioethics focus attention on the moral agent and not on the action, personal reflection or in the first person in the attempt to give an answer to the question "What type of person do I want to be?" or also "Who should I be?" in contraposition to the impersonal reflection in the third person that is limited to asking the question "What must be done?".

Virtue bioethics concerns the interior ethical motivation,

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[8] B. Gert, C.M. Cluver, D.K. Clouser, *Bioethics. A Return to Fundamentals*, Oxford University Press, Oxford 1997.

[9] E.D. Pellegrino, D.C. Thomasma, *A Philosophical Basis of Medical Practice*, Oxford University Press, New York 1987; E.D. Pellegrino, D.C. Thomasma, *For the Patient's Good: The Restoration of Beneficence in Health Care*, Oxford University Press, Oxford 1995.

considering the moral action not reducible to a mere extrinsic obedience to rules. It is a bioethical perspective that focuses the reflection on the concreteness and complexity of the situation, the need to formulate prudential judgements on single actions, flexibly adaptable to the single context in which the individual acts.

Thus understood, virtue ethics sets out to configure a correct relationship between philosophy and medicine, considering that the two disciplines cannot be substituted one with the other, nor can they be opposed one to the other. Philosophy must not impose itself on medicine claiming that it adapts to its conceptual categories, nor must it be subjected to medical knowledge which can use it to justify its own arbitrarily chosen ends. Virtue bioethics outlines a way out of this alternative in the setting up of a dialogue between the disciplines, or an exchange that does not generate methodological commingling but recognises epistemological specificity.

Philosophy in medicine is not the application of philosophical concepts to medicine (medical philosophy or philosophical medicine), but must be a critical reflection on medicine. Philosophy is called upon to understand the nature of medicine, its essence, and its goals. Starting from this internal understanding of sense is it possible to grasp the moral rules of medical practice in the virtues of the physician.

This is a bioethical elaboration which comes into the context of a humanistic-essentialistic vision of medicine, against the reductionist conception (on the basis of relativism, conventionalism, and pragmatism) which considers medicine a mere neutral quantitative and value-free accumulation of technical notions useful for practice. Rooted in the philosophy of medicine, bioethics recognises that the very nature of medicine lies in the qualitative understanding of man. In this sense medicine has, and cannot not have, an ethical value. The doctor is called upon, in the name of the vocation of the profession that they practise, to act "for the good of the patient", meaning by good the biomedical value of their health but also their global wellbeing, understood as objective and subjective good at the same time.

Identified in the faithfulness to trust and promise, in benevolence, compassion and prudence, virtue is the ethical obligation that springs from the "act of the profession" and from the

"medical act" before the "reality of the illness". It is the virtue of the "care" understood in the dual sense of cure and care, curing and taking care of. In this context, the cure/care is understood as the attempt to eradicate the cause of the illness, so as to restore in the therapeutic sense the patient's health in a holistic sense. In this respect, the theory of virtue has a pedagogical and clinical value with regard to doctors and healthcare workers, requiring constant and active commitment in their daily work, in the acquisition of the aptitude that might instil the formulation of judgements regarding each concrete case, an aptitude that goes well beyond the mere external obedience to principles formally expressed by theories.

The main objection to this theory consists in the lack of a theoretical framework, that can lead to relativism and situationism, and case by case evaluation.

1.5. Personalist theory

Personalism justifies the intrinsic dignity of the person recognised in every human being, irrespective of the phase of physical-psychic development (beginning or end of life), of the condition of existence (health or illness) or of the properties that they possess or the abilities that they are able to show (sensitivity, awareness, rationality, willingness) [10].

The personalist standpoint refers to the original philosophical conception of the person, ascribable to the classical Aristotelian formulation of "animale rationale" or to the Boetian (and later Thomist) formulation of "individua substantia rationalis naturae". In this conception a person is considered a concrete individual, biologically incarnated in a body, which has its own ontological nature, and which manifests itself in abilities and behaviour (in particular, precisely rationality), but is not ascribable to these.

The ontological theory of the person (or ontological personalism) justifies the priority of nature over functions (whether they be sensitive, rational, self-conscious, determined), holding that

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[10] H. Doucet, *The Concept of Person in Bioethics. Impasse and Beyond*, in D.C. Thomasma, D. Weisstub, C. Hervé (eds.), *Personhood and Health Care*, Kluwer Academic Publishers, Dordrecht 2001, pp. 121-128.

being a person means belonging to the same nature as each biologically human organism, at any phase of development, regardless of the exterior manifestation of certain actions or the conditions of the possibility of their expression. People are distinguished by their functions, they do not coincide with them, in as much as they transcend them. According to personalist bioethics, the ontological alternative is radical. Either one is a person or not a person.

In conditions of "potentiality" (not yet existing), "residuality" (no longer existing), "privation" (never existing), or the non realisation, transitory or permanent, of certain abilities (due to the incompleteness of the development or to the presence of factors, external or internal, which partially or totally hinder its manifestation), the human body does not deny the nature of the human being. It follows that the embryo, the foetus, the infant are "already" people, inasmuch that, even though all the properties have not yet been manifested at their highest level in the biological body being formed, the conditions constituting the necessary support exist for the continuous and progressive dynamic process, which will make the realisation of such features possible. In the same way, the brain-damaged, the person in coma, the insane are "still" people, because even though they are in existential conditions that do not permit the manifestation of certain abilities or behaviour, the absence of functions does not modify their ontological nature. One cannot be more or less persons, according to different degrees of intensity, on the basis of the level of physical or psychic maturation reached by the body/mind, or even regardless of the body/mind. In the personalist standpoint the human body and the person are closely and inseparably interconnected.

