“My mother’s doctor is refusing to give her antibiotics,” the caller told me in an urgent voice.

I asked why.

“He says that she’s ninety-two and an infection will kill her sooner or later, so it might as well be this infection.”

As disturbing as this call was, as outrageous the doctor’s behavior, I wasn’t particularly surprised. I have been receiving such desperate calls with increasing frequency for the last several years. Not every day. Not every week. But with sufficient regularity to know that something very frightening is happening to American medical ethics.

Among the more disturbing of such calls I have received was from John Campbell, whose teenage son, Christopher, had been unconscious for three weeks because of brain damage sustained in an auto accident. The boy had just been released from the hospital intensive care unit when he developed a 105-degree fever in the hospital’s “step-down unit.” Campbell asked the nurses to cool his fever. They replied that first they needed a doctor’s orders. Campbell asked them to obtain it, but Christopher’s physician was out of town and the on-call doctor said no. “It was an evening of hell,” Campbell says. “My son’s life meant less than hospital protocol. When the doctor refused to order treatment, the nurses said that there was nothing they could do.”
Campbell desperately tried to reach the on-call doctor himself, but the physician refused to take Campbell's phone calls or respond to his increasingly urgent messages. Meanwhile, Christopher's condition worsened steadily, his fever rising over a period of some twenty hours, to 107.6 degrees. Finally, the nurses—caught between a desperate father's pleas and a doctor's steadfast refusal to treat—instructed the on-call doctor to take Campbell's call.

Campbell demanded that his son's fever be treated immediately. The doctor refused. When Campbell grew more insistent, the doctor actually laughed. The boy was unconscious. His life was effectively over. What was the point?

"By this time," Campbell recalls, "my son's eyes were black as if he had been in a fight. He was utterly still. He was burning up. The back of his neck was so hot you couldn't keep your hand on it. I said to the doctor, 'This is not a joke! This is my son. His life is at stake. His temperature is over 107 and you are going to do something about it.'" Hearing the angry determination in Campbell's voice and perhaps fearing legal consequences if Christopher died untreated, the doctor finally acquiesced.

Shortly after treatment commenced, Christopher's temperature subsided. Soon he was moved to a rehabilitation center for therapy and began a slow recovery. Today, he lives at home with his parents where he is learning to walk with assistance. When not in rehabilitation, Christopher works at a local youth center where he feeds animals and counsels at-risk teenagers. Christopher is very glad to be alive—and his parents and the many troubled people he helps every day are glad, too.

I believe that stories such as Christopher's are symptoms of a disintegrating value system in health care, which defines the sickest and most disabled among us as having lives not worth living, which views expensive medical treatments for such people as a waste of valuable resources, and which accepts their demise as a legitimate solution to the difficulties caused by their serious illnesses and disabilities. In short, the ethics of health care are evolving into a stark utilitarianism, which has begun to undermine the "do no harm" credo that has, for millennia, been the cornerstone of medicine.

Such attitudes certainly seem to have contributed to the death of Anthony Shatter, my friend Kathy's father. On one otherwise unexceptional Sunday, Anthony, a healthy seventy-six-year-old man, beloved by his family, active in the community and his church, fell on his driveway and hit his head. Seriously injured, he was rushed by ambulance to the emergency room, where he received excellent treatment and was then hospitalized for further care. For the next few days Anthony seemed to be getting better, but then his brain began bleeding and he was hurried into surgery.

Anthony emerged from surgery significantly debilitated. He needed a ventilator to breathe and required medically delivered food and fluids. He was in and out of consciousness, some days awake and aware, other days virtually unresponsive. Anthony was not terminally ill. He was not permanently unconscious. He was, however, significantly disabled and almost certainly would be for the rest of his life.

Anthony's prognosis was difficult for the Shatter family. But a dark time became excruciating because of the changes they noted in the attitudes of Anthony's medical caregivers. In the beginning, they had clearly valued Anthony's life and enthusiastically provided him with optimum care, but now they urged the family to accept his quick death as the solution to his medical condition and to their own continuing emotional struggle. Indeed, to ensure that Anthony would die, his doctors pressured the family into authorizing the withholding of his tube-supplied food and fluids.

