

## CHAPTER 1

# *Technology, Tradition, and the Origins of Bioethics*

When the issues we now call bioethical first captured public attention more than a quarter century ago, far-reaching developments were already changing the way we give and receive medical care. These changes were rooted in the capacity of medicine to intervene into natural processes such that vast areas of life once subject to natural necessity or fate now became susceptible to human intervention. The effects wrought by this power to intervene are monumental, pervasive and apparently irreversible. They include the extension of medical authority over new areas of our lives, the expansion of technological control of the body, the transformation of questions about the place of illness and health in a morally worthy life into questions about which preferences technology should fulfil, the implications of pursuing the Enlightenment hope of a progressive elimination of pain and suffering from human life. These and other effects raise profound moral questions about the proper extent of the power of medicine over our lives, the moral and social limits of technological interventions, and the individual and social ends that the pursuit of health should serve.

The authors I discuss in this volume have devoted most of their work in bioethics to addressing questions such as these. Yet their preoccupations have been ignored by most mainstream bioethicists, whose own writings have remained strangely silent on these and related questions. The silence is strange because some of the most pressing problems bioethics currently faces—including the question of how to set limits on health care costs and the potential uses and abuses of genetic technology—seem to require reflection on the proper scope and limits of the technological transformation of medicine. My ultimate aim in this vol-

ume is to overcome this silence by putting such questions on the agenda of bioethics. But in order to accomplish this I must first understand the reasons for it. The silence is lamentable but on reflection not surprising. Standard bioethics, by which I mean the family of secular approaches rooted in the theories and principles of analytical moral philosophy that are dominant in the English-speaking world, is a product of modernity, and the moral task of modernity is to resolve conflicts between competing interests in order to secure social cooperation without appeal to robust views of the good. The agenda of standard bioethics, at the risk of oversimplification, follows accordingly: for every new issue that arises in biomedical research and care its task is to safeguard individual autonomy, calculate potential risks and harms, and determine whether or not a just distribution will follow. It would be foolish to deny the importance of this agenda.<sup>1</sup> Nevertheless, one blissfully ignorant of moral philosophy might wonder what the silence regarding the moral implications of the technological transformation of medicine would say if it were allowed to speak. Does it simply reflect the narrowness of modern moral theories, which eschew questions that seem to fall within the domain of sociology or religion? Or does it indicate a suppression of questions that challenge a deep but implicit moral agreement between standard bioethics and the effort to overcome the human subjection to fate or natural necessity?

In order to challenge standard bioethics in this way, it is not sufficient to argue that bioethicists fail to justify their basic principles or conclusions, since such a failure in execution need not implicate the agenda itself. Instead, this type of challenge requires a more fundamental inquiry into what accounts for the kinds of questions standard bioethics raises about the contemporary practice of medicine, the range of concerns it addresses, and the moral issues it believes are at stake. The pursuit of these questions calls for a certain kind of hermeneutical investigation—one that, in Charles Taylor's terms, seeks to understand the appeal of a cultural phenomenon by supplying "an interpretation . . . which will show why people found (or find) it convincing/inspiring/moving, which will identify what can be called the 'idees-forces' it contains" (Taylor, 1989, p. 202). This kind of interpretation identifies the moral sources which constitute the attractiveness or worthiness of the moral vision to those who adhere to it by constructing a narrative account of the origins and development of these sources. In this chapter I adapt (somewhat loosely) both the method and (with considerable modifications) the results of Taylor's investigation in order to articulate the moral sources of standard bioethics and of modern technological medicine. These sources, I argue, include moral convic-

tions about the importance of the relief of suffering and the expansion of human choice. These convictions are deeply intertwined with religious and secular beliefs about nature and attitudes and practices regarding the body. Together these convictions, beliefs, attitudes and practices constitute a transvaluation of traditional values regarding the body and the pursuit of health. In brief, a moral discourse that related the health of the body as well as its mortality and its susceptibility to illness and suffering to broader conceptions of a morally worthy life was succeeded by a moral discourse characterized by efforts to eliminate suffering and expand human choice and thereby overcome the human subjection to natural necessity or fate. The result is that standard bioethics moves within the orbit of the technological utopianism of what I call the Baconian project (my term for the new discourse and the set of practices in which it is embedded), and its agenda and content are designed to resolve certain issues and problems that arise within that project.

