

NCBI Bookshelf. A service of the National Library of Medicine, National Institutes of Health.

Wilson D. The Making of British Bioethics. Manchester (UK): Manchester University Press; 2014.

Conclusion

While she became associated with British bioethics following her engagement with IVF and embryo research in the 1980s, Mary Warnock is better known today for her views on euthanasia.¹ Warnock first engaged with this issue in 1993, when she was appointed to a House of Lords Select Committee that investigated whether there were circumstances in which ‘assisted dying’ might be permissible, when a doctor would not be prosecuted for ending a patient’s life or helping them end their own lives. After deliberating for a year, Warnock and her fellow committee members agreed that the law surrounding euthanasia should remain the same. They argued that doctors who actively killed a patient should continue to be charged with murder, while those who helped a patient end their lives should continue to be prosecuted for aiding or abetting suicide. In line with the legal distinction between killing and letting die, which underpinned the verdict in the *Arthur* case, the committee also agreed that doctors should not be prosecuted² for withdrawing or withholding treatment, or for administering a drug to relieve pain knowing it would shorten life.

Despite the Select Committee’s conclusions, euthanasia remained a contentious and high-profile issue. This was due in no small part to the campaigns of terminally ill patients such as Diane Pretty, who suffered from Motor Neurone Disease and sought legal assurances that her husband would not be prosecuted for helping her commit suicide. Although Pretty lost her 2002 case at the Court of Appeal and the European Court of Human Rights, continuing support for the ‘right to die’ led Lord Joffe, a human rights lawyer, to try and get the House of Lords³ to approve several Private Member’s Bills that permitted assisted dying under strictly defined circumstances.

Assisted dying also remained ‘in the public eye’ thanks to the regular and very public arguments of Mary Warnock.⁴ In 1998 Warnock claimed that bioethics had a vital role to play in debates on assisted dying, by ‘helping lift some of the burdens of value judgements from the⁵ shoulders of individual practitioners’ and determining whether the law was ‘too much out of line with ethical beliefs’. As she increasingly contributed to public debates, it soon became clear that the law was now out of line with Warnock’s own ethical beliefs. Although she and her fellow committee members had rejected calls for assisted dying in the early 1990s, she changed her views after watching Geoffrey Warnock suffer and eventually die from the lung disease fibrosing alveolitis in 1995.⁶

In a 2003 piece for the *Sunday Times*, Warnock voiced regret at having supported a ‘bad law’ and threw her weight behind Lord Joffe’s and Diane Pretty’s campaigns for legal change.⁷ In newspapers, television programmes and books such as *Easeful Death*, she now claimed that it was ‘inhumane’ to deny people the right to die.⁸ She argued that this included not only terminally ill patients, but also individuals who felt they were a burden on their families due to disability or old age. When it came to assisted dying, Warnock argued, doctors had⁹ a pressing duty, ‘unless their religion forbids it’, to respect the autonomy of dying, elderly and disabled patients.¹⁰ In a 2008 column for the *Observer*, she stressed that ‘we have a moral obligation to take other people’s seriously reached decisions with regard to their lives equally seriously, not putting our judgement of the value of their lives above theirs’.¹¹

Warnock’s support for assisted dying is significant in a number of respects. It shows, first, how¹² an individual’s ethical views are not fixed and can change according to what the *Observer* called ‘the lessons of life’. Secondly, and more importantly, it shows just how much authority bioethicists are thought to wield over public affairs. Whether they were for or against the ‘right to die’, journalists and politicians all agreed that Warnock’s involvement¹³ was hugely important because she had been ‘Britain’s chief moral referee for the past thirty years’.¹⁴ As the *Daily Telegraph* noted, opponents of assisted dying feared that her arguments ‘may find wider support because of her influence on ethical matters’.¹⁵ Members of a ‘Right to Life’ campaign group, for example, believed that Warnock’s influence ‘would sway people’ towards her views. And the Conservative MP Nadine Dorries similarly worried that ‘because of her previous experiences and well-known standing on contentious¹⁵ moral issues, Baroness Warnock automatically gives moral authority to what are entirely immoral viewpoints’.