The Shatters were appalled at the idea of dehydrating and starving someone they loved. After some back and forth, the hospital staff finally accepted the Shatters' decision. Six weeks after his accident,
Anthony was transferred to a rehabilitation hospital where, the Shatters believed, he would receive treatment to help restore as much physical and mental function as his condition would allow. The day of the transfer, in fact, he spoke briefly with his family. All were hopeful. Perhaps he could soon be brought home.

Unfortunately, Anthony didn’t get better. Moreover, at the new facility, the attitude of the personnel toward his life’s value was, if anything, worse than at the original hospital. Then one Friday morning, Anthony developed a high fever and his blood pressure dropped. “We wanted Dad treated,” Kathy says. “We demanded that a doctor examine him. Nobody showed up for hours. Dad was burning up and nothing whatsoever was being done. Finally, I spoke with an administrator and threatened to call the police if they did not take care of my father. He hemmed and hawed and reminded us that Dad wasn’t making progress. I screamed at him, ‘I am calling the police and telling them you are murdering my father by refusing to help him! Get a doctor to my dad’s bedside!’ That finally got some action.”

Anthony was taken to the hospital intensive care unit and was stabilized. But it was too late. He died early on Saturday morning.

The medical neglect of Kathy’s father, the refusal of the elderly woman’s doctor to treat her with antibiotics, the doctor’s derision of a desperate father’s request to reduce his son’s fever are not isolated or even atypical anecdotes. They are storm signals warning of a quickly developing ethical crisis in a medical world that increasingly devalues some human lives and views people at the margins as expendable. Traditional morality and medical ethics are crumbling before our very eyes.

The New High Priests

We have not entered this dark new world by chance. We have been steered into it by an elite that has increasingly dominated public and professional discourse about medical ethics and the broader issues of health care policy for the last three decades.

Medical ethics deals with the behavior of doctors in their professional lives vis-à-vis their patients. Bioethics, as it has developed over the last few decades, focuses on the relationship between medicine, health, and society. This last element allows bioethics to espouse values “higher” than the well-being of the individual and to perform the philosophical equivalent of triage. Because of the almost imperialistic view of their mandate, many bioethicists presume a moral expertise of breathtaking ambition and hubris. Many view themselves, quite literally, as forgers of “the framework for moral judgment and decision making,” those who will create “the moral principles” that determine how “we are to live and act,” fashioning a “wisdom” they perceive as “specially appropriate to the medical sciences and medical arts.” Indeed, some claim that “bioethics goes beyond the codes of ethics of the various professional practices concerned. It implies new thinking on changes in society, or even global equilibria” (my emphasis). Not bad for an intellectual pursuit that has only existed for about thirty years.

Bioethicists typically see their work as integrating “medical ethics and universal morality,” going beyond “a few general principles” toward determining “the meaning of the good life.” It is “both a discipline and a public discourse, about the uses of science and technology” and the “values about human life... with a view toward the formation of public policy and a teachable curriculum.” Put more simply, bioethics seeks to create a new morality of medicine that will define the meaning of health, determine when life loses its value, and forge the public policies that will promote a new medical and moral order. More than a set of tenuous speculations, bioethics in recent years has ossified into an ideology.

Undoubtedly, some bioethicists will angrily reject such a definition of their trade and calling. They act in good faith, they will contend. They are proponents of “quality of life” and only intend the creation of a better world. Besides, they will argue, bioethics is far from monolithic, the field contains widely divergent opinions about the issues and controversies they confront, ranging from assisted suicide, to cloning, to the definition of “health.” Moreover, many would undoubtedly claim, bioethics doesn’t have an end goal. It is more akin to a conversation among professional colleagues, a process that merely seeks rough consensus about the most pressing moral and medical
questions that arise in a social world affected by an ongoing health care crisis. Indeed, most bioethicists would recoil at the notion that they are “true believers.” Their self-image is that of the ultimate rational analyzers of moral problems and facilitators of ethical dialogue, who, were pipe smoking still fashionable, would sit back with pipe firmly in mouth and act as dispassionate mediators between advancing medical technology and the perceived need to impose reasonable limits on access to treatment as required by finite resources.