A hermeneutical account of this sort is designed to answer the question of what makes a moral framework or discourse worthy of adherence among those committed to it.<sup>2</sup> But because of their function, such accounts (Taylor's included) use the past in order to render the agent's current moral self-understanding more secure and to confirm the agent in his or her moral identity. Hence while a hermeneutical account is necessary to articulate the moral sources of standard bioethics, it alone is not sufficient to call the moral identity of the latter into question. It must therefore be corrected and supplemented by an adaptation of the type of archeological account that Michel Foucault specialized in (Foucault, 1972).<sup>3</sup> The archeological task is to show how a cultural phenomenon is limited by the range of concepts, objects, norms of reasoning, and so on that comprise its realm of discourse. Standard bioethics, from this perspective, participates in a discursive formation in which, for example, traditional ways of conceptualizing and objectifying the body in relation to moral ends and authorities were radically altered or replaced altogether. Hence the newer discourse could no longer articulate the moral insights and concerns of the earlier discourse, which were forgotten, distorted or rejected. This kind of inquiry is important as a correction or supplement to a hermeneutical inquiry because it shows how questions central to premodern traditions as well as more recent questions regarding the Baconian project itself will be marginalized or ignored in standard bioethics. Hence the silence regarding questions such as those I identified above.<sup>4</sup>

Taylor's hermeneutical method and Foucault's archeological method both require inquiry into the origins of moral discourses. The field of bioethics is, relatively speaking, still in its youth, and like most

youths it is unburdened by propensities to reflect on its origins. Nevertheless, those bioethicists who have engaged in such reflection have tended to narrate two accounts of the origin of their field. Both accounts find the origins of bioethics in cultural problems that allegedly require the types of solutions standard bioethics offers. One account refers to the need for solutions to the quandaries presented by modern technology, while the other refers to the need for a common morality to resolve a crisis of moral authority. It is, of course, in the interests of standard bioethicists to find the origins of their movement in these cultural needs. If technology presents moral problems that standard bioethics alone can resolve or if standard bioethics can claim a public moral authority that traditional moral schemes have lost, then as long as technology and contested moral authority are inevitable features of our culture, the agenda of standard bioethics—the questions, range of concerns, and moral issues it addresses—would be rationally vindicated.

I begin, therefore, by showing how technology does not require standard bioethics and how the latter obscures what is at issue in the crisis of moral authority, namely why the agenda of standard bioethics is still plausible despite its failure to resolve the crisis of moral authority. This leads to my alternative account which traces the agenda of standard bioethics to a moral discourse that excludes, marginalizes, or distorts the questions and concerns I alluded to in the opening paragraph. I provide in this chapter only a sketch of this discourse, which is developed further through authors treated in later chapters. But if I succeed here in showing how standard bioethics arises in a contingent and limited discourse, it then becomes possible to imagine a bioethical agenda constructed around other questions—questions such as those Plato raised, which concern the proper place of the technological control of the body in the moral lives of persons and communities. I believe that my account is rationally superior to those narrated by standard bioethicists; that is, I believe I give a more adequate account of the agenda of bioethics and the self-evident plausibility it has for many modern persons.<sup>5</sup> But in addition to giving what I believe is a more adequate account, my venture will succeed if it rescues from the margins a group of thinkers whose questions are as vital to the health of bioethics as they are absent from its current diet.

## BIOETHICS AND THE RISE OF TECHNOLOGY

Bioethicists trained in moral philosophy often assume that their field of study is the product of the remarkable technological develop-

ments of recent decades that have irrevocably changed the way medicine is practiced. In its simplest form, this argument appeals to the moral quandaries of modern technological medicine which, because they are believed to be unprecedented, render traditional medical and religious ethical systems obsolete. Technology, so the argument goes, has made it possible to intervene into natural processes in ways these religious and medical traditions never anticipated, producing moral dilemmas which they are incapable of resolving. As a result we are forced to make moral choices about matters on which they can provide no guidance. A new, philosophically grounded bioethics is therefore necessary. Now that there is such a bioethics, religious and medical traditions can be dismissed as relics of the past, to be replaced by the application of common moral principles or casuistical techniques to these unprecedented problems.

