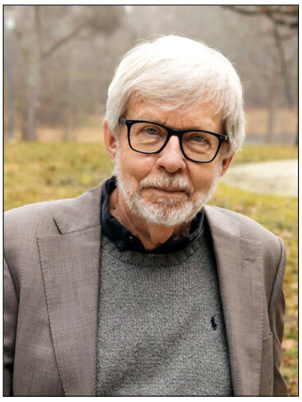
DOI: https://doi.org/10.31874/2309-1606-2025-31-2-17
UDC 17:608:17.03



Torbjörn Tännsjö *Nataliia Boichenko*

Between moral theories and medical reality: a conversation with Torbjörn Tännsjö on the ethics of life, death, and justice

This interview explores the relationship between moral theory and medical reality through an in-depth conversation with Torbjörn Tännsjö, one of the most influential contemporary utilitarian philosophers. Moving between normative ethics and concrete bioethical challenges, the dialogue addresses healthcare priority setting, triage in pandemics and war, euthanasia, disability, distributive justice, and global existential threats. Central attention is given to Tännsjö's methodological approach – described as "applied ethics turned upside down" – which relies on considered moral intuitions tested through crucial thought experiments and subjected to cognitive psychotherapy. The interview examines the practical relevance and limits of philosophical abstraction in real clinical contexts, particularly under conditions of scarcity, uncertainty, and moral distress. Special emphasis is placed on overlapping consensus among competing moral theories, the role of counterfactual reasoning in utilitarianism, and the ethical implications of aging, mental illness, and end-of-life decisions. Situating these discussions against the background of the COVID-19 pandemic and russia's full-scale war against Ukraine, the conversation highlights how extreme circumstances expose latent ethical assumptions embedded in healthcare systems. The interview concludes by

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reflecting on the place of bioethics as applied ethics, its educational mission, and its capacity to inform morally responsible decision-making without claiming privileged principles of its own.

Keywords: *bioethics, utilitarianism, normative ethics, applied ethics, healthcare priority setting, distributive justice, triage, moral intuitions, euthanasia.*

Nataliia Boichenko (NB): You are renowned not only as an outstanding scholar and Emeritus Professor at Stockholm University but also as a public intellectual whose voice resonates beyond your national borders. With your permission, in this interview I would like to explore issues of moral theory and bioethics not only from a foundational philosophical standpoint, but also in the context of the concrete challenges facing contemporary medicine, education, and policy.

I have selected few points that are of keen interest but have no obvious answers. Please share your thoughts on these points and perhaps add your own questions if they are relevant or provide more important development to these issues.

Torbjörn Tännsjö (TT): First, I am grateful for the opportunity to clarify my position on the questions you raise. It goes without saying that I a moved and impressed with your dedication to ethics during such difficult times. Here are my comments to each one of your questions.

NB: *I would like to begin with some clarifying questions regarding the provisions you outlined in your work "Setting Health-Care Priorities. What Ethical Theories Tell Us"* [Tännsjö 2019]. *At the beginning of the book, in the section "Moral Epistemology", you describe the specifics of applying and selecting appropriate moral theories for the distribution of limited resources in the healthcare field. You describe this procedural aspect as "applied ethics turned upside down". Could you explain this approach in more detail?*

TT: The general idea is that in our search of a correct moral theory we need to rely on our considered intuitions. When doing so se presuppose that there is such a thing as a correct moral theory and we presuppose also that our moral intuitions are somewhat reliable. The idea is not that we can always trust our intuitive moral responses, but that we can sometimes do so. In particular, we can do so when they have survived what I speak of as cognitive psychotherapy, i.e., when we have learnt all we can about their origin. An intuitive response, with a content, which has survived cognitive psychotherapy, I speak of as a 'considered' intuition.

So, which is the role of the intuitions. To be able to use them in a fruitful manner we need to construct crucial thought experiments where conflicting basic moral (distributive) theories give conflicting advice. If a theory gives advice at variance with the content of my considered intuition, I provisionally give it up. If it gives advice in accordance with the content of my considered

intuition, I provisionally accept it. However, here a caveat is in need. Several, mutually inconsistent theories, may all give advice compatible with my intuitive response in the situation. In that case I try to find out which theory gives the *best* explanation. This is no different from how we proceed in science. The theory that best explains our observation (in that case) gains evidential support from the observation (in moral theory: the intuition). Here, we search for the most general theory, a theory which can explain the relative success of other theories, and the theory which seems most fruitful in the future pursuit of moral philosophy.