Warnock’s views were seen as highly significant not for their rightness or wrongness, then, but more for the weight they carried thanks to her ‘moral authority’. We must not presume that this authority derived solely from her status as a member of the ‘Great and Good’ either, for other bioethicists are also regarded as high-profile and authoritative figures. In 1982 the BBC chose Jonathan Glover to present a *Horizon* programme on genetic engineering and enhancement, entitled ‘Brave New Babies’, in which he discussed ethical issues with scientists, students, members of

the public and his own children. The fact that a philosopher fronted an episode of the BBC's flagship science series again shows how bioethicists emerged as a 'new epistemic power' in Britain from the 1980s onwards.¹⁶ Some years later, in 2006, the *Independent* newspaper included John Harris in its 'Good List' of the 'fifty men and women who help make the world a better place'. Like Glover, Harris was a high-profile figure and the *Independent* claimed that his inclusion on the 'Good List' resulted from his status as 'a key player in the shaping of the moral debates around human fertility and bioethics'.¹⁷

The profile and authority that Warnock, Glover, Harris and others have attained demonstrates that bioethicists now play an equal and sometimes greater role than doctors and scientists in publicly discussing the ethics of issues such as assisted dying, embryo research and genetic engineering. Although the notion of moral expertise remains contested and many bioethicists refuse to acknowledge it, they are often portrayed as what the *Guardian* called 'ethics experts'.¹⁸ Thanks to escalating mistrust of club regulation, both in public and, crucially, in government, they derive their authority from being 'expert outsiders' who are independent from the profession or procedure under scrutiny.¹⁹

Their portrayal as 'ethics experts' confirms that bioethicists have indeed contributed to a shift in the location and exercise of biopower in Britain. The days of 'club regulation' are a thing of the past and we no longer believe that expertise in medical and scientific ethics is inscribed solely within doctors or scientists, imbued through professional training and the acquisition of specialist knowledge.²⁰ As previous chapters have shown, and as Nikolas Rose outlines, 'multiple forces now encircle' the work of doctors and scientists, and bioethicists are widely expected to help 'shape the paths taken, or not taken' by research.²¹ The public demand for bioethics also substantiates Brian Salter's claim that the late twentieth century has witnessed the growth of a 'cultural biopolitics', where bioethicists do not directly control bodies or populations *per se*, but help clarify the ethical values that determine the fate of technologies and procedures which can subsequently impact on individual and collective health.²²

But historical research can do more than simply corroborate these broad claims. Rabinow and Rose outline how contemporary biopower, in which we can include 'cultural biopolitics', combines three overlapping 'dimensions or planes'. These comprise a form of public discourse about living beings and the array of authorities that are considered competent to speak the truth; modes of subjectification in the name of individual and collective health; and strategies for intervention upon patients and populations. They argue that these planes are 'continually recombining and transforming one another' and claim that we therefore need to work on a 'small scale' in order to detail how and why configurations of biopower differ markedly over time and in different locations.²³ When we consider bioethics, history is vital for showing how bioethicists have had a different impact on these various aspects of biopower in specific locations, thanks to the outlook of individuals and professions, and their interplay with social and political factors.

If we take each of these 'dimensions or planes' in turn, it is clear that British bioethicists exerted their greatest influence in public debates. From the 1980s onwards they came to shape the discussion of issues that were once left to doctors and scientists. They were clearly deemed more than competent authorities in these debates, as their portrayals as influential 'moral referees' and the reward of knighthoods for 'services to bioethics' demonstrates.²⁴ Bioethicists also played a decisive role in the second domain of biopower and helped create new subjectivities when they led these public debates. In their discussion of assisted dying, IVF and other issues, they regularly framed patients and the public as empowered stakeholders who were 'entitled to know, and to control' biomedical practices.²⁵ These portrayals carried weight thanks to the way they reflected, and reinforced, the neo-liberal conception of individuals as 'active citizens' who were entitled to a greater say in the running of professions and public services.²⁶

Charting these links is central to understanding why bioethics emerged as a recognised term and approach in Britain. While calls for external involvement were by no means new, they gained traction in the 1980s because they dovetailed with the Conservative government's enthusiasm for oversight, transparency and public accountability. Yet bioethics was not simply the top-down result of political pressure, and owes as much to the agency of specific individuals and groups as it does to changing sociopolitical contexts. Figures such as Ian Kennedy and Mary Warnock endorsed outside involvement for specific reasons, such as empowering patients, introducing American forms of oversight and applying philosophy to practical affairs. Their public rhetoric was not simply a reaction to growing calls for external involvement but was fundamentally constitutive of it, which shows how these public figures generated and helped perpetuate the demand for bioethics, and played a major role in their own transformation into 'ethics experts'. At the same time, this changing context also led prominent doctors and journals to accept calls for external oversight, in the belief that it would maintain public and political trust in research.