This is a familiar way for bioethicists, physicians, lawyers, and policy experts to account for the origins of bioethics (Emanuel, 1991, pp. 9–14). But I believe it is mistaken. Why it is mistaken can be illustrated with reference to an event frequently mentioned in support of this view: the 1968 declaration on brain death by the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Death. The declaration was a response to moral difficulties occasioned by the capacity to sustain respiratory functions by mechanical ventilation and thus seems to supply a paradigm instance of technology creating an unprecedented problem requiring a novel solution. But the declaration and its place in the ongoing debate on brain death also provide evidence against this assumption. First, however novel are the problems posed by new technology, they are not always entirely unprecedented. Concern about how to define death has a long history in medicine (Lock and Honde, 1990) and in many religious traditions, and the same is true of many other “unprecedented” issues. Second, religious and medical traditions are just as capable of extending traditional insights to the new problems posed by technological medicine as they were when faced by the economic and political changes that accompanied the modern era. Some of these traditions, including rabbinic Judaism, have arrived at positions on brain death without using the principles or methods of secular bioethics (Bleich, 1989; Jakobovits, 1989). Third, as indicated by the continuing controversies over brain death and by the differences in the way brain death has been received in the United States and Japan, it is often impossible to generate moral principles and apply them to cases without involving oneself in deeply held cultural or religious beliefs and practices (Zaner, 1988a; Lock and Honde, 1990).

If the issue of brain death is representative, as I believe it is, then the moral dilemmas generated by new medical technology do not account for the moral appeal of standard bioethics nor rationally vindicate its agenda or content. The growth of new technology can not account for the attractiveness or worthiness of standard bioethics or justify its agenda.

## BIOETHICS AND THE CRISIS OF MORAL AUTHORITY

Of course, technology has been a determinative factor—perhaps the most determinative factor—in the practice of medicine over the past two centuries and especially the past half century. Indeed my argument below assumes the prominence of technology and points to an intimate relationship between standard bioethics and technology. But at this point I have argued only that the reign of technology, as Stanley Reiser calls it, does not require the reign of standard bioethics. Yet if technology itself does not require standard bioethics, one may ask how within such a short period of time standard bioethicists successfully claimed authority over the resolution of the issues raised by technological medicine both in the clinic and in public policy. This brings us to a second account of the origin of bioethics, which refers not to the advance of technology but to a crisis of moral authority. As an explanation of the rise of bioethics, it has two advantages. First, it addresses the loss of the moral authority of the medical profession, which was necessary for bioethics to gain moral authority, and of religious traditions, which accounts for the nature of the bioethics that gained this authority (namely, its secular and allegedly nonsectarian character). Second, it properly identifies the grounds of the claim to moral authority in bioethics, namely its confidence that it represents and articulates a common morality.

Although the history of the American bioethics movement is in its infancy there nevertheless seems to be some consensus that the movement originated when the medical profession began to turn some of its moral authority over to outsiders. This constituted a definitive break with a long tradition according to which medical ethics was the exclusive domain of the doctor (Rothman, 1990, pp. 185–187). There are various accounts of what led to this abdication of authority. Albert Jonsen argues that it began in the early 1960s in Seattle when the limited availability of a new procedure, chronic hemodialysis, “led to a radically new solution”: the delegation of the task of selecting patients to a committee composed primarily of nonphysicians (Jonsen, 1993). Jonsen, a philosopher, is interested in showing how the Seattle dialysis case

marked the beginning of the "new medicine" in which issues such as microallocation, which involve populations rather than individual patients, will be central to clinical practice (Jonsen, 1990). Jonsen apparently believes that most of the ethical issues raised during earlier phases of the technological transformation of medicine were in principle resolvable within the contours of an ethics internal to medicine, despite the de facto involvement of outsiders. The reason is that they were primarily questions regarding the proper treatment of individual patients. Not so the problems raised by the "new medicine," which includes genetics, disease prevention, measures of quality and futility of care, and so forth, all of which are population based rather than patient based. "Almost all the ethical problems faced by the old ethic could be resolved within the framework of a relationship between the professional and the patient; the ethical problems posed by the new medicine reflect the omnipresence of the population that stands behind that patient" (Jonsen, 1990, p. 35). The ethic internal to the medical profession has no answers for this new kind of problem.

In reality, of course, the ethic internal to medicine did not successfully resolve its problems on its own; as Jonsen acknowledges, third parties—in the form of bioethicists, patient advocates, and ultimately and most decisively, the courts—were involved early and often. From this perspective the crisis of authority derives not from the intrinsic limits of the internal ethic of medicine but from a breakdown of the confidence of outsiders in that ethic itself, those who represent it, or both. David Rothman argues that the abdication of authority began when the crisis over the ethics of human experimentation precipitated by Dr. Henry Beecher's exposure of unethical research practices brought philosophers, legislators and others into the arena of clinical research (Rothman, 1990). Rothman, a social historian, links the crisis in human experimentation to the larger rights movement of the time that curbed the discretion of constituted authorities to act in the supposed best interests of others. The linkage was assured "largely because the great majority of research subjects were minorities, drawn from the ranks of the poor, the mentally disabled, and the incarcerated" (Rothman, 1991, p. 10). Rothman concentrates on the factors that brought strangers to the bedside, but his analysis is an effort to understand how the outsider ethic, characterized by general rules or principles applied to cases, was able to replace the medical "bedside ethic," an anecdotal, case ethic taught not formally but "by example, by role modeling, by students taking cues from physicians" (Rothman, 1991, p. 9).