To give an example. We construct a thought experiment where one theory, utilitarianism for example, implies that we should save the life of a patient but where competing theory, such as prioritarianism, implies that it should be sacrificed. If I hold that the life should be saved, then the content of my intuition (in conflict with the implication from prioritarianism) is taken as evidence against prioritarianism. Again, I only do so if my intuition has survived cognitive psychotherapy and still strike me as trustworthy.

Two observations are of importance here. First, the fact that we must rely on thought experiment. This is typical of philosophy in general and of moral philosophy in particular. The reason is that the actual world is so muddy. We have no control of the circumstances of an action in concrete situation. There is no way in which we can isolate the relevant facts. We can do so, however, in abstract thought experiments, where we *stipulate* what will happen if I do one thing rather than another.

The other observation is that justification is personal. A thought experiment can be replicated by anyone, who can react to it. Hence, in moral philosophy justification starts and ends at home.

It could be added that this opens the way for epistemic relativism. Two individuals can be justified in conflicting moral beliefs.

Does it also open the way to moral nihilism? I think not, but that is a matter for some other occasion. I simple presentation of this can be found in my simple textbook *Understanding Ethics* [Tännsjö 2013]. A 4th revised edition is under way.

NB: *To what extent do you think that philosophical thought experiments can adequately capture the moral challenges faced in real medical practice? Within your concept of "cognitive psychotherapy" of moral intuitions, how might a physician distinguish between an intuition that has undergone such reflective scrutiny and a more immediate emotional response to a patient's suffering?*

TT: The idea of crucial thought-experiments belongs to normative ethics. Normative ethics is something moral philosophers are engaged in, of course, but also medical doctors, nurses, and lay people can and should take part. When together we think hard about basic normative questions, we deepen our understanding of basic positions in normative ethics. This allows for the

medical staff to return to the bedside with clearer heads and better methods of investigation. They can attempt to apply their knowledge to the situation they face. It is crucial that there is room for such detached thinking within a medical organisation. The role of the moral philosopher is to take part in it. We should avoid taking part when actual medical decisions must be reached, however, since here we lack the necessary expertise.

NB: *You say that in today's world, we need a new understanding of tolerance and its limits, and this can be done by using the moral theories you looked at (in the first part of the book), which come together to form an overlapping consensus on how to share and redistribute resources in healthcare. You mentioned John Rawls and his conception of justice, as well as the well-known ideas of Robert Nozick, but tell us, what does a fair distribution of resources look like to you? What are the distinctive features of this justice?*

TT: I think utilitarianism gives the correct verdicts on how to use scarce medical resources, but only when coupled with correct but highly controversial assumptions. However, one of the main points in my book is that most theories on distributive ethics seem to point in the same direction: we should use less of the scarce medical resources on what I call marginal life extension and more on the treatment of mental illness (and the care of people suffering from mental illness). We see here an example of what John Rawls has called an overlapping consensus. People who adhere to different theories arrive, for different and mutually inconsistent, reasons at the same conclusion. Another central claim in my book is more pessimistic. Even if there are good reasons for us to reallocate the resources in the manner we should do, if we were to abide by the theories in question, this is not something we in fact will do. Our fear of death and our irrationality stand in the way of such a policy.

It is of note that Robert Nozick's neoliberal theory is different from the ones I discuss in detail. According to Nozick, there exists no problem of how to allocate scarce medical resources. According to his theory of rights, based on self-ownership, it is up to each and any one to pay for the satisfaction of her medical needs, directly or through private insurance.

My discussion is the book is confined to systems of healthcare where healthcare is provided for through taxes. In such systems there is no way of avoiding the problem of priority setting in health care.