The human body has an uninterrupted development that has no leaps in quality. The quality leap is at the beginning and at the end of the process of continuous development. Either all the phases are equally important or none of them are. Any deviation from this logic introduces elements of arbitrariness. The possibility to identify a qualitative leap at one moment (precise or gradual) is not justifiable in the personalist stance.

The mistake of the "separationist" theories (which have separated the person from the human being) consists in not acknowledging that the presence of a function or the presence of

the conditions for its expression presupposes the existence of a subject. It is the existence of the subject that makes the exercise of certain functions possible, not the exercise of the functions that constitutes the existence of the subject. Sensitive, rational behaviours do not exist, but subjects incarnated in a body that feels, reasons and desires exist. Abstract qualities do not exist. Only the concrete determinations of a specific incarnated body exist, identifiable in the human person. Even though it is possible, in fact, to distinguish personal subjectivity from corporeal objectivity, it is not possible, to separate body and person inasmuch as they are united, constitutively in the humanity of being.

Besides, if the coincidence between person and function (sensitivity, self-consciousness, rationality and will) were true, also the adult human individual in a state of anaesthesia or analgesia, sleep, drunkenness or anyway the individual that showed intermittently or momentarily suspended the abilities required for the attribution of personal statute, would not be person.

The phenomenological approach also offers an argument in support of the identification of personal subjectivity and biological corporeity. We are our body, our cells, tissues and organs. We are a psychosomatic unity. The body subject that we feel inside our skin, in its vitality and suffering, is also body object. The co-presence of objectivity and subjectivity, of being and having constitutes the paradox and the mystery of our being human. We can say that we "are" and we "have" a body, as the point of convergence of somatic and psychic is inseparable. Even if the phenomenal manifestation of personal subjectivity appears to be imperceptible, faint and vague, it is a sign of human finiteness, not of the depersonalisation of the body.

In short, the ontology and the phenomenology of the human body show us that the empirical fact to "take seriously", at a bioethical level, is not what appears (the level and intensity of the external manifestation of certain properties, features and functions which are considered relevant), but the origin. Human nature is what we have in common, and does not make us different. Even though some confusion exists between phenomenology and ontology, or between what we perceive externally and what constitutes the being by nature, it must be recognised at

an objective level that it is the same life (or also, the life of the same human subject) which cannot gain or lose value according to the phase of development, without inevitably falling into some sort of discrimination.

The personalist ontological perspective has offered, within the context of the bioethical philosophical debate, a sound justification for the strong reasons for the respect of human life. If the essence of man is the tendency towards the full realisation of himself, there follows a duty to respect life in all its manifestations so that it may come to its natural end. Nature itself, in a finalistic standpoint, has a normative value, that every human being, through rationality, can know (cognitivism). Human life must be defended inasmuch as it is the expression of a personal life, dynamically intent on fully manifesting itself.

In ontological personalism, the principles proposed in bioethics are: the defence of life, its intangibility and the impossibility of disposing of it; the therapeutic principle according to which any intervention on life is justifiable only if it has the aim of curing the subject in question; the principle of freedom and responsibility where freedom recognises as an objective limit respect for others' life; the principle of sociality or the reaching of the common good by means of the good of the single.

The main objection to this theory is the identification of personalism with the religious perspective of 'sacredness of life', which in the name of the absolute value of life restricts individual autonomy and social usefulness.

1.6. Communitarian theory

The communitarian theory is not a homogenous and systematic perspective. It is rather a moral approach, inspired by the Aristotelian (in its reference to the common good) and Hegelian philosophy (in its distinction between abstract morality and concrete ethicality), in the conviction that ethics is embodied in the practices or social actions of the community, made up of groups of individuals (family, society, State) that define the shared collective values of "good life", also on historical and traditional bases.

This is a perspective that is in opposition with formalism and universalism, recovering at ethical level the reference to the

concreteness and specificity of the practice, with particular attention to virtue (in contraposition to principlism). This theory is in contrast with liberalism and utilitarianism, recognising that acting together as the cooperation and responsibility of the group for the individual and of the individual for the group goes beyond self-determination and convenience. In the community perspective, ethics has the constitutive function of defending the common good and solidarity.

Ethics with a community approach [11] focuses attention on the sharing of the ideals of a good life embodied in the practices of the historically and culturally positioned community, with particular reference to the rethinking of the objectives of medicine in view of the good of the community and the role of medicine in social life to elaborate a "socially beneficial medicine".

There is a proposal to return to the idea of community understood as a place where ethos is handed down (collective traditions, memories, history, culture, morals of a people), in which individuals are not isolated. In the community the values of reciprocity are rediscovered and the cooperation agreement is strengthened for the pursuit of intrinsic goods for a structured community life [12]. There is a reference to the practice of medicine and the values/virtues inherent in the medical profession. The emphasis is placed on the role that the traditional community practices can have in amending socially negative outcomes, promoting the ideal of good life as a common good.

Retaining that human society is made up of "spheres of justice", communitarian theory recognises that the concept of justice must be elaborated and founded communally, stating that healthcare must foresee rights at a decent minimum level of care for everyone and that every community must define its own standards of cure/care (the care should be proportional to the illnesses and not to wealth) [13].

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[11] D. Callahan, *The Troubled Dream of Life*, Simon & Schuster, New York 1993.

[12] A. MacIntyre, *After Virtue: A Study in Moral Theory*, University of Notre Dame Press, Notre Dame 2007.

[13] M. Walzer, *Spheres of Justice: A Defence of Pluralism and Equality*, Basic Books, USA 1984.