Despite their disagreements, therefore, Jonsen and Rothman both point to the emergence of bioethics in a crisis of moral authority that

challenged either the competence or the right of the medical profession to decide all ethical issues in the practice of medicine, and that replaced an ethic internal to medicine with a very different kind of ethic. What kind of an ethic was this? When persons outside the medical profession first began to claim some authority to judge ethical issues in medical practice, they proceeded in a familiar American way: by invoking a common morality allegedly shared by everyone against a parochial morality accessible only to a privileged few. Of course, "common morality" is an ambiguous term. It can refer to a set of universal moral beliefs or principles grounded in reason or intuition or to a philosophical reconstruction of the unsystematic, largely customary moral beliefs shared by members of a community or society. In recent years many bioethicists have shifted from the first to the second sort of account (cf. Beauchamp and Childress, 1994).

In relation to medicine the claim can take a milder form in which the author accepts what he or she takes to be the traditional moral commitments of medicine but re-describes them as a subset of the fundamental moral commitments of common morality. This was Paul Ramsey's approach (Ramsey, 1970b, pp. xi-xii). Or the claim could take a stronger form that stresses the incompatibility of traditional medical ethics with the common morality. The specter of medicine as anti-democratic and not accountable to those outside the profession was raised in the early work of Robert Veatch (Veatch, 1981, pp. 6, 89). In either case the claim is that bioethics, in distinction from traditional medical ethics, is grounded in common morality and is therefore capable of managing the new capacities of medicine.

Standard bioethics appeals to a common morality not only in contrast to a parochial professional tradition but also in the hope of overcoming the diversity and disagreement that is associated with religious traditions. In this context, the commonality is sought in secularity (or at least a limited consensus or convergence of various religious and secular beliefs), a nonsectarian posture, and standards of rationality or reasonableness that allegedly either transcend or may be shared by particular communities. However, the differences between this secular, nonsectarian, rational common morality, and religious moralities have often not been as glaring as those between the former and medical morality. One reason is that a key strategy of theologians involved in bioethical debates has been to insist that many of their moral arguments were either grounded in reason or compatible with the shared customary morality of the wider community.<sup>6</sup>

While few persons who accept the fact that they live in a pluralistic society would want to yield public moral authority to a particular



religious tradition, the embarrassing fact remains that bioethicists do not agree on either the method or the substance of their allegedly common morality. The result, as H. Tristram Engelhardt, Jr., argues, is that standard bioethics is infected with the same irreducible diversity and endless disagreement as the religious bioethics it seeks to distinguish itself from. Moreover, this is a necessary result for any secular, nonsectarian ethics that proposes content, because moral content is impossible without particularity (Engelhardt, 1995). The tenacity with which standard bioethicists cling to their claim to articulate a common morality in spite of their disagreements testifies eloquently to the modern anxiety about moral unity in the face of diversity and to the hope that a secular rationality could supply that unity where religion failed. But if standard bioethics fails to arrive at a morality that is substantive enough to resolve moral disagreements yet common enough to compel the rational agreement of all—if it fails, that is, to resolve the crisis of moral authority on its own grounds (i.e., rationality)—the question of why so many health professionals, bioethicists, and laypersons still find it compelling remains to be answered. My argument in what follows is that its attractiveness or worthiness has little to do with its alleged rational authority and much to do with its success in articulating and supporting certain modern moral convictions.

## BIOETHICS AND THE LOSS OF TRADITION

While the second account gets the issue of moral authority right, it ignores the deeper roots of the crisis of moral authority. As a result, it fails to account for the basic moral content shared by standard bioethicists in spite of their disagreements, for the exact grounds on which traditional forms of ethics are considered inadequate, and for the kinds of issues standard bioethics fails to address due to its moral commitments. The deeper roots of the crisis of moral authority involve the loss of tradition in the West. The loss of tradition means the loss of a certain moral discourse—one that places the pursuit of health in the context of the pursuit of a good life within the limits set by fate or necessity—and its replacement by a new moral discourse—one that is dedicated to overcoming the human subjection to natural necessity. This places the narrative of the origin of bioethics squarely within a narrative of the emergence of modern moral theories.<sup>7</sup>