The political demand for ‘non-expert’ involvement also allowed lawyers, philosophers and others to play a vital role in regulatory inquiries that had been traditionally dominated by doctors and scientists. This ensured that they had some influence in the third domain of biopower: helping to define ‘strategies for intervention upon collective existence in the name of life and health’ by developing guidelines for procedures such as IVF, gene therapy and xenotransplants.²⁷ These appointments gave bioethicists a major say in shaping legal guidelines for new techniques and allowed them to help determine whether, and when, entities such as *in vitro* embryos were entitled to legal protection.

But in contrast to their American counterparts, British bioethicists had far less say over medical treatment and research, which remains the major source of strategies for determining individual and collective health. This difference was not lost on participants at a 1987 ‘Anglo-American Conference on Biomedical Ethics’, which was held in New York and co-sponsored by the New York Academy of Sciences, the Hastings Center and the Royal Society of Medicine.²⁸ During a planning meeting, members of the British organising committee, which included Gordon Dunstan and Sir Douglas Black, had suggested that an ‘interesting and fruitful’ approach would be to look at ‘topics that reveal differences between the UK and USA’.²⁹ Staff at the Hastings Center claimed that discussing the ‘marked differences’ between Britain and the United States would ‘foster an understanding and mutual appreciation for the work that goes on in each country and, moreover, should enable participants to return to their countries with new insights for dealing with the issues confronting them’.³⁰ Both organising committees initially proposed that papers could look at contrasting approaches to embryo research, which ‘continues in the UK, but has been almost completely stopped in the USA’. But they eventually agreed that the most fruitful discussion would result from concentrating on the role that bioethicists played in determining ‘the rights and duties of physicians and patients’ in either country, since it was here that the greatest differences were apparent.³¹

The legal philosopher Gerald Dworkin, then working at Queen Mary University in London, highlighted the major differences in his paper on the ‘delicate balance’ between ethics, law and medicine in Britain and the United States. Dworkin claimed that British bioethicists exerted less influence over medical practices thanks partly to the ongoing lack of a ‘permanent review body’ such as the President’s Commission, which drew up guidelines for new procedures and also issued guidelines for medical treatment in the United States.³² Shortly before it was disbanded in the early 1980s, the President’s Commission had recommended the establishment of hospital ethics committees which included bioethicists, doctors and community representatives. Although this recommendation was not legally binding, many hospitals established their own ethics committees to conduct reviews whenever a family and their doctor disagreed about life-sustaining treatments.³³ Dworkin noted that in Britain, by contrast, where there was a ‘long overdue’ need for a national committee, bioethicists only influenced practices as members of occasional *ad hoc* committees into new technologies, remained in the minority of professional bodies such as the BMA and were completely absent from NHS hospitals.³⁴

Dworkin and other speakers also outlined how the growth of hospital ethics committees, and the influence bioethicists had on clinical care, stemmed from an increasingly litigious culture in the United States, where judges often ruled against doctors and ‘the traditional paternalistic role of the adviser is being more and more questioned’.³⁵ With American doctors ‘exposed to increased liability to litigation’, they viewed ethics committees and bioethical advice as a vital way of resolving conflict and forestalling damaging legal cases.³⁶ Dworkin and other speakers noted that the British courts, by contrast, continued to endorse the *Bolam* ruling and ‘prefer to accept rather than condemn the practices and ethical standards of the medical profession’.³⁷ As Ian Kennedy acknowledged in *Unmasking Medicine*, and as the endocrinologist Sir Raymond Hoffenberg detailed in his paper, the continued ‘hands-off’ stance in Britain was widely seen as a precondition of the welfare state, where ‘it is accepted that limitation of choice, indeed of the range of treatment, is part of the price we pay for open and free access to our health service’.³⁸