That may be their self-image, but it is also a dodge and a self-deception. Once bioethics moved away from ivory tower rumination and began actively influencing public policy and medical protocols, the field, by definition, became a goal-oriented “movement” attempting to affect political outcomes. Indeed, University of Southern California professor of law and medicine Alexander M. Capron notes that from its inception, “bioethical analysis has been linked to action.”11 Even historian Albert R. Jonsen, a bioethicist himself, calls bioethics a “social movement.”12 Has there been any social movement that was not predicated, at least to some degree, on ideology? Moreover, the bioethics pioneer Daniel Callahan, co-founder of the Hastings Center, a bioethics think tank, has admitted that “the final factor of great importance” in bioethics gaining societal respect was the “emergence ideologically of a form of bioethics that dovetailed nicely with the reigning political liberalism of the educated classes in America.”13

I asked the author, medical ethicist, and physician Leon R. Kass his opinion about my belief that bioethics has become an ideology. Kass told me, “With due allowances for exceptions, I think there is a lot to be said for that view. There are disagreements about this policy or that, but as to how you do bioethics, what counts as a relevant piece of evidence, what kinds of arguments are appropriate to make, there is a fair amount of homogeneity. If you don’t hew to that view, you are considered an outsider.”14

The noted sociologist Renee C. Fox, a close observer of bioethics from its inception, told me in a similar vein, “I would call it an inadvertent orthodoxy. You could even call it ideology, depending on how you define the term.” She added, “I do think bioethics has gotten institutionalized. It is being taught in every medical school in this country. The training people receive and the content of the curriculum of the short courses as well as the masters and doctoral programs can be quite formulaic. In that sense, I think you could talk properly about orthodoxy.”15

Sociologist Howard L. Kaye, author of The Social Meaning of Modern Biology,16 believes that this bioethics establishment sees its agenda “less as an attempt to arrive at an ethical regulation of biomedical developments” than as a program of “biology transforming ethics.” Kaye observes that many bioethicists “believe fervently that there needs to be a radical transformation in how we live and how we think based on new biological knowledge because our values, our ethical principles, our self conception are based on outmoded religious ideas or philosophical ideas that they think have been discredited.”17 If Kaye is correct—and there is abundant evidence that he is—the ultimate bioethics agenda is startlingly radical: dismantling traditional Western values and mores and forging a new ethical consensus based on values most people do not presently share.

This would be of little consequence if the bioethics movement were relegated to the cultural fringe. But bioethics advocacy is pervasive within the nation’s most important institutions. In the last thirty years—financed by tens of millions of dollars in foundation grant money—bioethics ideology has spread throughout the depth and breadth of the educational, medical, legal, business, and governmental establishments to become one of the most influential cultural forces in the country. Members of the bioethics elite serve on influential federal and state government policy commissions, influencing the evolution of public policy and popular views. They write health policy legislation and they consult in medical controversies at the clinical level, often influencing life-and-death decisions. Both theoretical and clinical bioethicists testify as expert witnesses in cutting-edge lawsuits and submit “friend of the court” briefs in appellate cases of major significance. They appear on television and in the print media as “expert” commentators. They advise important politicians, all the way up to the president of the United States.

But the greatest influence of bioethics ideology is in education. Bioethics is taught to every medical school student, significantly
influencing the attitudes of our doctors of tomorrow toward the health care system generally and their future patients specifically. Bioethics instruction is also provided to other university and postgraduate students destined to become lawyers, business executives, government policy makers, and educators. For those who wish to make a career in bioethics itself, there are more than thirty postgraduate programs in our leading universities, whence graduates go on to become consultants to nursing homes and HMOs, clinical bioethicists in hospitals and organ procurement centers, or fellows in the nation’s medical and bioethical think tanks.

More immediately, the current generation of national, state, and local health care policy decision makers, clinicians, and professional leaders are being steeped in bioethics ideology in continuing education courses and symposia. Many universities around the country sponsor “short courses” in bioethics designed to train nurses, administrators, and other medical professionals who work at the clinical level how to make clinical decisions from a proper bioethical approach, thereby spreading the influence of bioethics to the bedside. For example, the University of Washington sponsors an annual five-day summer seminar designed to teach “physicians, nurses, social workers, chaplains, attorneys, teachers, and other professionals involved in the care of patients or the education of providers” the “concepts, methods, and literature” of the new medicine inspired by bioethics advocacy.\(^{18}\)

Bioethics is now an international movement. Bioethics advocacy exists in virtually every developed country. Moreover, the movement is continually seeking to expand its global influence. For example, the International Society of Bioethics urged recently that “the teaching of bioethics be incorporated into the educational system” of nations around the world.\(^{19}\)