In order to describe this loss of tradition I will sketch some rather formal features of medical and religious moral traditions. The accounts are formal—I do not claim that they describe any single historically

identifiable practice or community. Nor do I claim that premodern societies were marked by practices that conformed to a unified moral vision that is now lost. Rather, I offer these accounts as instances of a range of moral concerns that characterized premodern practices and communities but that modern moral discourse disavows and disallows.<sup>8</sup>

An adequate description of medicine as a traditional practice would clarify the relation between knowledge and technical skill, on the one hand, and health as an end for the particular patient being treated, on the other hand. As such, medicine is a practical art. It assumes an understanding of health as a standard of bodily excellence or "an activity of the living body in accordance with its excellences" (Kass, 1985, p. 174). But it also recognizes that this standard must be specified with reference to each person, so that the task is to determine the nature and degree of health appropriate for a particular patient. Hence medicine requires general knowledge about excellent bodily functioning, insight into the relation of this functioning to the capacities and roles of a particular patient, and awareness of the possibilities and limitations of facilitating or restoring functioning for this particular patient. It is impossible to achieve competence without this threefold knowledge because one can identify a skilled practitioner only by his or her ability to fulfill the possibilities and observe the limitations of bodily health for a particular patient.<sup>9</sup>

Three important points follow. First, the standards and ends of medicine exist in a complex relation to the practice itself: medicine is not a set of technical skills in the service of ends that can be described apart from standards of excellence of bodily functioning, but what this excellence is for any given patient involves more than the body. Second, these standards need not and will not be static. Hence there is room in principle for technological change and for growth of insight. As with any practice, "conceptions of goods and ends which the technical skills serve . . . are transformed and enriched by extensions of human powers and by . . . regard for its own internal goods" (MacIntyre, 1984, p. 193). But, third, this transformation and enrichment will occur within the recognition of health as a mortal good and of human beings as destined to suffer disease and die (Kass, 1985, p. 163).

I now turn to the characteristics of the moral authority of a religious tradition. These characteristics may or may not be explicit; for some persons they may be almost entirely customary. An adequate description of such a tradition would include its account of the nature and proper ends of human beings, and of the virtues that either constitute those ends or enable one to attain them. It would also include an account of how one attains the proper ends of life, the obstacles (both

internal and external) one encounters, the authorities (official or unofficial) that lead and instruct one, and the powers (for example, divine grace) that assist one. Such a tradition will also include norms, rules, and prohibitions. These specify actions or modes of conduct that are either required or ruled out in order to engage in this way of life. For example, both the major precepts of the natural law in Thomas Aquinas and the five moral precepts in Theravada Buddhism specify the necessary conditions for embarking on a way of life devoted to reaching the higher ends in each tradition. One justifies these precepts by showing how that way of life depends on observing them. Without some such norms and prohibitions it would be impossible for that way of life to be the distinctive form of belief and practice that it is. Moreover, from within such a way of life, these norms, rules, and prohibitions will have a casuistical framework in which they are refined, contested, and sometimes abandoned; conflicts between them are resolved; and rules and authorities for interpreting them are identified and contested.

Such a tradition will possess two characteristics relevant to health and illness. First, it will provide an account of how bodily health is related to the ends of life, what degree of health is necessary to attain those ends, and how suffering thwarts or helps one to realize those ends. Second, when technology brings new areas of bodily life into the realm of medical intervention, both those ends themselves and certain norms and prohibitions will place limits on the pursuit of health and the means by which it is pursued.

These characteristics of medical and religious traditions are absent in the modern moral discourse that challenged these traditions. This modern discourse, or so I argue, accounts for the cultural content on which bioethics draws. Charles Taylor's reconstruction of the sources of the modern moral self offers one fruitful way of understanding this discourse (Taylor, 1989). What follows relies heavily on key elements of Taylor's interpretation, though I alter it, add to it, and apply the resulting product to medicine. One of the chief characteristics of the modern moral discourse according to Taylor is the moral valuation of ordinary life. For Protestant Christianity human effort is fruitless in attaining salvation, which comes through divine grace alone. Hence rather than directing one's life toward the attainment of moral and religious perfection, human effort is to be directed toward serving the needs of one's neighbors. This is done by engaging in the pursuits of ordinary life such as family and work. But if the needs of one's neighbors are to be met, one's work must be disciplined and effective. It became clear beginning with Francis Bacon that effectiveness would require an instrumental approach to nature, ultimately including human nature, in

order to fulfil its moral project. In this spirit Bacon praised the mechanical arts and disparaged speculative science for doing nothing “to relieve and benefit the condition of man” (Bacon, 1960, pp. 71–72; cf. Taylor, 1989, p. 213).

