

The Natural and the Moral Order: What's to Blame?

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“You cannot derive ought from is.” This is a lesson that has been taught generation after generation for centuries. Yet it is regularly ignored. Raine has a story that helps make sense of this. When we want to think about what is right, to understand what constitutes a good society or a good life or a good set of actions---or to figure out how to achieve these---we need a model of order; and our most readily available, and perhaps only suitable, model is that of the order of nature. The natural order becomes our model for the moral order.

I want to develop this story by exploring some examples from an area I have been working in recently, jointly with philosopher of social science Eleonora Montuschi and Eileen Munro, author of the UK Government's 2011 *Munro Review of Child Protection: child welfare*. Here we see that ideas about the moral and the natural order are inextricably intertwined and that different understandings of the natural order flow across to the moral. The central conduit between the two are linked views about causality and responsibility. So, although I illustrate with the child welfare cases, the lessons should apply far more broadly.

When it comes to thinking about causality, there is a venerable tradition in philosophy that pictures the modeling relation the other way round: from the moral order to the natural. This tradition is rooted in the idea that causation, though a relation of central importance to our ability to predict and control, is not a genuine *sui generis* relation in the natural world. What then is it? There are, first off, various versions of the currently popular manipulation theory of causality, that causes are things we can manipulate to produce results. The canonical

version of a second account of what it is due to the legal philosophers H.L.A. Hart and Tony Honoré, who single out from the net of events in the past of an outcome, that the cause is the event that is contrary to the norm, where very often this will be a legal, moral or social norm. The Hart and Honoré account will play a role in my discussion but it is not my central focus for I am looking to cases where different ideas about how causes operate in the natural order support different moral and social norms.

Let us begin with a case. In 2004 in the London Borough of Haringey, 17-month-old Peter Connelly was found dead in his crib. The child had suffered fractured ribs and a broken back after months of abuse at home. His mother, her partner and a lodger were jailed for his death. Peter had been seen by health and social services professionals from Haringey Council 60 times in the eight months before he died. In consequence, blame was heaped on the Director of Haringey Children's Services, Sharon Shoesmith. For instance, the Minister of Education Ed Balls sacked Shoesmith with immediate effect in a live press conference on television; and both the news media and the public were openly hostile to Shoesmith. She even received death threats in the mail for her supposed role in Peter Connelly's death.

There seem to be two rationales for this. One is the desire for prevention; the other, outrage and the need to punish. A BBC news interviewer represented the first when he urged: If nobody accepts the blame, "...how can we stop it happening again?"¹ Eileen Munro gives a good sense of the second when she says: "When society is shocked and outraged by a child's terrible tale of suffering, there seems a basic human desire to find a culprit, someone to bear the guilt for the disaster and to be the target of feelings of rage and frustration."²

Shoesmith defended herself and her Services: "We should not be put into blame"; it does not produce "anything productive" and obscures "the bigger picture".³ If not that, then what

should we do? Munro offers an alternative, though not incompatible, perspective when she claims that one should see “child protection as a systems problem.”⁴

These two moral perspectives mirror two different models of the production of outcomes in the natural order. The first focuses on causal processes, or causal chains; the second, on what I have called “nomological machines” and subsequent work, primarily in the philosophy of biology, labels “mechanisms”.

Causal processes first. A causal process or causal chain is a series of happenings, each one of which produces the next, one after the other, until at last the outcome in view is achieved. Studying these processes is the meat and potatoes of much of modern scientific endeavor, from process tracing in biomedical science and toxicology to a vast variety of statistical comparative methods, including the rampant use of randomized controlled trials in medicine and increasingly in social science, that aim to show *that* such a process has occurred, albeit without tracing out its steps. And when it comes to policy, from education to crime to early childhood intervention or aging, there is now a huge evaluation industry whose job is not just to measure outcomes to determine whether a policy has been followed by the desired outcomes but rather to show whether the policy was responsible for those outcomes---whether the policy and the outcome were connected by an appropriate causal process.

This kind of evaluation methodology is at the heart of the blame attribution we observe in cases like that of Peter Connelly. As Munro describes, when a tragedy like the death of Peter Connelly occurs, “The standard response is to hold an inquiry, looking in detail at the case and trying to get a picture of the causal sequence of events that ended in the child’s death... We are tracing a chain of events back in time to understand how it happened....”⁵

Here the moral and natural order dissolve into one another. Where does the backwards

tracing stop? As Munro points out, the “events that bring the investigation to a halt usually take the form of human error.”⁶

Munro also notes a peculiar feature of these child welfare cases, reflected in the death threats that Sharon Shoesmith received, which connects them with the Hart and Honoré account of causation: “Unlike the police investigation, which focuses on the perpetrators of the homicide, these inquiries focus primarily on how the professionals acted, judging them against the formal procedures for working with families and principles of good practice.”⁷ That is, they look for deviations from the norms of professional behavior: “Practitioners did not comply with procedures or lapsed from accepted standards of good practice.”⁸

But as a UK Department of Health pamphlet explains,

There are two ways of viewing human error: the person-centred approach and the system approach. The [person-centred]... approach focuses on the psychological precursors of error, such as inattention, forgetfulness and carelessness. Its associated countermeasures are aimed at individuals rather than situations and these invariably fall within the “control” paradigm of management. Such controls include disciplinary measures, writing more procedures to guide individual behaviour, or blaming, naming and shaming.⁹

And this is just what we saw in the case of Sharon Shoesmith with Ed Balls and the BBC interviewer.

