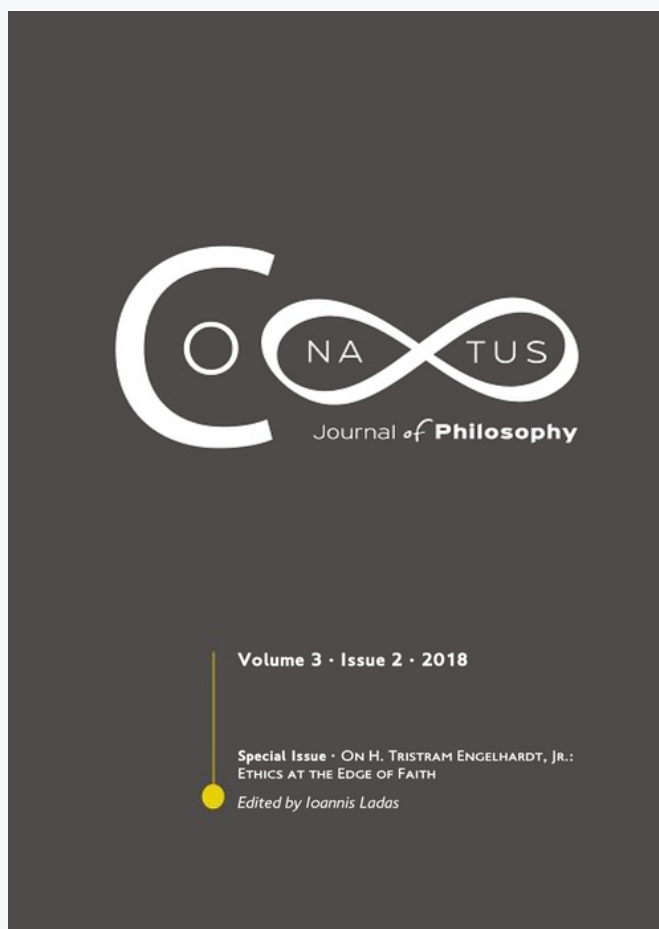


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Bioethics and Reason in a Secular Society: Reclaiming Christian Bioethics

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Bioethics and Reason in a Secular Society: Reclaiming Christian Bioethics

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Abstract

Bioethics evolved from traditional physician ethics and theological ethics. It has become important in contemporary discussions of Medicine and ethics. But in contemporary secular societies the foundations of Bioethics are minimal in their content and often rely on procedural ethics. The Bioethics of particular communities, particularly religious communities, are richer than the procedural ethics of a secular society. Religious Bioethics, situated within religious communities, are richer in content in general and in the lived reality.

Key-words: *secular, multicultural, Bioethics, consent, faith*

Bioethics provides a fascinating starting point to study contemporary cultures, public argument, and intellectual history in the West. Bioethics emerged, in part, as a result of the scientific and technological developments in medicine. Another influence on the emergence of Bioethics in secular societies has been the emergence of moral pluralism that comes from respect for individuals and cultures. In tracing the evolution of the field one can more clearly understand the challenges for secular Bioethics and the appeal, for many people, for a religious basis for Bioethics. I will argue that Bioethics in a morally pluralistic society will be limited in terms of its content. So, it is not surmising that people will also look to their own religious traditions to give content to their decisions.

I. Defining Bioethics: The Emergence of the Field

In recent years there has been a good deal of reflection on the development of Bioethics as a distinct field.¹ These reflections, though diverse, can serve as a basis

¹ Jennifer K. Walter, MD and Eran P. Klein, MD, Eds, *The Story of Bioethics: From Seminal Works*

for understanding the field and can help us understand the challenges for developing public Bioethics in a secular society.

If someone knew nothing about the history of medicine or Bioethics that person might wonder about the relationship of ethics and medicine before the emergence of Bioethics in the late 1960s.² Contemporary discussions in Bioethics can sometimes leave the impression that there was no ethical reflection in medicine before the emergence of Bioethics. Of course, this is a false impression which is easy to correct. There has been long association of philosophy, ethics, and medicine dating to the ancient Greek schools of medicine and many of these associations have been about ethics. In the ancient world there were several different schools of philosophical reflection about medicine. One thinks of Hippocrates, Galen, Democrates, Plato, and Aristotle³ as examples of ancient philosophical reflections on medicine. However, these schools, though they differed in many respects, were primarily concerned about the conduct of the physician's conduct in a paternalistic relationship. In addition to philosophical and medical reflection there has also been extensive theological reflections on ethics and medicine in many religious traditions.⁴ Indeed, one can argue that contemporary Bioethics emerged from the writing and reflections of theologians and religious thinkers.⁵

In light of this long history of ethical reflection involving medicine, one might ask: Why was there a need to develop a new area of ethical reflection that has been named Bioethics? Why not simply rely on the various traditions of medical ethics which already existed? I would argue that there are at least three developments that encouraged the emergence of Bioethics as a field distinct from the traditional sources of medical ethics.