Faced with little threat of legal interference, British doctors continued to assert that involving outsiders in clinical treatment would harm patient care and damage the morale of doctors.³⁹ These arguments ensured that politicians did not take ‘an obtrusive role’ when it came to medical practices, despite their enthusiasm for oversight, while they were also supported by figures such as Ian Kennedy, who promised that they were not looking to judge medical care on a ‘case-by-case basis’.⁴⁰ As Gordon Dunstan outlined in his conference paper, this ensured that while philosophers and lawyers played a central role in determining clinical practices in the United States, ‘in the United Kingdom we locate those functions firmly within the profession of medicine: the doctors themselves are the moral agents we hold accountable for their decisions’.⁴¹

The papers from this ‘Anglo-American Conference’ illustrate that while bioethics has certainly played a role in reshaping our contemporary ‘politics of life’, its impact has varied according to social, political and professional factors in different locations. The influence that bioethicists exert over the various settings where biomedical knowledge is generated and deployed, such as the clinic, the courtroom, regulatory commissions and the public sphere, differs considerably within and between countries. If we are to draw any broad conclusion from this evidence, then, it is that British bioethicists enjoyed considerable influence in public debates and *ad hoc* committees that drew up guidelines for new procedures, but had less influence in governing medical treatment than their colleagues elsewhere. Yet this also comes with an important caveat, for by showing how the influence and contours of bioethics are ‘fluid and changing with context’, history reminds us that its status and authority are likely to change in future, both in Britain and elsewhere.⁴²

Remaking bioethics?

Indeed, there are signs that such a change is underway if we look at British bioethics today. While the broader climate has been conducive in the past, changing political and financial priorities now threaten bioethics with ‘retrenchment and decline’.⁴³ Criticism of the ‘ideology of accountability’ has grown since the CHAI was shelved and continues to prompt questions about who should judge medical and scientific practices. This was clear in March 2010, when Labour’s Health Secretary, Andy Burnham, responded to claims that regulation was ‘stifling’ innovation by inviting the Academy of Medical Sciences to review the governance of biomedical research.⁴⁴ The Academy’s working party was chaired by the pharmacologist Sir Michael Rawlins and was composed predominantly of senior doctors and scientists, with only three of its nineteen members drawn from outside the NHS or the biomedical research sector.⁴⁵

Their report, published in January 2011, argued that medical progress was being ‘seriously undermined by an overly complex regulatory and governance environment’.⁴⁶ The committee echoed Onora O’Neill when they claimed that there was no evidence to suggest that increased oversight had ‘enhanced the safety and wellbeing of either patients or the public’.⁴⁷ They argued instead that oversight had ‘the potential to undermine public health by delaying important medicines being investigated in clinical trials’.⁴⁸ Their solution to this ‘cumbersome’ environment notably lay in ‘streamlining regulation’.⁴⁹ This entailed the formation of an overarching Health Research Agency (HRA) that would ‘bring together the regulatory functions that are currently fragmented across multiple bodies’.⁵⁰ While the committee’s report claimed that the HRA should contain some patient representatives and a mixture of ‘medical, scientific and ethical’ professionals, it stressed that oversight worked best when conducted by ‘an informed committee with relevant expertise’.⁵¹

Crucially, the proposals of this ‘Rawlins report’ dovetailed with the policies of the Conservative–Liberal Democrat coalition that had been formed after no party gained an outright majority in the 2010 general election. Coalition politicians quickly agreed that a sizeable national deficit should be reduced by cutting government spending and rationalising public services. Partly thanks to this austerity programme, and partly thanks to an ideological rejection of ‘big government’, they pledged ‘a radical simplification of the regulatory landscape for medical research’ after the election.⁵² Writing in the *Observer* shortly after this announcement, the Prime Minister David Cameron notably promised ‘no interference – just real power for professionals’.⁵³

In October 2010 coalition politicians announced the planned abolition of 192 advisory bodies, including the HFEA, the HTA and the HGC.⁵⁴ They proposed that the HFEA’s regulation of fertility treatments should move to the Care Quality Commission, while its research licensing work and the functions of the HTA were to be absorbed by ‘a new super-regulator’.⁵⁵ After the coalition approved the Rawlins report in its March 2011 budget, it announced that this super-regulator would be a new Health Research Authority, which was established in December 2011 and began work on creating ‘a unified approval process’ for biomedical research (after concerted appeals, the HFEA was ultimately saved from this ‘bonfire of the quangos’ in 2013).⁵⁶ The government’s ‘simplification’ of the regulatory landscape also underpinned the reconstitution of the HGC as an Emerging Bioethics and Advisory Committee (ESBAC) in 2011, which was tasked with advising ministers and relevant stakeholders on ‘emerging healthcare scientific developments and their ethical, legal, social and economic implications’.⁵⁷