The Department of Health itself note the parallels in the moral and natural order involved:

Aside from treating errors as moral issues, [the person-centred approach] isolates unsafe acts from their context, thus making it very hard to uncover and eliminate recurrent error traps within the system.¹⁰

The system approach, in contrast, takes a holistic stance on the issues of failure. It recognises that many of the problems facing organisations are complex, ill-defined and result from the interaction of a number of factors.¹¹

So, what's a system? Systems---or "mechanisms"---are our second model of how outcomes are produced in the natural order. This model admits causal processes but the processes are not basic. They are in need of deeper explanation. What causal processes can happen and what ones will happen regularly depend on an underlying mechanism that gives rise to them. A mechanism is composed of a number of different parts interacting in some kind of arrangement that makes it explicable why some kinds of causal processes will occur and others will be precluded. A toaster is a mechanism. The structure of the toaster---its parts and the way they are arranged and interact---explains why it is possible to produce toast by plugging it in and pressing on the lever.

But mechanisms need not be mechanical in any sense and indeed, as I mentioned, much of the philosophical work on them recently has been done in studying biology. For instance, when we investigate the firing of neurons, we discover that the receipt of neurotransmitter particles produces a potential difference across the wall at one end of the neuron which causes the movement of this potential difference to move along the neuron. It's no accident that this process happens, nor that it happens in neurons and not in other places. The scientists investigating this process discovered sodium selective pores in the lining of the neuron wall which open and close to control the movement of a cloud of sodium ions into and out of the neuron, thus supporting the propagation of a potential difference along the neuron. They were learning what the relevant parts of the "mechanism" are and how the arrangement and interactions of these parts allow the causal process under study to occur.

Nor need mechanisms be relatively sturdy, as the toaster is; they can be fragile and easy to break, like a fragile peace. Nor need they be static. They can be dynamic, they can change and they can evolve. They can have porous boundaries and it may be ill-defined what it is in and what is out of the mechanism at any time or whether we continue to see the same mechanism across changes in parts and their interactions, or the same. What matters is that it is the way some parts are arranged and interact that makes possible and explains the causal processes that happen and that are likely or unlikely to happen.

Social systems, made up of interacting individuals and institutions with their norms, conventions and habits---these too are mechanisms: mechanisms that afford causal processes. Some support desirable causal processes, or undesirable; other make it difficult for these processes to occur. And with this model too, the natural and the moral order dissolve into one another. This is vividly illustrated in the US National Academy of Sciences' *To Err Is Human: Building a Safer Health System*:

The title of this report encapsulates its purpose. Human beings, in all lines of work, make errors. Errors can be prevented by designing systems that make it hard for people to do the wrong thing and easy for people to do the right thing. Cars are designed so that drivers cannot start them while in reverse because that prevents accidents. Work schedules for pilots are designed so they don't fly too many consecutive hours without rest because alertness and performance are compromised.¹²

The NAS report urges: "The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system."¹³

From the systems point of view, the causal process model is the wrong model, not just for the natural order, because it focusses only on surface phenomena and misses out on explanatory depth, but for the moral order. For the kinds of preventative measures the causal process

model leads to---recall the UK Department of Health examples: disciplinary actions, writing more procedures to guide individual behavior, or blaming, naming and shaming---these measures are generally unlikely to stop these kinds of sequences occurring.

Whether or not the natural order is our most plausible or most available model for moral order, at least in these cases of causation and responsibility the two cannot be easily pried apart.

¹ “Shoesmith: ‘I don’t do blame’,” last modified May 28, 2011,

http://news.bbc.co.uk/today/hi/today/newsid_9499000/9499424.stm.

² Eileen Munro, “Improving practice: Child protection as a systems problem,” *Children and Youth Services Review* 27 (2005): 378.

³ “Shoesmith: ‘I don’t do blame’”.

⁴ Munro, “Improving practice,” 375.

⁵ Munro, “Improving practice,” 377.

⁶ Munro, “Improving practice,” 378.

⁷ Munro, “Improving practice,” 377.

⁸ Munro, “Improving practice,” 377-378.

⁹ UK Department of Health, *An organisation with a memory: Report of an expert group on learning from adverse events in the NHS* (London: The Stationery Office, 2000), 20.

¹⁰ UK Department of Health, *An organisation with a memory*, 20-21.

¹¹ UK Department of Health, *An organisation with a memory*, 21.

¹² Linda Kohn, Janet Corrigan, and Molla Donaldson, eds., *To Err Is Human: Building a Safer Health System* (Washington, D.C.: National Academy Press, 2000), ix.

¹³ Kohn, Corrigan, and Donaldson, eds., *To Err Is Human*, 5.