First, I will argue that traditional medical ethics was really physician ethics⁶ and

to *Contemporary Explorations* (Washington, DC: Georgetown University Press, 2018).

² I use the term field consciously to distinguish Bioethics from specific disciplines. While Bioethics has been dominated by philosophical and legal thinking it is an interdisciplinary field engaging medicine, law, philosophy, theology, and many other disciplines. See Albert Jonsen, *The Birth of Bioethics* (New York: Oxford University Press, 1998).

³ Paul J. Carrick, *Medical Ethics in the Ancient World* (Washington, D.C.: Georgetown University Press, 2001).

⁴ Joseph Fletcher, *Morals and Medicine* (Boston: Beacon Press, 1960); Edwin F. Healy, *Medical Ethics* (Chicago: Loyola University Press, 1956); Immanuel Jakobovits, *Jewish Medical Ethics* (New York: Block, 1958); Paul Ramsey, *Fabricated Man* (New Haven: Yale University Press, 1970); James Gustafson, *The Contributions of Theology in Medical Ethics* (Milwaukee: Marquette University Press, 1975); Richard McCormick, *Health and Medicine in the Catholic Tradition* (New York: Crossroad Press, 1984).

⁵ Lisa Sowle Cahill, *Theological Bioethics Participation, Justice, and Change* (Washington, DC: Georgetown University Press, 2006).

⁶ H. Tristram Engelhardt Jr. and Kevin Wm. Wildes, "In The Beginning: The Emergence of Secular Bioethics", in *Advances in Bioethics: Bioethics for Medical Education*, eds. R. Edwards and E.E. Bittar, (Stamford, CT: JAI Press, 1995).

that the field emerged in response to the new choices and challenges brought about by the development of medical knowledge and technology. In the development of real choices in medicine there came a recognition that there are other people, beyond physicians, who are involved in medical decision making. A key influence in the development of Bioethics was the development of scientific medicine. The nineteenth and twentieth century witnessed the grounding of medical epistemology in the basic sciences. The modern understanding of illness is rooted in an anatomical, physiological, bacteriological, and now genetic causal factors. Changes in medical epistemology in the modern age have been tied to new, scientific standards for the acquisition and validation of knowledge. One could argue, more accurately, that modern medicine was born when the clinic and the laboratory became conjoined.⁷ This union of the clinic and the laboratory transformed medicine in a number of ways. The union of the clinic and the laboratory provided a basis for the development of scientific medical knowledge and related technological interventions. Laboratory research became essential to clinical practice and research.

In the contemporary world of medical miracles, we often forget the radical impact of the scientific model on medical epistemology and medical practice. The joining of the laboratory and the clinic led to a transformation of medical knowledge and to the development of medical technology and interventions. From the development of effective surgery to the manipulation of human genes, the physician, as medical scientist, has been transformed from an observer to a manipulator of nature and the body. These scientific possibilities have led to the transformation of expectations and goals of medicine.⁸

For most of its history there was very little that medicine could actually do to help patients. Gradually, with each success, the social expectations of medicine have changed. In contemporary first world nations, people have come to think of medicine as curative.⁹ In the past people looked to god, or the gods, primarily for a cure. Cures often were thought to be miraculous. Medicine was looked to alleviate the suffering of patients but not, necessarily, to cure them. Today, in first world medicine, we expect medicine to cure patients. Some have argued that with the development of knowledge and technology the very purpose of medicine has changed.

The changes that have taken place in medicine have not only been driven by the development of medical knowledge and technology. They have also been driven, in part, by development of other technologies, like the automobile or the computer, or sociological developments like the urbanization of society. These types of changes

⁷ H.T. Engelhardt Jr., "Recent Developments in the Philosophy of Medicine: The Dialectic of Theory and Practice and the Moral-Political Authority of Bioethicists", paper APA Eastern Meeting, 28 December 2000.

⁸ See, for example, David Callahan, *False Hopes: Why America's Quest for Perfect Health is a Recipe for Failure* (New York: Simon & Schuster, 1998).