While ESBAC had a wider remit than the HGC, committee members and the Department of Health were clear it should not be regarded as a national bioethics committee.⁵⁸ The government’s austerity programme, meanwhile, ensured that ESBAC had fewer financial resources than its predecessor and was expected to undertake ‘adept networking and collaborations with external bodies in order to pool resources’.⁵⁹ Unusually for a body with the word ‘bioethics’ in its title, ESBAC was chaired by the clinical pharmacologist Sir Alasdair Beckenbridge, and only seven of its seventeen members were non-doctors or scientists.⁶⁰

At the same time, David Cameron's 'Big Society' initiative, which encouraged charities and private firms to assume roles previously fulfilled by the state, meant that politicians were less likely to establish public inquiries into science and medicine and appeared to limit the scope for 'official bioethics'.⁶¹ This was made clear in a recent Commission on Assisted Dying, which was established not by the government but by the entrepreneur Jonathan Lewis and the author Terry Pratchett. To retain their policy influence, bioethicists will have to accommodate these changing structures. And if future commissions or inquiries are no longer state-supported, bioethicists will have to ask questions about their legitimacy and possible bias – especially following criticism of industry-funded bioethics in the United States, where critics argued that bioethicists were unwilling to 'bite the hand that feeds them'.⁶²

The future of many academic bioethics centres is also threatened by the coalition government's decision to cut university funding and increase student fees.⁶³ In an obituary of Mary Lobjoit, who died in 2011, Margaret Brazier, Raanan Gillon and John Harris warned that 'cash strapped' institutions were likely to attach 'less value' to postgraduate degrees in bioethics, which attract fewer students than courses in medicine, science or engineering.⁶⁴ At the time of writing, some of these centres, which act as entry points to the field, are scheduled to close and others face an uncertain future.⁶⁵

Brazier, Gillon and Harris defended these academic centres by claiming that they provided 'a service to the community as a whole and not just an indulgence for our own academic passions'.⁶⁶ While some assert the continued utility of their work, others claim that bioethics must change if it is to survive. Richard Ashcroft, for example, criticised the 'formalism' and predictability of existing approaches and urged the adoption of new strategies 'to reinvigorate research and debate on our field'.⁶⁷ This included the incorporation of methods from fields such as sociology and anthropology, which Angus Dawson argued should encourage consideration of the commercial, political and cultural factors that 'go beyond the autonomous decisions of individuals' and would help shift the focus in bioethics to 'the complex web of social relations that binds us all'.⁶⁸

These arguments found a receptive audience among social scientists, who were also encouraged to undertake practically oriented work thanks to the continued enthusiasm for 'impact' among universities and research councils. Sociologists and anthropologists, among others, now moved beyond previous critiques of bioethics and outlined how it might benefit from empirical methods. They argued that a more 'bottom-up' approach, based on dense knowledge of particular social settings, would help connect bioethics to the actual expectations of doctors and patients, who regularly displayed preferences, values and forms of reasoning different to those prioritised in bioethical texts.⁶⁹ As social scientists increasingly published in bioethics journals and sat on regulatory commissions, many talked of an 'empirical turn' in bioethics and described it as a 'dynamic, changing and multi-sited field'.⁷⁰

But others contested this shift and claimed that the different approaches that now constituted bioethics were 'not all complementary'. The expanding number of methods and participants, they argued, 'begin from distinctive premises about human nature, justice and social organization and often proceed to different normative conclusions'.⁷¹ To Ruth Macklin, 'increased subspecialization' and the potential for disagreements threatened nothing less than 'the death of bioethics (as we once knew it)'.⁷² As these arguments show, there is still no consensus on what bioethics is or how it should function, and it continues to be remade in line with changing professional and political outlooks. What form and emphasis bioethics will take in future remains unclear, but it is likely to be different from the approach that took hold in the 1980s and 1990s. As Onora O'Neill remarked in 2002, it appears there is still 'no complete answer to the old question: "who will guard the guardians?"'⁷³

Footnotes

Notes

- 1 Jasanoff. Designs on Nature. :152.
- 2 For more background, see Kemp Nick. Merciful Release: The History of the British Euthanasia Movement. Manchester: Manchester University Press; 2002.
- 3 Joffe's conditions were that two doctors must certify that a patient was mentally competent; that the patient must sign a document stating their wish to die; that they must have alternatives explained to them; that they must be able to change their mind in the period between signing the form and death taking place. For more detail, see Warnock Mary London: Continuum; Dishonest to God: On Keeping Religion Out of Politics. 2010:45–46.
- 4 Warnock Mary, MacDonald Elisabeth. Easeful Death: Is There a Case for Assisted Dying? Oxford: Oxford University Press; 2009. p.

vii.