NB: *The second part of your book contains extremely interesting and relevant ideas about the application of ethical theories in real life. Since the book was published during the global COVID-19 pandemic, some of the statements in your work have become a useful moral guide for healthcare workers. This primarily concerns triage. In the context of full-scale war in Ukraine, triage is perceived in our society as a necessary but rather strict procedure for determining the priority of providing assistance to victims (mostly on the battlefield). In your opinion, is it possible and advisable to apply fairly strict triage rules to epidemic*

or pandemic situations in peacetime? The question I ask you to clarify is – when exactly the regional spread of a disease becomes a pandemic threat, and therefore when such triage procedures can be applied? In this context, I am interested in your opinion on the decisions of some countries' governments not to comply with WHO decisions or to withdraw from this organization altogether. What is your attitude towards such decisions?

TT: In philosophical discussions about triage, it is fruitful to focus on extreme situations given to us by war and pandemics. This is because in such situation it is impossible to avoid the question: to whom should scarce resources be given? However, the need to set priorities is always with us. This has to do with the phenomenon of opportunity costs. When scarce resources are given to one individual, others must stand back. There is furthermore a tendency to favour individuals with a conspicuous need. Those who suffer the opportunity costs are often merely statistical figures. Since they are not identified, we have difficulties in sympathizing with them. But ideally, statistical persons should count for no less than identified ones. In war and in situation of mass casualties in general, there is a need first of all to see to it that there are resources to distribute in the first place. Those who hold necessary roles in society must be given absolute priority. Those who cure for us, defend our lives, and so forth, must be given strict priority. It is a good idea if they are identified *before* the situation has become critical. Once these with absolute priority have been identified and given their due, standard thinking should guide us. It is a pity that it rarely does. Here my general ideas of focusing less on marginal life extension and more on mental suffering applies. Younger patients should also be given priority before older ones (regardless of whether the matter is assessed from utilitarian or egalitarian grounds, as I show in my book) [Tännsjö 2019]. Yet, again, it is difficult to gain support for such a regulation. In extreme situations most people tend to think like utilitarians. However, in more mundane and relaxed contexts ideas such as respect for 'human dignity' tend to stand in the way of clear thinking. One idea which has turned out to be an obstacle even in extreme situations is the one that we must never give priority to one patient before another one and certainly, not to a younger patient before an elderly one. It has been said that such priority setting violates a principle of human dignity. This is a mistake, however. The idea of equal value for human individuals (dignity) only means that we should be impartial when priorities are set. We should rely only on relevant aspects of the situation. And the age of a patient is a relevant consideration when a choice must be made. We honour the dignity of each patient when setting the priorities with strict reference to, and only to, their *relevant* characteristics.

NB: *You are considered one of the most influential utilitarians of our time. In a conversation with Professor Peter Singer* [Filosofisk podcast 2022]*, you discuss the characteristics of utilitarianism as an example of consequentialist*

ethics, noting that this theory has certain weaknesses. In this context, I have a question about counterfactual situations and counterfactual values: what significance do they have from the point of view of utilitarianism? When thinking about the consequences of their decisions, people often ask themselves, what would have happened if they had acted differently? It seems to me that by taking a certain counterfactual position [Boychenko 2017], *they choose a certain contextual meaning for their behavior – sensual, emotional, rational, value-based, etc. – and give it unconditional significance (something like Foucauldian "historic apriori") in relation to all other possible contexts – within the framework of adhering to a certain strategy for our behavior. Could you describe in more detail the relevance of applying the concept of counterfactuality in the context of utilitarianism and its potential for ethics in general?*

TT: Since 1977 (when I came across arguments against moral realism and found them wanting) I have been a moral realist. Since even longer I have been a hedonistic utilitarian. I think an action is right if and only if there was nothing else the agent could have done such that, had she done it, the sum-total of happiness in the universe would have been larger. To be of any practical importance this criterion of right action presupposes that sometimes, when an agent performs an action, she could have acted differently. Otherwise, all performed actions are vacuously right. I believe that, in a sense relevant to morality, we 'can' sometimes act differently from how we do. I here build on an idea put forward by G.E. More to the effect that I could have performed a different action if it is true of me that, had I decided to perform this different action, I would have done so. Could I have decided differently? The concept of free action does not presuppose that I could, hence we avoid an infinite regress. Together with a former student and present colleague, Maria Svedberg, I have developed this idea more in detail [Svedberg & Tännsjö 2017]. However, this abstract criterion of right action, even if it is correct, is of little help in practical life. We know very little about the consequences of our actions and let alone about what *would* have happened had we acted differently. And to try to account for the relevant alternatives in a situation is also an action. How much time should we devote to it? Again, we face an infinite regress. The solution is to accept moral scepticism about our practical lives and yet, for all that, try to do ones best to do as little harm and as much good as possible. It is necessary to device a decision-procedure we can follow consistently in the hope that when we do so the result is at least not worse than if we would have proceed in any other manner. We must give up on the idea that we should always perform the right action. The exact device of the method of decision-making differs from situation to situation and from agent to agent.