⁹ Eric Cassell, *The Nature of Suffering and the Goals of Medicine* (New York: Oxford University Press, 1991).

are important factors as they have made these new medical technologies accessible to men and women in society.¹⁰

While the development of medical knowledge and technology are necessary conditions to understand Bioethics, these developments alone are not sufficient to explain the emergence of this field. These scientific and technological developments are only part of the story. The creation of real choices and alternatives is a major element in the emergence of the field. To understand other elements that contributed to the field it is important to recall that traditional medical ethics had relied principally on two sources of moral guidance. One source was the traditions of professional, physician ethics.¹¹ The other source for traditional medical ethics was theological ethics which was well developed in a number of religious traditions.¹² Why were these sources no longer able to guide the practice of medicine in its contemporary scientific practice? To understand why neither of these sources are sufficient for contemporary medicine one must, I think, take the phenomena of moral pluralism and cultural diversity into account. What I mean by moral pluralism is the phenomenon in which people hold, not only different moral views on an issue (e.g., abortion), but also that they work out of different moral frameworks and methodologies.¹³

The development of medical knowledge and technology creates real choices and decisions for people; especially patients. Traditional medical ethics had been focused on physician ethics and judgment about what was good for a patient.¹⁴ The development of scientific medicine gave patients choices and options about the course of treatments to be pursued or refused. If the physician and patient shared the same moral values and way of thinking, such choices may not be all that problematic. However, when patients and physicians hold different views, the understanding of medical ethics needs to be transformed beyond the judgment of the physician alone.¹⁵ Determining what is in the patient's best interest cannot be judged by the physician alone. The physician may speak to the medical best interest of the patient but not, necessarily, the overall best interest of the patient. To make such best interest judgments the patient needs to be involved. Furthermore, in secular societies there are likely to be different religious views that shape people's judgments about what is morally appropriate. That is why procedures like informed consent has come to play such a central

¹⁰ See, K. Wildes, "Reshaping the Human: Technology, Medicine, and Bioethics", *Jahrbuch für Wissenschaft und Ethik*, ed. D. Hüber, 227-236 (Berlin: Walter de Gruyter, 2003).

¹¹ L. B. McCoullough, "Laying Medicine Open: Understanding Major Turning Points in the History of Medical Ethics", *Kennedy Institute of Ethics Journal* 9 (1999): 7-23.

¹² See note 7.

¹³ K. Wm. Wildes, S.J., *Moral Acquaintances: Methodology in Bioethics* (Notre Dame: University of Notre Dame Press, 2000).

¹⁴ Robert M. Veatch, "Doctor Does Not Know Best: Why in the New Century Physicians Must Stop Trying to Benefit Patients", *Journal of Medicine and Philosophy* 25 (2000): 701-721; Robert M. Veatch, *A Theory of Medical Ethics* (New York: Basic Books, 1981).

¹⁵ See Robert M. Veatch, *Theory of Medical Ethics* (New York: Basic Books, 1981).

role in both clinical and research ethics. Such procedures allow people to exercise judgment about what is in their best interest.

Moral pluralism not only affects the relationship of patients and physicians. It also affects the profession of medicine itself. A key part of the classical notion of a profession was that there was a moral dimension to the profession. Many people still assume that professionals act in ethical ways and that it is reasonable to have fiduciary expectations of professionals. However, with a more widespread moral pluralism, there will be different view about what is appropriate or inappropriate professional conduct. From abortion to physician assisted suicide and economic structures of medicine one finds a wide range of opinions among physicians about what is appropriate behavior. So, it becomes more and more difficult to sustain claims based on an internal morality of medicine which had been a cornerstone to traditional medical ethics. The internal ethic of physicians becomes less and less tenable.

At the same time, one cannot assume, in a secular, pluralistic society, that theological ethics will supply the type of guidance that is needed. In several religious traditions there have been long, well developed reflections on medicine, its uses, and ethics. In light of these traditions it is not surprising that theologians played such an important role in the development of Bioethics. Many who first grasped the profound impact of developing medical knowledge and technologies were theologian. They were often the first voices to raise broader social questions that transcended traditional physician ethics. As the field of Bioethics began to emerge it is not surprising that many theologians, working out of faith traditions that addressed questions of medical care, would be interested in these questions. These traditions had long standing reflections on medicine and health care. They were able to easily engage the changes that were taking place in medicine. Yet, fairly quickly, theology came to play less and less of a public role in Bioethics. The role of theology and religious commitments has been a difficult question not only for Bioethics but for many areas of public life in the United States. But, as ethicist Daniel Callahan has argued, Bioethics became acceptable in America because it pushed religion aside.¹⁶ Callahan does not argue that religious thought became irrelevant to these questions. Rather he argues as Bioethics became a form of “public” discourse¹⁷ it moved to more the more “neutral” languages of philosophy and law and away from the closed language of the medical profession and theological discourse.¹⁸

Third, the development of medical knowledge and technology often involved the investment of public resources and may be subject to public regulation. There are

¹⁶ Daniel Callahan, “Why America Accepted Bioethics”, *Hastings Center Report*, Special Supplement (1993): 8-9.