- 5 Warnock. Commentary on “Suicide, Euthanasia and the Psychiatrist” :129.
- 6 In a 2005 interview with the *Observer*, Warnock outlined how her views on euthanasia stemmed from Geoffrey Warnock’s illness, and admitted that his death had been hastened after a medically qualified friend gave him morphine. See McKie Robin. There’s Something About Mary. *Observer*. 2005 June 12; Available online at www.guardian.co.uk/uk/2005/jun/12/schools.education/print (accessed 15 February 2014).
- 7 Warnock Mary. I Made a Bad Law – We Should Help the Ill to Die. *Sunday Times News Review*. 2003 December 23;;9. See also Carr-Brown Jonathon. Peers Recant on Mercy Killing. *Sunday Times*. 2003 December 23;;14.
- 8 Mary Warnock, quoted in McKie, ‘There’s Something About Mary’.
- 9 Warnock Mary. Legalise Assisted Suicide for Pity’s Sake. *Observer*. 2009 October 19; Anon. Dementia Patients’ “Right to Die” *BBC News*. 2008 September 19; Available online at <http://news.bbc.co.uk/1/hi/7625816.stm> (accessed 21 February 2014).
- 10 Warnock. I Made a Bad Law. For more on Warnock’s views on assisted dying and autonomy, see Warnock. *Dishonest to God*. :46–50.
- 11 Warnock. Legalise Assisted Suicide for Pity’s Sake.
- 12 McKie. There’s Something About Mary.
- 13 *Ibid*.
- 14 Beckford Martin. Baroness Warnock: Dementia Sufferers May Have a “Duty to Die” *Daily Telegraph*. 2008 September 18;;11.
- 15 Nadine Dorries, quoted in Beckford, ‘Dementia Sufferers May Have a “Duty to Die”’.
- 16 Salter, *Salter Bioethics and the Global Moral Economy*. :564.
- 17 Anon. The Good List 2006: The Fifty Men and Women who Make Our World a Better Place. *Independent*. 2006 September 1; Available online at <http://www.independent.co.uk/news/people/profiles/the-good-list-2006-414252.html> (accessed 15 February 2014).
- 18 Dyer Claire. Ethics Expert Calls for Legal Euthanasia. *Guardian*. 1994 April 26;;3. This article refers to Ian Kennedy, who urged the House of Lords Select Committee to support a change in the law to allow assisted dying in specific circumstances.
- 19 Boseley Sarah. Man on a Mission. *Guardian*. 2003 June 25;;C2. In this sense, we might conclude that bioethicists offer a prime example of the ‘interactional experts’ who Harry Collins and Steve Evans claim have emerged in recent decades. ‘Interactional experts’, in their view, complement or replace ‘specialist experts’ in public debates and decision-making processes. They have specialist expertise pertaining to a particular field, such as philosophy or law, and apply this expertise to fields in which they have no specialist expertise, such as science or medicine, to satisfy growing demands that policymaking should include ‘the opinion of the consumer’. See Collins, Evans *Rethinking Expertise*. :134. While the emergence of bioethics appears to support elements of this work, more research is needed, thanks in part to ongoing questions over whether there is such a thing as ‘bioethical expertise’ See, for example, Archard. *Why Philosophers Are Not and Should Not be Moral Experts* [PubMed: 19659852] Warnock. *A Question of Life*.
- 20 Rose. *The Politics of Life Itself*. :30–31.
- 21 Rose Nikolas. *Democracy in the Contemporary Life Sciences*. *Biosocieties*. 2012;Vol. 7:459–472. (p. 461).
- 22 Salter. *Cultural Biopolitics, Bioethics and the Moral Economy*.
- 23 Rabinow, *Rose Biopower Today*. :203–205.
- 24 *Ibid*, p. 203.
- 25 Warnock. *A Question of Life*. :xiii.
- 26 Reubi. *The Human Capacity to Reflect and Decide*. :355. [PubMed: 23035387] See also Rose. *Powers of Freedom*. :164–167.
- 27 Rabinow, *Rose Biopower Today*. :203.
- 28 Papers related to the organisation of this conference are held at the National Archives: FD7/2677.
- 29 Gordon Dunstan (chair), *Proposed Anglo-American Conference on Biomedical Ethics*. A Planning Meeting held at the Royal Society of Medicine. 1986 February 26; National Archives: FD7/2677.
- 30 Callahan Daniel. *The Hastings Center: Anglo-American Conference on Biomedical Ethics*. 1986 National Archives: FD7/2677.