Take first political authorities engaged for example in priority setting in healthcare. Here it is natural for them to spend considerable time on finding out which are, in a situation, the relevant alternatives. In a next step it is of im-

portance to investigate different possible outcomes of the choices open to the authority. The probability of different outcomes must be assessed and their relative value (measured in terms of happiness among everyone affected). In a further step it is reasonable to opt for the choice where expected happiness is maximized.

Note that the first step here must be taken without being preceded by any rational calculation (otherwise the problem with an infinite regress opens). A special problem is that the choice must be based on a realistic assessment of what people will in fact to, rather on what people ought to do. Future moral mistakes must be considered. This has shown to be of the utmost importance when scarce resources are distributed in a publicly financed healthcare system.

On a personal level the method of decision-making is likely to take a more complex form. In some situations, assess the relevant alternatives and try to maximise expected happiness. In other situations, however, rely on habit and allow yourself some spontaneity. No one wants to befriend a person who always calculates the expected happiness of her actions!

Regardless of how you do, you must acknowledge that you will perform less than perfect actions. You must be satisfied with an attempt to do the best you can, and to do so in the hope that this is best you *can* do. In the end, it all boils down to a matter of hope and trust.

NB: *Continuing the dialogue on the characteristics and limitations of various moral theories, I would like to address John Stuart Mill's assertion that individuals may live and act as they please as long as their actions do not harm others. In your opinion, can we today take such a detached position and feel like autonomous moral agents without obligations to others? What is your opinion about ethical minimalism in general, and how does this position align with the principle that ethics always provides people with ethical maxims as guidelines for their behavior?*

TT: Taken literally Mill's slogan is hopeless. Just think of tax evasion. If you do not pay your taxes the effects on others are negligible. However, it should not be permitted to evade taxes. The simple solution is perhaps to add that also actions of *a kind* such that, when many people perform them cause harm to others, should be prohibited. I feel sympathetic to such ethical minimalism when practiced on a personal level. However, political problems are of another order and here an activist position is required. We live in a world where global existential threats are real. I think of the possibility of all-out nuclear war and global heating among other things. The individual should be involved in such political matters, even if, from an individual perspective, participation seems to make little sense. Remember that only a slight possibility that my action will be decisive to the outcome renders my action rational, given how much is at stake. The stakes are *huge* in relation to global existential threats.

It is sometimes said that utilitarianism is overly demanding in terms of self-sacrifice. This may be so in some cases, but the reason why it is demanding in those cases is not best explained with reference to any problem with utilitarianism. The explanation can instead be found with reference to the world as such and the bad state in which it is. In a well-ordered and peaceful welfare state there is room for us all to relax.

I realise that it may sound naïve, bordering on cynicism, to say so to people who live in a situation of war. And yet, we must keep our hope for the future.

NB: *One of the interesting methodological elements of your work "Setting Health-Care Priorities. What Ethical Theories Tell Us" is the reference to considered moral intuitions and the practice of cognitive psychotherapy. You noted that moral intuition requires clarification of its origin before it can be used as evidence (of a moral position). In other words, on the one hand, you presented a rigorous analysis of moral theories, and on the other, you confirm the intuitively perceptible "inner language of moral choice." Perhaps rational reasoning is a necessary prerequisite, but it cannot be considered a sufficient basis for ethical decision-making? So what is the role of moral feelings in ethical decision-making?*