¹⁷ Arthur L. Caplan, “What Bioethics Brought to the Public”, *Hastings Center Report*, Special Supplement (1993): 14-15.

¹⁸ See L. B. McCullough, “Laying Medicine Open: Understanding Major Turning Points in the History of Medical Ethics”, *Kennedy Institute of Ethics Journal* 9 (1999): 7-23.

questions about how much a society should invest its resources into such research and technology. And there are questions about the extent of government regulation, and the justification for it, of emerging technologies. In a secular society, with different religious traditions there will be real challenges to determine the extent and manner for religious traditions and communities to have voice in the regulatory arena.

Bioethics then emerges as the result of several developments in contemporary secular societies. First there is the development of medical knowledge and technology which expands options and creates real choices in medical care. With these choices the question arises of who is the appropriate authority to decide what is or is not appropriate treatment. Such choices involve more than medical judgment. Second, the Bioethics emerges, in part, as a response to the multiculturalism and moral pluralism in secular societies like the United States. The emergence of different moral voices and views means that there will be differing views on appropriate medical care. Again, this judgment about what is appropriate care is more than a strict medical judgment. Third, the field emerges as a way to help people from different moral views navigate these choices and cooperate together. In studying the emergence of the field one can make the claim that Bioethics provides an insight into the life and practices of a society.

The tension of global and cultural ethics is a new version of an ancient problem. It was a problem faced by the Romans with their multi-cultural empire. Multi-culturalism and moral pluralism represent a challenge for Bioethics in a secular society. The difficulty will be to avoid a complete relativism where only power wins the day or the simple assertion of a global ethic.

II. Bioethical Consensus in a Secular Society

There has been an ancient tradition which intertwines Medicine and Ethics. Contemporary Bioethics reflects not only a change in the field but also represents significant shifts in contemporary culture. There are rich traditions of medical ethics which are part of religious traditions. (examples/footnotes). And, there is an ancient tradition of medical ethics based in physician ethics (cites). Contemporary Bioethics, I would argue, drew out of these different traditions. And, I would argue that the shift came about for two reasons. One was the success and development of Medicine which offers people a wide array of choices and decisions. One of the key questions becomes the role of the patient, or her agent, in making those decisions, because contemporary Western societies are much more diverse and pluralistic.

Bioethics is often understood as a field that resolves such moral controversies by appeal to reason. In trying to understand the claims that are often made for global Bioethics it is essential to understand the claims that are often made in the name of "bioethical consensus."¹⁹ The notion of consensus is important for those who want

¹⁹ One can argue that given the dilemmas of modern moral philosophy to speak about moral

to claim global Bioethics. The claims about consensus are something like a bioethical *Ajus gentium* in a field that understands itself as resolving controversies. The field must address questions about how well it is able to mediate and resolve bioethical controversies. Success in such resolution is crucial to the idea of global Bioethics. But, in order to gage the extent of such success it's worthwhile to look below the surface of such consensus.

A. Pluralism and Consensus

Consensus can take place at a number of different levels: at the level of belief, it affects theory and cognition; at the level of action, it is pragmatic and practical; and at the level of values, it enables coherence and motivation. For consensus to play an important role in bioethical method one needs to understand which of these levels is being asserted. Thus, it becomes important to ask why a consensus exists.²⁰ Is it mindless conformity? Is it about a submission to or support of existing power structures? Or is the consensus driven by the weight of appropriate evidence? Nicholas Rescher suggests that one should ask whether the consensus being appealed to is an idealized version of consensus or one that is practically attainable. Philosophers tend to use the former while social scientists deploy the latter. Understanding what is meant by consensus when it is used in Bioethics is important for exploring the extent and nature of normative claims. Also, it is important to understand at what level consensus attributed. As I will argue, there are a number of judgments that are embedded in moral judgment and understanding where the consensus actually occurs is important. It could take place on a very general, broad level (e.g., Do good and avoid evil). But as a field Bioethics often addresses much more particular, specified judgments. So, when people appeal to a Abioethical consensus it is important to probe and understand what is being appealed to.

One way to understand the complexities of moving from general to particular judgments is to examine moral judgment. The nature of agreement, disagreement, consensus, and dissensus is best understood through an analysis of moral judgments. Of course, the questions of judgment take us back to the assumptions people make about the field of Bioethics. Is the field to function as the clinical Answer person or the clinical Solomon when there are moral disputes? Moral judgments should be understood not simply as choices about what should be done in a particular situation, but as involving logically prior judgments about how one justifies such choices. One's assumptions about moral rationality are a prior judgment that commit one to

truth that philosophers have shifted claims away from truth towards consensus. In Bioethics, for example, see, Jonathan D. Moreno, *Deciding for Others* (New York: Oxford University Press, 1995).