The philosopher and theologian Richard John Neuhaus described this oozing of bioethics belief into every nook and cranny of the West’s institutions most succinctly several years ago when he wrote, “Thousands of ethicists and bioethicists, as they are called, professionally guide the unthinkable on its passage through the debatable on its way to becoming the justifiable, until it is finally established as the unexceptional.”\(^{20}\)

It is worth reflecting upon what has become unexceptional in our medical and moral lives. Twenty years ago, for instance, it would have been unthinkable to dehydrate people to death by removing their feeding tubes because they were cognitively disabled. It might even have been criminal. Today, due in large part to vigorous advocacy by bioethicists, which in turn has led to court cases and then to new laws permitting the practice, it is routine in nursing homes and hospitals throughout the country.\(^{21}\) Fifteen years ago, legalized assisted suicide was virtually unthinkable in the United States and Canada. Today, thanks in large part to advocacy by bioethicists, it is deemed justifiable, not only in Oregon where it is now sanctioned by law, but if public opinion polls are accurate, elsewhere in the country. It was once unthinkable to procure organs from someone in a coma. Today, some of the most mainstream bioethicists and physicians in the organ transplant community dispassionately debate the issue in bioethics and medical journals.

The new medicine, ethics, public policies, and philosophical beliefs that bioethics espouses are being forced upon a reluctant public. Dr. Leon Kass explains: “There is a kind of condescension toward the views of the general public [among bioethicists] and a considerable divide about core moral views. The American people, as a whole, are a religiously affiliated or God-believing people and it is on the basis of the wisdom of these traditions that they express their fears about the threats to sanctity of human life and to human dignity.” On the other hand, mainstream bioethicists specifically reject these values. “At its founding bioethics involved a fair number of people who came at it from a religious perspective but the field has since been taken over by a secular form of doing ethics that is very little informed by any kind of metaphysical or transcendent view.” Thus, bioethicists proclaim answers to our most pressing moral questions based on attitudes, sensibilities, and mores that are not shared by the very people who are supposed to benefit from their “moral expertise.” Kass warns, “There is the very real danger that what constitutes a ‘meaningful life’ among the intellectual elite [who make up the bioethics establishment] will be imposed on the people as the only standard by which the value of human life is measured.”\(^{22}\)
John Keown, a University of Cambridge law professor and lecturer in the law and ethics of medicine, accurately identifies this fundamental conflict:

Traditional common morality, as its name suggests, comprises ethical principles common to civilized cultures. The notion that there are certain objective principles which societies must respect if they are to qualify as civilized, has been expressed in the West in the Hippocratic Oath, in Judeo-Christian morality, the prohibition against killing the innocent, and in the common law. ... But much of modern bioethics is clearly subversive of this tradition of common morality. Rather than promoting respect for universal human values and rights, it systematically seeks to subvert them. In modern bioethics, nothing is, in itself, either valuable or inviolable, except utility.23

Creating a Hierarchy of Human Life

"The traditional Western ethic," a California Medicine editorial stated in 1970, "has always placed great emphasis on the intrinsic worth and equal value of every human life." This "sanctity of life ethic," the editorial continued, has been "the basis for most of our laws and much of our social policy" as well as "the keystone of Western medicine. ... This traditional ethic is being eroded at its core and may eventually be abandoned. ... Hard choices will have to be made ... that will of necessity violate and ultimately destroy the traditional Western ethic with all that portends. It will become necessary and acceptable to place relative rather than absolute values on such things as human lives."24

In the decades since these chilling words were written, this is exactly what has happened. Rather than believing in inherent human equality, most contemporary bioethicists measure the value of human life subjectively. Instead of embracing the human community—which means all of us—they worry instead about the "moral community," which in theory and often in practice excludes some of us. For most bioethicists, basic human rights are not inalienable, but must be earned by criteria they have created. Thus, equality ceases to be a universal vision.

If these words seem harsh, consider the thinking of the late Joseph Fletcher, a philosopher whose ideas had enormous impact on the West in the second half of the twentieth century. Fletcher is most famous for creating "situational ethics," which emphasize "cutting loose from moral rules" and view "reasoned choice as basic to morality."25 Applied to medical ethics and health care, situational ethics made Fletcher, in Albert R. Jonsen's term, "the patriarch of bioethics."26

Fletcher was a radical utilitarian whose stated goal was to maximize human happiness and minimize suffering. That sounds good in the abstract, but in fact, once he had freed himself from "moral rules" Fletcher developed a worldview that was paradoxically both anarchic and totalitarian. Thus, in the name of human freedom he supported the wildest ideas, such as the manufacture of chimeras (part human, part animal) through genetic engineering.27 Yet individual humans per se actually counted for little in his scheme, and those he perceived as interfering with the general pursuit of the greater happiness were expendable.