TT: The reference to intuitions, when moral theories are put to test in crucial thought-experiments, should not be understood to refer to *feelings*. In many situations, we have reasons to be suspicious of our immediate feeling, such as when we feel that it is wrong to push the big person onto the tracks in the trolley-example where this is the only way of saving several lives. So, in the metaphysical laboratory we should be suspicious of our feelings. However, in our ordinary life, we can often trust our emotive reactions and see them as heuristic devices helping us to the right action. In normal circumstances, one should not attempt to save lives through killing. At the same time, we need to reflect also on such emotive spontaneous reactions. Sometimes we realise that it is right to act against them, such in situation of warfare. There is a definite risk, however, if you systematically set to one side your emotive reaction of care for others, even if this is something for the time being you must do. You should realise that by doing so you jeopardize your position as a compassionate fellow human being, and you should as soon as possible take measures to return to more standard reactions. It is of note that also in medicine the same disregard of spontaneous moral emotions must take place. You must be prepared to cause the patient suffering and to put your knife in her. If not, you will not be able to save her life. Again, it is of importance to be aware of the effect on your moral character where, in the best interest of your patient, you put your compassion on pause. There must always be way back to standard moral thinking.

NB: *The following questions will concern bioethics too. In your recent speeches and interviews, you often talk about the global environmental crisis.*

Indeed, this crisis is one of the most important problems of our time. Back in 1971, a creator of the modern concept of bioethics Van Rensselaer Potter, in his book "Bioethics: A Bridge to the Future" [Potter 1971]*, called this interdisciplinary field of research the science of survival. In your opinion, will bioethical education contribute to solving the global problems of human survival? To what extent should the ideas of bioethics be disseminated in modern education? Should it be a basic understanding of general principles, or, in the context of a global environmental crisis, should each profession develop its own practical solutions that take these general principles into account in a way that is specific to that profession?*

TT: I see bioethical education, not as a field where specific principles are taught or particular solutions to particular problems are advocated. I see bioethics as applied ethics, and since applied ethics relies on normative ethics, where there is no such thing as the state of the art, it would be ridiculous to act as if there existed one. In bioethics people should be invited to think hard about hard choices, to see the relevance of both normative theories and often intricate non-moral facts, to become more sensitive to what is at stake. It is of importance to learn when different opinions depend on fundamental moral disagreement and when they depend rather on different opinions regarding non-moral facts. Since there is no unanimity about basic normative theories it is also of utmost importance to see where a kind of overlapping consensus exists. This is an important theme in my book on priority setting in healthcare.

NB: *You are the author of many books that significantly influence and shape the understanding of contemporary bioethics – "Coercive Care: The Ethics of Choice in Health and Medicine"* [Tännsjö 1999]*, "Terminal Sedation: Euthanasia in Disguise?"* [Tännsjö 2004]*, "The Repugnant Conclusion. Essays on Population Ethics"* [Tännsjö & Ryberg 2004]*, "Taking Life: Three Theories on the Ethics of Killing"* [Tännsjö 2015]*, "Setting Health-Care Priorities: What Ethical Theories Tell Us"* [Tännsjö 2019]*. What place, in your view, should bioethics occupy in the structure of present-day ethics? Does bioethics offer its own values, norms, principles, virtues, and practices, or does it merely interpret classical ethical values, norms, principles, and virtues in a specific way?*

TT: In a way, I have already answered this question. I see bioethics as applied ethics, and applied ethics cannot be separated from normative ethics. In normative ethics every serious theory articulated since antiquity is still with us and, in the most charitable interpretations, they each have competent thinkers who defend them. Again, it is of interest to distinguish between fundamental moral disagreement about bioethical cases and merely a difference of opinion about non-moral empirical fact, bad reasoning, and so forth. It is also of importance to search for situations where an overlapping consensus can be reached. This is what can be accomplished by the bioethicist, but noth-

ing more. There exist no special values, norms, principles, and virtues in bioethics, apart from those we know from ethics as such.