The instrumental approach to nature was supported by a theological conviction that God has ordered nature for the preservation and enhancement of human life. Nature is therefore governed by divine providence as in the Stoic and medieval cosmos, but the conception of a providential order has changed. The ancient and medieval conception of nature as a teleological order from which a hierarchy of ends could be derived was replaced by the burgeoning conception of nature as a law-governed mechanism, susceptible to human control and neutral with regard to ends—an order, therefore, which permits human control for the purposes of human preservation and well-being. As Taylor argues, from this perspective Baconian science could be viewed as an avenue to the fulfillment of Protestant moral and religious aspirations. Its turn from contemplation of nature to control of nature allowed nature to be used for its proper twofold purpose: to glorify God (rather than serve as an end in itself) and to benefit human beings (Taylor, 1989, pp. 231–233).<sup>10</sup>

Up to this point, the roots of modern morality are in Protestant Christianity. But as Taylor emphasizes, radical Enlightenment thinkers such as Jeremy Bentham were able to understand their secular agenda as a superior way of affirming ordinary life and expressing benevolence. According to them, the affirmation of ordinary life meant being true to the demands of ordinary human nature and so identifying good with pleasure and evil with pain. The Protestant commitment to meeting the needs of the neighbor now became a set of obligations to prevent and remove the causes of pain and to maximize the quantity of pleasure. As Taylor argues, this made it possible for the first time to put the relief of suffering (and the avoidance of cruelty) at the center of the social agenda. This emphasis on the relief of suffering in turn resulted in a new standard for all remaining conceptions of religious, moral, and legal order: Do they lessen the amount of suffering in the world or contribute to it? (Taylor, 1989, p. 331). From now on all these conceptions of order would have to present their credentials for relieving suffering to gain admission to the moral realm, credentials few such conceptions could produce.

Not surprisingly, this new moral agenda was closely connected with the loss of the belief in divine providence that had sustained the Protestant moral enterprise. Ever since the nominalists it had been difficult to support belief in divine providence on philosophical grounds,

and as the mechanistic explanation of nature reached its climax with Newton, providential and the remaining teleological approaches to nature were both discredited. Confidence in a providential order therefore gave way to a growing emphasis on the need to extract the preservation and enhancement of human life from an indifferent nature by means of technological labor. This has implications for the approach to suffering. While the loss of ideas of providence or a meaningful cosmic order removes the incentive to find any religious or cosmic meaning for suffering, the mechanization of nature means that suffering from natural causes is no longer an inevitable feature of the world but is, to the extent that human beings are capable of controlling nature, an object of human responsibility. Hence the new worldview both requires the elimination of suffering and makes it possible.

The contrasts with traditional ways of life are clear. First, the meaning of bodily life, which was once determined by an account of its excellent functioning and limited by its subjection to fortune, will now be determined by its susceptibility to technological control. The medical wisdom of learning the limits of healing and accepting the mortality of the body will yield to Bacon's admonition to call no disease incurable and, even more presciently, to orient medical knowledge to the prolongation of life (Bacon, 1894, pp. 163, 166–168). Second, the concern with the preservation and enhancement of ordinary human nature combined with the concern to relieve suffering means that health will become an end in itself rather than a condition or a component of a virtuous life. Medical care will be devoted to relieving and eliminating suffering wherever it is found rather than to the management of health for the pursuit of virtue. Third, rules and prohibitions limiting what can be done to the body to relieve suffering will appear to be at best insufficiently concerned about suffering and at worst arbitrary and even cruelly insensitive.

This combination of technological control over nature (including the human body) and a moral commitment to relieve suffering by preventing the harms and eliminating all the conditions and limitations that threaten bodily life accounts for a large part of the nature and task of medicine in the modern era. The unquestioned commitments to technological control of the body for the sake of eliminating "misery and necessity" constitute much of what I call the Baconian project. But there is one more chapter to the story. A second aspect of the modern moral framework is what Taylor calls inwardness. Inwardness has deep Augustinian and Cartesian roots, but during the Romantic period it surfaced in the inner conviction of the importance of one's own natural fulfillment. The idea is not only that each individual is unique and

original but that this uniqueness and originality determines how he or she ought to live. There is an obligation (more aesthetic than moral) for each person to live up to his or her originality (Taylor, 1989, pp. 370–376). What follows from this is the importance contemporary moderns place on free self-determination. Together with the ideal of universal benevolence, self-determination also leads to the idea of the subject as bearer of rights of immunity and entitlement. From this follows expectations that the expansion of the reign of technology over the body should be accompanied by, and in fact should make possible, the expansion of the reign of human choice over the body, and that medicine should enable and enhance whatever pattern of life one chooses.