Early on, Fletcher dismissed the traditional medical "reverence for life," sniffing that "nobody in his right mind regards life as sacrosanct." Developing his thesis from the then newly won right to abortion, Fletcher distinguished mere "human life" from what he called "personal life." "What is critical is personal status," he wrote in 1973, "not merely human status." Fletcher created a list of "criteria or indicators" that he hoped could be used to divide society between those individuals who possessed "humanhood" and those who did not—between "truly human beings," deserving of great moral concern, and others who were "subpersonal" and of scant consequence.28 Here, he used the terms "humanhood" and "truly human" not as biological descriptions but as subjective terms connoting those people he considered to have the highest moral value.

The immediate problem facing Fletcher, and those contemporaries who agreed with him, was to devise a method that would allow them to cull the human herd. Toward that end, Fletcher proposed a formula to gauge the quality of a human life "for the purposes of biomedical ethics."29 These included fifteen qualities to measure and define humanhood, among them the following:
CULTURE OF DEATH

Minimum Intelligence (Score too low and one is deemed "mere biological life.")

Self Awareness ("Essential to the role of personality.")

Self Control (If someone is not in control of him or herself, "the individual is not a person.")

A Sense of Futurity ("Subhuman animals do not look forward in time.")

Memory ("It is this trait alone that makes man ... a cultural instead of instinctive being.")

Concern for Others ("The absence of this ambience is a ... clinical indication of psychopathology.")

Communication ("Disconnection from others, if it is irreparable, is dehumanization.")

Neocortical Function ("In the absence of the synthesizing function of the cerebral cortex, the person is non existent. Such persons are objects, not subjects.")

Fletcher also factored five "negative" points into his thesis. For example, he claimed that man is not "anti-artificial" and that "to oppose technology is self-hatred." Thus, "a baby made artificially by deliberate and careful contrivance, would be more human than one resulting from sexual roulette—the reproductive mode of subhuman species" (my emphasis). Fletcher dismissed the notion of innate human rights: "Man is not a bundle of rights. The idea behind this is that such things are objective, pre-existent phenomena, not contingent on biological or social relativities." In other words, Thomas Jefferson was all wet.

To understand how dangerous the thought of the patriarch of bioethics really is, one need only read Fletcher's 1975 essay "Being Happy, Being Human." Here he describes participating in a panel discussion of the treatment of babies born with serious birth defects. A physician who cared for a profoundly mentally retarded boy reported that while possessing a very low IQ, the child was clearly happy and clearly a human being. Fletcher coldly dismissed the human worth of this defenseless child—and many other mentally retarded people:

Idiots are not, never were, and never will be in any degree responsible [because they cannot understand consequences of action]. Idiots, that is to say, are not human. The problem they pose is not lack of sufficient mind, but of any mind at all. No matter how euphoric their behavior might be, they are outside the pale of human integrity. Indeed, sustained and "plateau" euphoria is itself prima facie clinical evidence of mindlessness.

Such a provocation had a purpose: to gain support for the notion that killing "idiots" could, depending on the facts of each individual case, be ethical and right, and that such decisions, rather than even being morally portentous, were merely a "clinical" matter. In the case of disabled infants, Fletcher wrote elsewhere, killing should simply be considered "postnatal abortion." "

Not every bioethicist agrees with every idea Joseph Fletcher ever expressed. Nor will every radical policy Fletcher ever promoted eventually become culturally or medically acceptable—although many of them, such as dehydrating to death cognitively disabled people, which Fletcher proposed as early as 1974, already have. But it is telling that Fletcher was not dismissed by the fledgling bioethics movement as some fanatic kook when he advocated infanticide, "research on living fetuses outside the womb," combining human and animal DNA, and dehumanizing cognitively disabled people. In fact, his ideas were given immediate respect, which allowed them to travel from the realm of the unthinkable, to borrow Richard Neuhaus's terminology, into the region of the debatable, whence many have gone on to become unexceptional.