NB: *In your works and public discussions, you often mention the theme of euthanasia. In your book "Taking Life: Three Theories on the Ethics of Killing"* [Tännsjö 2015], *you devoted a special chapter to this issue. How, in your opinion, can the theory of fundamental human rights, including the right to life, be reconciled with euthanasia? Do you agree that criticism of euthanasia is primarily based on moral grounds: on the one hand, there is a potential for negative moral consequences not only for close relatives and medical professionals who may feel responsible for the patient's death, but also for society as a whole and its moral values; on the other hand, there is a suspicion of a cynical pseudo-rational approach, when the voluntariness of euthanasia is questioned, and the real reason is considered to be the lack of healthcare resources, which more or less insistently "pushes" severely ill patients to a fatal decision?*

TT: There was a time when the discussion about assisted death, for an against, was at the centre of bioethics. We are past that time it seems to me. Now it is taken for granted in most discussions that some form of assisted death should be legal, and in many countries, and in a growing numer of countries assisted death has been legalized. The reason it has come to be accepted is that not only do we live longer, but our death is also prolonged. Advanced intensive care can go on for absurdly long time. Moreover, the right of the patient to decide for him- or herself is now taken for granted.

All this means that discussion today is not about whether assisted death should be legal, but in which form it should be legal. Should it be legal only in the form of physician assisted suicide or also as euthanasia, where the doctor, given that certain requirements are fulfilled, kill the patient? Should it be required that the patient is terminal, and supposed to be dead anyway within half a year, or is time irrelevant? Should euthanasia take place only when patients suffer from somatic illness, or should also patients with mental illness qualify?

These are the topics on the agenda right now. My view is the most liberal one. There is only room her to sketch or gesture at my arguments. Not only should physician assisted suicide be legal, but euthanasia should be legal too. Why? We know from the Netherlands that most patients who can chose prefer euthanasia to physician assisted death, which strikes them as a more secure option. They do not want to do the killing themselves and they fear that, when time has come for it, it might be too late. No time limit should be set. The patient need not be terminal. Protracted suffering is worse than more limited (in time) suffering. Psychiatric diagnoses should be included. All suffering is mental (pain is a mental phenomenon) and it doesn't matter if it is caused by a somatic or a mental illness. It is crucial, however, that the patient when he or she asks for euthanasia, and is granted the right to it, is competent. This

means that a patient who is psychotic or in a deep depression cannot gain the right to euthanasia before the acute symptoms are (for the time being) gone. Given such a right to assisted death we can all live more secure acknowledging that, if we may come to need assisted death it will be provided for us. Most people will not use the right to assisted death but all can enjoy the security given by the knowledge that it is available if needed.

Is this overly liberal? I think not. It is crucial that the patient considers the suffering from the disease as unbearable. And it is crucial that two doctors ascertain that the illness cannot be cured. Finally, it is crucial that the provision of euthanasia is only a right, not an obligation on the part of the medical doctor.

Does such a system mean that patients may come to be pushed to a fatal decision, for example with regard, not to their own well-being, but for the sake of the economy of society at large or in relation to the situation of close ones?

If the system is regulated and constantly scrutinized by authorities, the former concern seems misplaced. Very little economic gain for the healthcare system will be made from such a practice anyway.

The thought that people might want to end their lives because they find this to be in the best interest of their close ones may in some cases be correct. But is it not a respectable ground for the decision when you make it in the interest of your close ones? There are for example aesthetic aspects of terminal illness. If you want to spare your close ones some of the uglier aspects of your terminal illness, you should be allowed to do so. After all, concern for others is a perfectly legitimate ground for decisions in other situations. Why not when you are dying?

I can't help suspecting that some of the fear of euthanasia, to the extent that it is still with us, has its ground in a fear and denial of death as such. There is a tendency to think that life can go on for ever. But it cannot. We are replaceable, and we will be replaced.

It is comforting from the point of view of utilitarianism that, what matters in the final analysis, is that there is happy life in the future (for example in the form of my children, grandchildren, and so forth), not that I myself is necessarily around.

NB: ***I would like to clarify:*** *You mention that euthanasia should also be legalized for psychiatric cases. How, then, can the danger of abuse be avoided in systems (countries) where there is distrust of medicine or corruption?*

In your opinion, could palliative and hospice care programs serve as an alternative to different forms of euthanasia?