Taylor argues that the Victorian era brought together these Enlightenment and Romanticist trends and bequeathed them to us—along with a view of history as a story of moral progress over our forebears, a progress marked by our greater sensitivity to and eradication of suffering and our greater latitude for human choice. This view enabled the Victorians to be convinced of their moral progress over the age of religion even as it enables their successors in this century to be convinced of their moral superiority over the Victorians (Taylor, 1989, pp. 393–396). As a result, medicine is based on practices and techniques of control over the body rather than on traditions of wisdom about the body. The task of public policy is to negotiate rights of immunity and entitlement rather than to determine the place of health, illness, and medical care in a well-lived and responsible life and in a good community. Traditional moral injunctions that limit or inhibit what medicine can do appear arbitrary, but there is no broader framework to evaluate and criticize the commitments of modern medicine. In the absence of such a framework the commitment to eliminate all suffering combined with an imperative to realize one's uniqueness leads to cultural expectations that medicine should eliminate whatever anyone might consider to be a burden of finitude or to provide whatever anyone might require for one's natural fulfillment. This does not mean that individual conceptions of this burden or this fulfillment are necessarily arbitrary. But it does mean that modern moral discourse provides no vocabulary with which to deliberate about what makes some such conceptions better or worse than others.

This brief sketch of modern moral discourse allows us to identify the major cultural values that standard bioethics draws on and expresses in its agenda and content. The connection of these values to the Baconian project helps explain the silence of standard bioethics on questions that challenge that project. Moreover, it shows us how this discourse, with its new ways of conceptualizing and objectifying the

body and nature, and its new moral valuations, makes it impossible for the moral questions and insights of the discourse of traditional ways of life to gain a hearing. In the modern discourse, moral convictions about the place of illness and health in a morally worthy life are replaced by moral convictions about the relief of suffering and the expansion of choice, concepts of nature as ordered by a telos or governed by providence are replaced by concepts of nature as a neutral instrument that is brought into the realm of human ends by technology, and the body as object of spiritual and moral practices is replaced by the body as object of practices of technological control. From this new perspective the moral and practical concerns of traditional discourses are obfuscated, marginalized, or rejected. But if standard bioethics derives its content and its plausibility from a contingent discourse rather than from the problems of modern technology or moral authority and its "objective" solution to these problems, a space is cleared for consideration of a bioethic that calls the agenda and content of standard bioethics, or at least their dominance or exclusivity, into question.

But before embarking on that project, three points must be made clear. First, I do not believe that there once was a golden age when medical care was grounded in a robust view of the good or that individual choices now are necessarily arbitrary. Nor do I believe that it is possible or desirable to reverse the technological revolution in medicine and simply return to traditional ways of life. Still less do I believe that publicly enforced consensus about these matters is possible or desirable. On the contrary, efforts to retrieve tradition must take account of the advantages of technology. My argument is the more modest one that modern moral discourse provides no vocabulary with which to deliberate about the meaning of corporeality, what moral purposes the body serves, what goods health should serve, or what limits the control of our bodies by technology should observe. Hence it allows for no discussion of what kinds of suffering should be eliminated, what kinds of choices human beings should make, and what role technology should play in all of this. Second, I do not argue that a commitment to the methods, theories, or principles of standard bioethics entails an explicit endorsement of the Baconian project. But neither is standard bioethics neutral with regard to that project. Negatively, the rejection of all substantive judgments about the moral meaning of bodily life and the ends technological control over the body should serve eliminates any in-principle objection to the Baconian project. Positively, standard bioethics fosters commitments to the elimination of suffering and the expansion of human choice within the moral constraints set by modern moral theories. I illustrate this positive commitment in the following chapter.

Third, my account simply identifies some features of the modern moral framework and does not do justice to the rigor with which some bioethicists have articulated and balanced these features.

Nevertheless my account allows for two conclusions in regard to the two accounts I have criticized. These conclusions should indicate why I believe my account is superior to those accounts in disclosing the moral appeal of standard bioethics. But by accomplishing this, these conclusions also indicate better than those accounts do how this moral appeal makes the quest for an alternative to standard bioethics so difficult. First, in regard to technology, it shows how the reign of technology expresses, and is perhaps in part produced by, the deepest moral commitments of modernity: the commitments to eliminate suffering and expand the range of human choices. If I am right about this, modern technology does not render traditional moralities obsolete or call for a new morality so much as it expresses and carries out an existing (modern) morality. Nor does it merely signal a will to dominate nature that levels all moral values and leads to nihilism, as many humanist and existentialist critics of technology charge.<sup>11</sup> Rather, modern technology is surrounded and infused by a certain kind of moral purpose. That this was the case for early prophets of technology is clear to Albert Borgmann in his summary of the projects of Francis Bacon and René Descartes.