That is not to say there was no intellectual resistance within the early bioethics movement to the steady growth of this sort of secularist, radically utilitarian thinking. A strong countermovement, led by theologian Paul Ramsey, provided a significant challenge to the Fletcher school for many years. Ramsey believed that people owed each other a duty of fidelity based upon "covenant responsibilities," rooted in "justice, fairness, righteousness, faithfulness, canons of loy­alty, the sanctity of life, hesed agape [steadfast love], or charity." This meant, according to Ramsey, that there is "sacredness" in "bodily
life" from which flow our mutual duties to care for each other, including the most weak and vulnerable among us.38

Where Fletcher's approach was a bioethical version of anything goes, Ramsey stood firmly against the idea that the ends justify the means. Where Fletcher sought to create invidious divisions among people based on whether they measured up to his humanhood criteria, Ramsey explicitly rejected the entire plan as immoral. "Fletcher is simply a sign of the times," Ramsey worried as he asserted that creating a checklist to judge how people should be treated in health care was wrong because it was to "play God as God plays God."39

Gilbert Meilaender, a theologian and ethicist who has been part of this struggle for decades, characterized the contest between Fletcher and Ramsey for the soul of bioethics as a three-decade war. Unfortunately, the war seems to have ended with a clear victor. Few of Ramsey's books remain in print, while most of Fletcher's books and articles are readily obtainable. In the end, it was Fletcher, not Ramsey, who became the "patriarch" of modern bioethics. Fletcher, not Ramsey, was the one who "articulated where bioethics was heading well before the more fainthearted were prepared to develop the full consequences of their views."40 Philosophy professor Courtney S. Campbell puts it succinctly: "Joseph Fletcher was a bit of a maverick for his time, but looking back from the 1990s, it is very clear that his approach has come to predominate in bioethics."41

Once someone like Fletcher secured a beachhead, it was only a matter of time before someone like Peter Singer would stage his much-publicized landing in bioethics. One of the world's most influential contemporary utilitarian bioethicists/moral philosophers, Singer takes Fletcher's original formula and extends it to even more radical ends. Whereas Fletcher sought to determine who had moral value strictly for the benefit of humans, Singer expands the "moral community" into the world of animals.

Singer contends that being human, in and of itself, is irrelevant to moral status; what counts is whether a "being" is a "person." He reduced Fletcher's multipoint formula to "two crucial characteristics" of a "person": rationality and self-consciousness.42 Species is irrelevant; Singer claims that by these criteria some animals are persons, including "whales, dolphins, monkeys, dogs, cats, pigs, seals, bears, cattle, sheep, and so on, perhaps even to the point where it may include all mammals."43 On the other hand, some humans would not be persons, including newborn human infants, whether disabled or not, and people with advanced Alzheimer's disease or other severe cognitive disabilities—people whom Singer claims are not self-conscious or rational. Singer makes an explicit moral comparison between these humans and fish or fowl, which unlike "higher" animals are not persons either: "Since neither a newborn infant nor a fish is a person the wrongness of killing such beings is not as great as the wrongness of killing a person."44

To someone unacquainted with the mindset of contemporary bioethics discourse, such ideas may simply sound weird and off the wall. But as I will later show, they actually are the foundation for Singer's claim that infanticide and involuntary euthanasia of cognitively disabled people can be justified while most human use of animals, whether for food, clothing, entertainment, or in medical research, should be prohibited.

In another world and time, Peter Singer's advocacy would make him an intellectual outcast. He actually is in bad odor in Germany and Austria, where he cannot speak without generating angry protests from people who consider his opinions Nazi-like.45 But many in bioethics and academia embrace him. Far from being the fringe character that ideas like those mentioned above should make him, Singer is invited to present papers at seminars, symposia, and philosophy association conventions throughout the world. His 1979 book, Practical Ethics, which unabashedly advocates infanticide and euthanasia while decrying "discrimination" based on species (a bizarre notion Singer labels "speciesism"), has become a standard text in many college philosophy departments. Singer is so mainstream that he even wrote the essay on ethics for the Encyclopedia Britannica. Most disturbingly, in 1999 he became a permanent member of the Princeton University faculty, as the Ira W. DeCamp Professor of Bioethics, a prestigious tenured chair at the university's Center for Human Values.