TT: The spectre of medical systems where corruption exists and, even worse, where political misuse takes place (think of the Soviet use of psychiatry), is a real one. It is difficult to design a system of end-of-life decisions that is robust given such dangers. I have no clear ideas about this. However, we

should see to it that prejudices against disability, even metal disability, doesn't lead to a situation where mentally disable people are denied services of which other patients can avail themselves. I see palliative care and hospice care as natural parts of the system of healthcare, but these specialities should also include euthanasia as a possible choice for patients who prefer to forego not only curative attempts when these are in vain, but also further palliative care. In Belgium euthanasia is part of the system of palliative care. This works well and this is as it should be, it seems to me.

NB: *How do the principles of bioethics (principle of autonomy, principle of nonmaleficence, principle of beneficence, principle of respect for human dignity)* [Boychenko 2023] *relate to the possibility of ending life through euthanasia?*

TT: I am sceptical about these principles. Each one of them could be made precise (in different ways), but when we make them precise we realise that they are mutually inconsistent. Or they can at most be seen as some kind of pro tanto norms; in that case they are all true but it is up to us in particular circumstances to assess which one of them it is that takes precedence (in the situation) over another one. They give no guidance as such.

It is more fruitful to approach the topic of euthanasia in the manner I just did, without any mention of the "big four".

NB: *In your opinion, is it possible to develop a constructive dialogue between utilitarian arguments in favor of euthanasia and perspectives based on Christian ethics and emphasizing the sanctity of life? Do you think there are points of intersection that could make such a discussion more fruitful?*

TT: According to the sanctity of life doctrine it is wrong, period, intentionally to kill an innocent human being. This means that individual cases of euthanasia are wrong. This doesn't settle the question about legislation, however. According to utilitarianism, euthanasia should be legal, if such legislation has the best consequences. It is of note that there is no simple way of reaching the conclusion that it must be wrong to legalize euthanasia, when the matter is assessed from the point of view of the sanctity of life doctrine. To legalize euthanasia is not intentionally to kill any innocent human being. The reason to legalize it could be to have euthanasia taking place under secure and ordered circumstances, acknowledging that if it is illegal it will yet take place but beyond official scrutity. The adherent of the sanctity of life doctrine would not take part in euthanasia, but could perhaps tolerate it in the manner President Bill Clinton was said to tolerate abortion. Abortion should be safe, legal, and rare, he claimed.

NB: *In the already mentioned conversation with Peter Singer, you discussed the topic of disability* [Filosofisk podcast 2022]. *Utilitarian moral theories are often criticized because of the position of their supporters (in particular Singer) on the right of parents to terminate a pregnancy if the foetus is diagnosed with a serious illness. German philosopher Jürgen Habermas has a book in which he argues*

that "the decision to shape a future person's identity through prenatal genetic intervention threatens the freedom and equality to which all persons are entitled as a birthright" [Anderson 2005]. *What are your thoughts on these statements? Can sufficient arguments be made in favor of Peter Singer's position?*

TT: Prenatal diagnosis, abortion, preimplantation genetic diagnosis and eventually gene editing presents a problem in relation to which we need to confront disability. It is a correct observation that Peter Singer and I have approached the topic slightly differently.

I have argued that the state should not regulate our procreative decisions. Why? If the state permits for example that we abort foetuses with trisomy 21 (Downs) but not foetuses with a particular gender (female), the state sends the message that there is no problem with being female but there is a problem with Downs. Some living individuals with Downs may then feel a threat. Are they not welcome in society? A liberal system means that no such threat is posed by the state. But while procreative decisions should be up to the prospective parents, the moral question remains. Are there situations where certain conditions should be avoided through abortion, preimplantation genetic diagnoses or (in a likely future) genetic editing?

There are such cases, I have argued. There exist severe genetic diseases (such as cases of Krabbe Disease) so grim that no one should need to be born with them. However, such diseases are rare. Most abortions after prenatal diagnoses concern foetuses with Downs. Have we moral reasons to avoid that people with Downs be born? No, I have insistently argued. I have argued from the point of view of hedonistic utilitarianism that people with Downs lead as good lives as most people. J.S. Mill was wrong, I have claimed, when he held that it is better to be a dissatisfied Socrates than a satisfied fool. It is of note that for a long time Singer was, unlike me, not only a prescriptivist but also a preference utilitarian. He has not come to accept both moral realism and hedonism. We now agree on basic matters in moral philosophy. His turn to hedonism *should* affect his stance on the abortion of foetuses with Downs, it seems to me.