The main goal of these programs seems to be the domination of nature. But we must be more precise. The desire to dominate does not just spring from a lust of power, from sheer human imperialism. It is from the start connected with the aim of liberating humanity from disease, hunger, and toil, and of enriching life with learning, art, and athletics. (Borgmann, 1984, p. 36)

Indeed, one of the most characteristic features of technological medicine is the confidence among its practitioners that the elimination of suffering and the expansion of human choice, in short, the relief of human subjection to fate or necessity, are (so long as abuses in implementation are avoided) unambiguous goods whose fulfilment is made possible by technology—a confidence standard bioethics supports and defends.<sup>12</sup> The moral purpose that surrounds technology and the moral confidence it inspires is precisely what makes it so difficult to criticize the reign of technology in medicine—a task that would be relatively easy were modern technology simply nihilistic or were the moral purpose it represents unambiguously flawed.

Second, in regard to moral authority, the foregoing account shows why moderns allow medicine to extend its authority over new



areas of life. But it offers an additional reason why standard bioethics was able to usurp much of this authority. This reason refers not to the claim of standard bioethics to articulate a common morality in place of the parochial ethic internal to medicine but to its greater success in giving individual persons a sense of control over the powers of medicine. One can divide the history of the American bioethics movement into three phases in which medical authority was challenged on these grounds. The first phase was dominated by the abuses of human experimentation documented by Beecher, and gave rise to demands for informed consent and truth telling. The second phase was dominated by the series of cases from Karen Ann Quinlan to Nancy Beth Cruzan that established the right of patients to the termination of life-sustaining treatment. This phase continues in the current controversies over physician-assisted death. The third phase may have begun with the Helga Wanglie case and will decide whether or not patients (or their surrogates) can demand medical treatment that their physicians believe is medically ineffective. Each phase can be interpreted in terms of a struggle in which medical authority defined by the ethic internal to medicine was (or will be) subordinated to the authority of the choice of the individual patient. Once again, the challenge to standard bioethics faces a greater challenge from this perspective. The claim of standard bioethics to have articulated a common morality is open to immediate objections. Engelhardt's argument that there is not only disagreement among the theories themselves but that any moral content assumes particularity is relevant here. The argument that standard bioethics is not really neutral toward all views of the good but rather articulates its own thin view of the good whose main features are roughly those I have described in this section is a hard-won argument, but has clear evidence in its favor. However, it is not immediately clear, and thus is much more difficult to show (as I try to show in my discussion of Foucault in chapter seven), that standard bioethics has actually failed to give authority and control over technology to individuals rather than to medicine (or to society through medicine), or that gaining such control for its own sake is not the ultimate purpose of bioethics.

It is one thing, therefore, to challenge the self-understanding of standard bioethics by pointing out the moral discourse that lends it its agenda, content, and plausibility; it is quite another (and much more difficult) thing to argue that its moral purpose and its understanding of human freedom are inadequate and to argue for an alternative agenda and content for bioethics. Fortunately, as the following chapters indicate, arguments for such an alternative are as old as the bioethics movement

itself. Unfortunately, as I will argue in several of these chapters, many of these arguments concede too much to the modern moral framework to supply an alternative to it.

## CONCLUSION

What, then, is the origin of the agenda of standard bioethics? The discourse in which religious and medical traditions were displaced. And what gives this agenda its plausibility? Its support of the effort to control natural necessity in the absence of the capacity to find any moral or spiritual place for the body as finite, mortal, and subject to fortune. To question standard bioethics, therefore, is to question the most fundamental assumption of a society rooted in the Baconian project: the assumption that in the absence of such a capacity, the power of technology over our lives has truly benefited us and has truly made us more self-determining. Whether these values and this assumption will survive new crises such as micro- and macroallocation and the appropriateness of genetic interventions, or whether these crises will lead to a recognition of the limits to and the costs of the effort to relieve the human condition is unknown. What is clear is that these limits and these costs have been the subject matter of a countermovement in bioethics whose major figures I examine in the chapters that follow. But before turning to the countermovement, it is necessary to say more about how standard bioethics supports the Baconian project. To that task I now turn.