²⁰ Nicholas Rescher, *Pluralism: Against the Demand for Consensus* (New York: Oxford University Press, 1993), 15.

a particular view of the moral world. For example, those in the natural law tradition understand moral rationality in a different way from those who deploy an instrumentalist view. Charting the geography of judgment reveals a number of points for potential agreement and disagreement.

The reality of moral pluralism in a secular society illustrates that there are many ways in which to construct the categories of the moral world. By distinguishing the three levels or types of judgment (object, justification, foundation) involved in moral argument, the spectrum for possible moral agreement and disagreement is greatly increased. It ranges from a strong sense of agreement, in which we are of one mind on how and why to proceed, to a weaker sense of proceeding together but only for a specific, limited venture.

The complex spectrum of relationships that lies between complete agreement at the levels of object, reason, and foundation to complete disagreement on those levels can be summarized under eight headings.

1. Object level agreement with agreement on justification and foundations.
2. Object level agreement with agreement about justification and disagreement about foundations.
3. Object level agreement with disagreement about justification.
4. Object level agreement with agreement/disagreement in part on the levels of justification.
5. Object level agreement with disagreement about both justification and foundations.
6. Object level disagreement with agreement on justification and foundations.
7. Object level disagreement with justificatory agreement/disagreement in part.
8. Object level disagreement with disagreement about justification and foundations.²¹

The possibilities and the limits of each genus of controversy resolution in Bioethics can be analyzed under these eight headings. To reach agreement regarding justification there needs to be prior agreement on what counts as a relevant moral appeal and what is a proper set of moral reasons to which one could turn. Unless moral agents stand within the same foundational framework, they will not reach agreement on how moral judgments are justified.

Boyle's essay raises the difficulties associated with moral judgment. The more carefully one examines the complexities of moral judgment the more cautious one

²¹ K. Wm. Wildes, S.J., *Moral Acquaintances: Methodology in Bioethics* (South Bend: University of Notre Dame Press, 2000).

should become about the possibility of a global Bioethics. Even if there is significant agreement on a global level, which there often is not, it is hard to grasp how such agreement will help on the level of judgment which so often at the heart of Bioethics.

The different levels of judgment point out the fragility of any claim for consensus. The levels should make anyone skeptical of the depth of any consensus.

B. The Sociology of Agreement and Consensus:

The field of Bioethics has been marked by the work of numerous committees and commission on the national and international level. It is a field that has also been marked by the work of institutional ethics committees and review boards. The work of these groups has been important to establishing the credibility of the field. The work of various Bioethics commissions and committees provide examples of moral agreement in a secular, morally pluralistic culture. Given that commissions have played an inspirational role in the development of Bioethics, it is important to examine how such committees and commissions achieve agreement. The sociology of such commissions raises important and interesting questions about what conclusions can be drawn from their work. The first question bears on the composition these committees. Usually people who are selected for such work are, at least, moral acquaintances. One rarely finds individuals with strongly different views appointed to the same committee or commission. In the selection of members, the committee's agreement is already being managed. A second question focuses on the committee's process. Such groups are shaped by a dynamic toward reaching a consensus.²² The expectation, before the commission begins work, is that the committee will reach consensus on certain recommendations. A third question focuses on the establishment of the agenda of the committee. Insofar as the committee is mandated to act in certain questions (and not in others) the possibility of disagreement is reduced. Notice how the work of such groups contrasts with the exchanges between individuals with great moral differences.

The control of the agenda is a crucial point often overlooked in the heralding of agreement by committees. A necessary condition for resolving a moral dispute is consensus regarding the essence of the dispute. So often in Bioethics the most difficult problem is the lack of a common description of a moral controversy (e.g., abortion, assisted suicide). Is abortion about rights of choice or the killing of an innocent human being? Is physician assisted suicide an act of mercy or an act of murder? If an agenda is established before a committee or commission begins its work, then the mapping of a general moral geography has already begun. The agenda not only

²² See Jonathan Moreno, "Consensus, Contracts, and Committees", *The Journal of Medicine and Philosophy* 16 (1991): 393-408; and J. Moreno, "Consensus By Committee: Philosophical and Social The Concept Aspects of Ethics Committees", in *The Concept of Moral Consensus: The Case of Technological Interventions into Human Reproduction*, ed. K. Bayertz, 145-162 (Dordrecht: Kluwer Academic Publishers, 1994).

identifies the problem, but also provides a way whereby differences are confined and minimized.