- 31 Dunstan (chair), Proposed Anglo-American Conference'; Callahan, 'Anglo-American Conference on Biomedical Ethics'
- 32 Dworkin Gerald. The Delicate Balance: Ethics, Law and Medicine. *Annals of the New York Academy of Sciences*. 1988;Vol. 530:24–36. [PubMed: 3408073] (p. 34).
- 33 On how the percentage of hospitals with ethics committees doubled between 1983 and 1985, see Rothman. *Strangers at the Bedside*. :255–257.
- 34 Dworkin. *The Delicate Balance*. :35.
- 35 Ibid.
- 36 Ibid, p. 21. See also Stevens. *Bioethics in America*.
- 37 Dworkin. *The Delicate Balance*. :24.
- 38 Hoffenberg Raymond. A Tale of Two Cultures; Do We Differ? *Annals of the New York Academy of Sciences*. 1988;Vol. 530:16–23. [PubMed: 3044219] (p. 19). See also Kennedy. *Consumerism in the Doctor–Patient Relationship*. *Listener*. 1980 December 11;:777–780. (p. 778).
- 39 Salter. *The New Politics of Medicine*. :58.
- 40 Hoffenberg. *A Tale of Two Cultures*. :19. Kennedy. *The Unmasking of Medicine*. :119.
- 41 Dunstan Gordon. Two Branches from One Stem. *Annals of the New York Academy of Sciences*. 1988;Vol. 530:3–6. [PubMed: 3044221] (p. 5).
- 42 De Vries, et al. *Social Science and Bioethics*. :5.
- 43 Turner. *Does Bioethics Exist?* :779. Montgomery. *Lawyers and the Future of UK Bioethics*.
- 44 Academy of Medical Sciences, 'Media Statement', March 2010. Available online at www.acmedsci.ac.uk (accessed 15 February 2014). Calls for a review of research governance were originally made in the Academy of Medical Sciences document on *Reaping the Rewards: A Vision for UK Medical Science* (London: Academy of Medical Sciences, 2011). Available online at <http://www.acmedsci.ac.uk>.
- 45 The full list of members is given in Appendix A of the Academy of Medical Science's final report. See Professor Sir Michael Rawlins (chair), *A New Pathway for the Regulation and Governance of Health Research*. London: Academy of Medical Sciences; 2011. p. 114. The non-medical or scientific members were the bioethicist Mike Parker, chair of the Ethox Centre at the University of Oxford; Genevra Richardson, a lawyer from King's College, London; Paddy Storie, a teacher from Harpenden.
- 46 Ibid, p. 2.
- 47 Ibid, p. 3.
- 48 Ibid, p. 84.
- 49 Ibid, pp. 30, 4.
- 50 Ibid, p. 4.
- 51 Ibid, pp. 85, 82.
- 52 Cressey Daniel. UK Embryo Agency Faces the Axe. *Nature*. 2010;Vol. 466:674. [PubMed: 20686541]
- 53 Cameron David. This is a Government that Will Give Power Back to the People. *Observer*. 2010 September 11;:18.
- 54 Cressey. UK Embryo Agency Faces Axe. :674. [PubMed: 20686541] See also Gentleman Amelia. A Quiet Battle for Life: IVF Regulator Aims to Show its Worth. *Guardian*. 2011 January 10;:7.
- 55 Cressey. UK Embryo Agency Faces Axe. [PubMed: 20686541]
- 56 Watts Geoff. New Body Aims to Streamline Approval and Regulation of Research in NHS. *British Medical Journal*. 2011;Vol. 343:7950. [PubMed: 22147933] Sample Ian. Two Healthcare Regulators Spared Axe But Face Efficiency Review. *Guardian*. 2013 January 25;:16.
- 57 Blackburn-Starza Anthony. UK Government's New Bioscience Advisory Body Starts Recruiting. *BioNews*. 2012 March 19; Available online at www.bionews.org.uk (accessed 15 February 2014).