As to the quote from Habermas, his claim relies on a category mistake. It makes poor sense to claim that a birthright of a child has been violated when it is born as the result of prenatal diagnosis and abortion (of a possible sibling) or gene editing. We here run against the well-known identity problem. Had not this child been born with the genetic history it has, *it* would not have been born at all. At best someone else would have been born in its place. So, unless it would rather have been not born at all we could not sincerely claimed that any birthright of it has been violated. I discuss problems like these in an entry on the repugnant conclusion in *Stanford Encyclopedia* [Arrhenius et al., 2024] presently under revision.

NB: *The issue of disability is very relevant for Ukrainian society today, as we have many wounded defenders of Ukraine and civilians who have suffered from*

the consequences of russia's military aggression. Our new reality is that society will need to adapt to a large number of people with disabilities. In your opinion, what bioethical theories, cases, and tools will be useful for our society to integrate these people into social life as much as possible?

TT: I must confess that the practical aspect of this matter is beyond my expertise. My general take on disability in discussions about priority setting is that we should acknowledge our capacity of adapting to disabilities. When we calculate the value of a medical measure in terms of QALYs (qualitatively adjusted life years) we should assess these with reference to how people who have experienced the disabilities perceive them. This capacity to cope with disability bodes well for how many of these people could be integrated successfully in society. However, there is no doubt that an important problem for the integration is prejudice against disabilities. When the war heroes come home it is natural to give them a warm welcome, but soon they may come to experience another tough reality. People are unable to grasp their true capabilities, and many fear disability as such and keeps a distance for that sake. It is then of crucial importance that society is prepared to help them to a well-functioning life where they can also find a place in the fabric of society; to do so is both a way of acknowledging them as the important resource they constitute and to give then continued sympathy and understanding. To counter prejudice, education of the public is a necessary objective for society. This is the only thing I have published on the topic of disability and utilitarianism [Tännsjö 2009].

NB: *Thank you, Professor, for the interview.*

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***Торбйорн Тенсйо, Наталія Бойченко*. Між моральними теоріями та медичною реальністю: Розмова з Торбйорном Тенсйо. Про етику життя, смерті і справедливості**

Це інтерв'ю досліджує взаємозв'язок між моральною теорією та медичною реальністю через глибоку розмову з Торбйорном Тенсйо, одним із найвпливовіших сучасних філософів-утилітаристів. Рухаючись між нормативною етикою та конкретними біоетичними викликами, в діалозі розглянуто питання встановлення пріоритетів охорони здоров'я, сортування пацієнтів під час пандемій та війни, евтаназії, інвалідності, розподільчої справедливості та глобальних екзистенційних загроз. Центральна увага приділяється методологічному підходу Тенсйо, який описується як «прикладна етика, перевернута з ніг на голову», – який спирається на продумані моральні інтуїції, перевірені за допомогою ключових уявних експериментів та піддані когнітивній психотерапії. В інтерв'ю розглядається практична актуальність та межі філософської абстракції в реальних клінічних контекстах, особливо в умовах дефіциту, невизначеності та морального дистресу. Особливий акцент робиться на перекриваючому консенсусі між конкуруючими моральними теоріями, ролі контрфактичних міркувань в утилітаризмі та етичних наслідках старіння, психічних захворювань та рішень про кінець життя. Розглядаючи ці дискусії на тлі пандемії COVID-19 та повномасштабної війни росії проти України, в розмові підкреслюється, як екстремальні обставини викривають приховані етичні припущення, вбудовані в системи охорони здоров'я. Інтерв'ю завершується роздумами про місце біоетики як прикладної етики, її освітню місію та її здатність інформувати про прийняття морально відповідальних рішень, не претендуючи на власні привілейовані принципи.

Ключові слова: *біоетика, утилітаризм; нормативна етика; прикладна етика; пріоритизація в охороні здоров'я; розподільча справедливість; тріаж; моральні інтуїції; евтаназія.*

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