Understanding these sociological elements should lead philosophers and ethicists to be cautious about how one should evaluate the claims of agreement and its depth. It is helpful to remember that agreements and disagreements can be found at a number of points in bioethical discussions. We simply need to be clear on what is being agreed to and not make extravagant claims.

There are a number of interesting examples of consensus ethics and statements in public Bioethics. One recent contrast is the work of President Clinton's National Bioethics Advisory Commission (NBAC) and President Bush's President's Council on Bioethics (PCB). Both groups examined the question of stem cell research. While there were similarities of opinions, each group reached differing conclusions about the direction, and ethical justification for, federal policy on stem cell research. When President Bush did not renew the terms of two members of the PCB who had dissenting views on embryo research²³ it provided an interesting example of managing bioethical consensus. James Childress gives an older, though very insightful account of ethical consensus in the public forum.²⁴

²³ Scott Smallwood, "Bush Drops 2 Supporters of Embryo Research From Bioethics Panel", *The Chronicle of Higher Education*, 1 March 2004 <http://chronicle.com/prm/daily/2004/03/2004030103n.htm> and "Two Scientists From Bush's Bioethics Council Say Panel's Reports Favor Ideology Over Facts", G. Blumenstyk, *The Chronicle of Higher Education*, 8 March 2004 <http://chronicle.com/prm/daily/2004/03/2004030801n.htm>.

²⁴ James Childress provides an interesting and instructive case study in the management of agreement and consensus in Bioethics. Childress examines the deliberations of the Human Fetal Tissue Transplantation Research Panel (hereafter, HFTTR). In 1988 a moratorium was declared on the use of federal funds for HFTTR by Robert Windom, then Assistant Secretary for Health (U.S. Department of Health and Human Services). The National Institutes of Health appointed the HFTTR Panel in the fall of 1988 to respond to ten questions raised by Secretary Windom. Even before it began work, Secretary Windom and the NIH had given the HFTTR Panel significant help in its task since the framing of issues directs the ways in which any moral problem can be resolved. The framing process itself can make the moral pluralism of a committee more manageable. In the case of the HFTTR Panel, Assistant Secretary Windom had set the agenda in his ten questions. Childress notes that Windom's questions focused on the linkage between abortion and HFTTR practices. Indeed, Childress argues that Windom's questions constrained the Panel's deliberations. Childress himself makes the point that a different set of questions could have led to different outcomes. What is of interest here is that the process of deliberation and its outcome were helped and directed by the charge given to the Panel. As one looks to the agreements and consensus of panels, commissions, or hospital ethics committees, one needs to examine how the boundaries and agenda of deliberation were established. Childress also addresses the issue of dissent in the panel's work. He says that two of the eleven members had substantial dissent. The two dissenting Panel members produced a dissenting report, such that Apanelists in the majority later expressed their concern that such a long and eloquent dissent would simply smother the report's brief responses. Childress notes that an additional meeting of the Panel was called to structure the form of the final report so that it would not be overwhelmed by the dissenting report. The discussion of dissent raises two important questions. First, how much agreement is necessary to a consensus? If a committee is unanimous, the consensus is obvious. However, absent unanimity, and when there is strong dissent, the degree

Childress's observations remind us that when people claim agreement, it is important to know what types of questions were asked and agreed to. His account raises anew the question of how and what kinds of agreement are possible in a secular, morally pluralistic society. Contrary to the Jonsen-Toulmin experience in the work of the National Commission, Childress cites agreement on the level of principle.²⁵ It is possible that different methods of Bioethics may be appropriate to different activities. For example, issues of public policy, or institutional policy, may be better articulated as principles insofar as principles give broad guidelines for actions. At the same time, particular clinical issues may be better addressed by the agreement of cases. Since method and content cannot be separated it is clear that different methods reflect different moral views.

Committees and commissions have come to play a central role in Bioethics. From local hospitals and nursing home ethics committees to national policy commissions, committees have taken on important roles in moral deliberations. As one examines the work of such groups, one becomes aware, however, of the importance of power and control in guiding the resolutions of such committees. The power to set the agenda, membership, and timetable are crucial to reaching any agreement. The Childress account helps us to understand how the agreement of such commissions is managed. It relies on both the agenda of the commission being set and the members of the commission not dissenting in bad faith. That such agreements are managed should not be surprising. Governments, like the people who run them, often seek the opinions of others to support a desired policy or to suppress an unpopular one. The Health Care Task force of the Clinton Administration assembled an ethics task force. Members of the task force shared some common assumptions about society and health care that were important for their deliberations.²⁶ It is not hard to imagine how the conclusions of the committee would have been very different had its membership been altered in substantial ways.