- 58 Meeting minutes and terms of reference for ESBAC can be found online at www.gov.uk/government/policy-advisory-groups/emerging-science-and-bioethics-advisory-committee (accessed 21 February 2014).
- 59 Hogarth Stuart, Salter Brian. Emerging Science and Established Problems – Governing Biomedical Innovation in the UK. *BioNews*. 2012 April 11; Available online at www.bionews.org.uk (accessed 15 February 2014).
- 60 Blackburn-Starza Anthony. Alasdair Beckenbridge Appointed Chair of Emerging Science and Bioethics Advisory Committee. *BioNews*. 2012 May 21; Available online at www.bionews.org.uk (accessed 15 February 2014).
- 61 Montgomery. Lawyers and the Future of UK Bioethics.
- 62 Elliot Carl. Should Journals Publish Industry-Funded Bioethics Articles? *Lancet*. 2005;Vol. 366:422–424. [PubMed: 16054943]
- 63 The coalition imposed an upper limit of £9,000 per year on undergraduate fees, although postgraduate fees can be much higher. Since the majority of bioethics courses are offered at postgraduate level, applications are likely to be affected by this increase.
- 64 Brazier, et al. Helping Doctors Become Better Doctors. :2–3. [PMC free article: PMC3359522] [PubMed: 22518049]
- 65 See, for example, Morgan John. Keele’s Philosophers Stare into the Abyss. *Times Higher Education Supplement*. 2011 March 18; Available online at www.timeshighereducation.co.uk/story.asp?story-code=415539 (accessed 15 February 2014).
- 66 Brazier, et al. Helping Doctors Become Better Doctors. [PMC free article: PMC3359522] [PubMed: 22518049]
- 67 Ashcroft. Futures for Bioethics. :ii. [PubMed: 20500757]
- 68 Dawson. Futures for Bioethics. :224.
- 69 See, for examples, Hedgcock Adam. Critical Bioethics: Beyond the Social Science Critique of Applied Ethics. *Bioethics*. 2004;Vol. 18:120–143. [PubMed: 15146853] Lopez Jose. How Sociology Can Save Bioethics ... Maybe. *Sociology of Health and Illness*. 2004;Vol. 26:875–896. [PubMed: 15610471] de Vries Raymond. How Can We Help? From “Sociology in” to “Sociology of” Bioethics. *Journal of Medical Law and Ethics*. 2003;Vol. 23:279–292. [PubMed: 15301193] Haimes Erica. What Can the Social Sciences Contribute to the Study of Ethics? Theoretical, Empirical and Substantive Considerations. *Bioethics*. 2002;Vol. 16:89–113. [PubMed: 12083157] Kleinman Arthur. Moral Experience and Ethical Reflection: Can Ethnography Reconcile Them? A Quandary for “The New Bioethics” *Daedalus*. 1999;Vol. 128(no. 4):69–99. [PubMed: 11645882]
- 70 De Vries, et al. Social Science and Bioethics. :2–3. See also Borry Pascal, Schotmans Paul, Dierickx Kris. The Birth of the Empirical Turn in Bioethics. *Bioethics*. 2005;Vol. 19:49–71. [PubMed: 15812972]
- 71 Turner. Does Bioethics Exist? :778. see also Bracanovic. Against Culturally Sensitive Bioethics. [PubMed: 23888330]
- 72 Macklin Ruth. The Death of Bioethics (As We Once Knew It). *Bioethics*. 2010;Vol. 24:211–217. [PubMed: 20500758] (p. 211).
- 73 O’Neill. Autonomy and Trust in Bioethics. :6. Emphasis in original.

© 2014 Duncan Wilson.

This electronic version has been made freely available under a Creative Commons (CC-BY-NC-ND) licence, thanks to the support of The Wellcome Trust. A copy of the licence can be viewed at <https://creativecommons.org/licenses/by-nc-nd/2.0/uk/>.

Monographs, or book chapters, which are outputs of Wellcome Trust funding have been made freely available as part of the Wellcome Trust's open access policy

Bookshelf ID: NBK248690