Again, a good example of such managed solutions in the presidential Bioethics of stem cell research. The Clinton Administration's NBAC made recommendations about the use of embryos for stem cell research which were more open and liberal than those made by President Bush's Bioethics Commission, it is clear from the guidelines that he set out that the recommendations will be much more conservative and

of consensus is difficult to ascertain. Second, is the consensus based on the moral issues? A consensus report may play on certain ambiguities. Childress, for example, points out that the questions raised by the Assistant Secretary were empirical, legal, medical, scientific, and moral. As one listens to claims of consensus it is important to determine whether the consensus is actually about the moral questions.

²⁵ Childress, 165ff. It is worth noting that Albert Jonsen and Stephen Toulmin offer a different account of consensus building. They argue that the National Commission reached consensus around cases (not principles) from which principles were articulated.

²⁶ Norman Daniels, "The Articulation of Values and Principles Involved in Health Care Reform", *The Journal of Medicine and Philosophy* 19 (1994): 425-434.

restrictive.²⁷ The Commission will reach very different conclusions from the last presidential commission because the membership is decidedly different and the contours of the questions have been set in very different ways.

Members are selected and agendas are set so that a desired result may be achieved. The members of the commission, unlike the Senate (in its role to advise and consent), are bound to the agendas given them. What emerges from this account is a picture of agreement that is often carefully managed and crafted. The result may be an agreement that is more causally achieved and less rationally justified than we craved. This confusion about the nature of agreement occurs often in Bioethics. The tendency is to draw principled conclusions when the conclusions are more sociological in nature.

In many ways the very emergence of Bioethics as a field (section I) argues against any thick notion of global Bioethics. Bioethics emerged in response to questions of ethics in the clinic, medical research, and the development of public policy. It emerged, in part because there were new choices for patients and researches brought on by medical advances and the advancement of medical knowledge. But these choices highlighted the differing moral views in a morally pluralistic society. And, even when views are held in common, there are differences in moral judgment as Boyle notes. Bioethics emerges as a field precisely because there isn't a global ethic that men and women can agree to. Bioethics emerges because there is disagreement and what often passes for consensus is more a matter of illusion than substance.

Just as there has been a great deal of emphasis in Bioethics on respect for persons, and their judgments, the phenomenon of global Bioethics raises important questions about respect for cultures and cultural diversity. It is not often clear, and seldom explored, how global Bioethics do not degenerate into some form of cultural imperialism.

III. Possibilities and Limits for Public Bioethics

As one examines the controversies in Bioethics it seems that the potential for a global bioethical consensus is limited. This ought not to be surprising in a morally pluralistic, secular society. Rescher notes that any talk or use of consensus must also investigate dissensus.²⁸ Consensus and dissensus, like health and disease, dissensus are dialectical terms, and one cannot be understood without the other. In general, the over emphasis on consensus has led to an over emphasis on agreement and not enough attention being paid to disagreement.

²⁷ See National Bioethics Advisory Commission, *Ethical Issues In Stem Cell Research*, June 2000. For current documents by The President's Council on Bioethics go to <http://www.Bioethics.gov>.

²⁸ Nicholas Rescher, *Pluralism: Against the Demand for Consensus* (New York: Oxford University Press, 1993).

That there should be dissensus in Bioethics is not surprising. If morality is part of a way of life and ethical reflection is grounded in moral experience, then different experiences will lead to different views of what is or is not morally appropriate behavior. One way to understand these different bioethical views is by using a moral relativist view. Often, when people use terms like moral pluralism they are employing a relativist position. The relativist view is that it really does not matter which position one holds on any matter. However, a problem with this view is that if one holds it, he or she will have no incentive to reach a consensus with anyone who holds different views. There is no reason for anyone to negotiate a consensus if he or she has no reasons to hold any position whatsoever. Furthermore, the relativist view also leaves us with no intellectual or moral argument against the use of power simply to impose a position. We are left in a position where might makes right. An alternative argument would be that in a secular world, which may have many differing moralities, the only source of moral authority will rest with the human person. People are able to work together, morally, by consent and agreement. It is the web of agreement and consent that becomes the basis of moral authority in a secular world filled with many gods and commandments.

In thinking through the language of global Bioethics it might be helpful to make a distinction. Morality is part of a way of life. It is often tied to particular cultures and communities. If one thinks about global Bioethics from this perspective it does not seem very useful. But, if one view the question in terms of respect for persons as moral agents, then one can talk about a thin sense of global Bioethics in terms of respect for persons and cultures. In such a view of the world one can talk of moral friends, who live in a moral community and share a thick moral world view, moral strangers who have differing world views but who can cooperate in moral endeavors by using public, agree upon procedures of agreement and consent, and moral acquaintances who rely on proceeds but share some overlapping moral views. In such a world of respect and moral pluralism a person, and a community, needs to understand his/her moral commitments. In such world a person and community will often face a question of cooperating with others in different moral enterprises. To maintain their integrity they will need to know their moral values so they can understand what can and cannot be compromised.

An alternative approach, articulated by Rescher and helpful for Bioethics, is perspectival pluralism.²⁹ This position holds that a person needs to have the Acourage of one's convictions. One needs to know the positions she or he holds and how they differ from other positions. Such knowledge is crucial to compromise and consensus. These are essential to living out a notion of integrity. Any meaningful practice of global Bioethics will involve a respect for these differences, often significant, in a multi-cultural world.

²⁹ Childress, 105.

IV. Faith Based Bioethics

It is very understandable why, in a secular, pluralistic society like the United States a philosophical Bioethics would emerge. However, as one examines the content of such a Bioethics one will find it is very empty of meaningful content. And, in contrast, one will find that most religious traditions have very thick and rich contentful Bioethics for members of their communities. The challenge, for those religious traditions will be to decide how they want to interact with a contemporary morally diverse world. Some traditions will ignore the rest of society and live within their own frameworks and faith. Other traditions will try to convert others to their way of life and Bioethics.

No matter how a community will encounter the broader society in which it lives, it will be important for communities most importantly to know their moral traditions. A moral tradition is to be lived and to be lived it must be known and understood. So, it will be important for members of a community to know and understand their tradition. That will be important for the members and the community. It will also be important for the broader, diverse society. A multicultural society is enriched by the communities which live within it. So, understanding and respect will help to enrich the society. At the same time, the society will be enriched, morally, by the diversity and living respectfully of other traditions and communities.

Conclusions

Bioethics has emerged for a number of reasons. The development of medical technology has created choices where once there was only chance. Also, there are real moral differences about what choices should or should not be made. Yet, there is a need to find ways for people with different moral views to work together in medical research and delivery. As one examines the agreement in the bioethical consensus one recognizes that the consensus may not be what people often hope that it is. Agreements in the field are not all the same. Nor are all disagreements the same. The more one understands the complexity of moral judgments, and the various types and degrees of agreement, the more one understands how limited the force of agreements often is and how important disagreements are often masked. Scrutiny of the bioethical consensus reveals more dissensus than first appeared.

A natural law method to Bioethics will yield general moral guidance but not specific judgments. An analysis of moral judgement leads to more modest views on the possibilities for a global Bioethics. Solomon also raises important questions about the possibilities for global Bioethics by posing the export problem. One can turn the problem around and see the essential dilemma in a different light. If there is really global Bioethics, can we import as well as export Bioethics or is there a Bioethics trade surplus? Even if there is "thick" agreement concerning a moral view of the

world, the application of the view will vary in particular judgments. Some may argue that this criticism is unfair as it is a problem for every systematic moral view. This would be a fair objection except that many in the field of Bioethics have portrayed the field as responding to very particular questions and moral controversies.

Even in the midst of moral pluralism and fragmentation many scholars hope to find some common moral ground. But, in contemporary societies marked by moral pluralism one can ask to what extent a *jus gentium* exists. One could argue that what does bind people of different moral views together is the role of consent of free individuals. Such a view also limits government intervention and regulation in bioethical matters. This common ground allows others, outside a moral community, to raise questions about the moral practices of a community. I have argued elsewhere that the realm of procedural ethics, based on consent and agreement, provides our best hope of a common ground. This procedural ethics will not provide the rich, thick ethic that many long for in a global ethics. But it can provide a thin framework for limited, common moral conversation. One can understand the thin agreements of procedural ethics only if they are built on thicker, richer understandings of the moral life. Absent such overlapping values the procedures could not succeed ethically. Procedures need some form of moral justification if they are to be moral. If there are procedures that transcend moral communities then they may provide a way to identify the common ground of moral acquaintances. The agreement about procedures provides a way to articulate the overlapping agreements that exist for moral strangers and acquaintances.

In the end we are left with as many questions as answers. How might we explore, and respond, to the global questions that Boyle has raised about the ability to critique a particular moral community. How might we respond to the export problems raised by Solomon? If the domestic problems are as significant as he argues, can we even speak of a Aregional Bioethics? These questions are not trivial. As Bioethics continues to play a role in the development of health care policy, the way the field is conceived will have a direct bearing on the evolution of policy and the authority given to policy makers.

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