The person/nonperson distinction is generally accepted throughout bioethics and increasingly applied to animals, as Singer has
advocated. The British academic John Harris, the Sir David Alliance Professor of Bioethics and director of the Institute of Medicine, Law, and Bioethics at the University of Manchester in England, defines a person as “a creature capable of valuing its own existence,” which he believes could include people, animals, extraterrestrials and machines, but not some humans such as infants “during the neonatal period.” To Harris, who has mastered Fletcher’s casuistry, it is not wrong to kill nonpersons or fail to save their lives:

[To] kill or to fail to sustain the life of a person is to deprive that individual of something that they value. On the other hand, to kill or to fail to sustain the life of a nonperson, in that it cannot deprive that individual of anything that he, she, or it could conceivably value, does that individual no harm. It takes from such individuals nothing that they would prefer not to have taken from them.... Nonpersons and potential persons cannot be wronged in this way [killing them against their will] because death would not deprive them of anything they can value. If they cannot wish to live, they cannot have that wish frustrated by being killed.46

Similarly, Georgetown University’s Tom L. Beauchamp, co-author with James F. Childress of Principles of Biomedical Ethics, an influential bioethics textbook, asserts that personhood and nonpersonhood designations may soon inform us whether we can use people as objects of exploitation:

Many humans lack properties of personhood or are less than full persons, they are thereby rendered equal or inferior in moral standing to some nonhumans. If this conclusion is defensible, we will need to rethink our traditional view that these unlucky humans cannot be treated in the ways we treat relevantly similar nonhumans [emphasis added].47

To see how dehumanizing such thinking becomes, pay close attention to the following description of the dying process of a “nonperson” human written by Baruch A. Brody, the director of the Center for Medical Ethics and Health Policy at Baylor College of Medicine in Houston, Texas, in a bioethics book about how death should be redefined:

Consider the organism that suffers damage to its brain so that it is no longer conscious and can no longer engage in responsive voluntary movement. At some later stage, it loses the capacity to breathe on its own so that its respiration must be supported artificially. At a later stage, its capacity to regulate hormonal levels stops. Somewhere during this time period, its auditory pathways stop functioning. Finally its heart stops beating. Is it really meaningful to suppose that the organism died at some specific point in the process? ... Isn’t it more reasonable to say that the organism was fully alive before the chain of events began, is fully dead by the end of the chain of events, and is neither during the process.48

Such prose is not only disrespectful, it is dangerous. Once people are defined as “organisms,” they have been utterly stripped of their humanity. Such objectification, as we shall see later in the book, is the key that opens the door to plans currently on the bioethics drawing board to exploit “nonperson” humans as if they weren’t people but merely natural resources.

Not all bioethicists are as candid as Fletcher, Singer, Harris and Beauchamp in their scorn for human equality and the sanctity-of-life ethic. The influential law professor and bioethics author Ronald Dworkin, whose affect on the Montana Supreme Court I mentioned earlier, argues in his book Life’s Dominion that killing the weak and helpless can actually be a method of upholding the inherent value of all human life.49 Unlike the other bioethicists previously mentioned who disdain traditional Judeo-Christian morality, Dworkin claims that the argument between those who support practices such as abortion or euthanasia and those who oppose them isn’t even an argument about whether the sanctity of life is a sound principle. Everyone agrees that it is, he claims, “We disagree so deeply because we all take so seriously a value that unites us as human beings—the sanctity or inviolability of every stage of every human life. Our sharp divisions signal the complexity of the value and markedly different ways that different cultures, different groups, and different people, equally committed to it, interpret its meaning.”50

Yet in Dworkin’s hands, the exact meaning of “sanctity of life,”
much like the meaning of art, is left to each person to determine individually. Thus, Dworkin says having an abortion is not denying life's sanctity to the human fetus, but upholding life's sanctity for the woman who doesn't want it to become a baby. "It may be more frustrating to life's miracle when an adult's ambitions, talents, training and expectations are wasted because of an unforeseen or unwanted pregnancy than when a fetus dies before any significant investment of that kind has been made." Regardless of where one stands in the great pro-life/pro-choice cultural divide, to assert that having an abortion is somehow to embrace "the inviolability of every stage of every human life," as Dworkin does, is simply ludicrous.

Dworkin similarly asserts that euthanasia is not actually a rejection of the sanctity of life, but an embrace of it. "People who want an early, peaceful death for themselves are not rejecting or denigrating the sanctity of life," he writes. "On the contrary, they believe that a quicker death shows more respect for life than a protracted one." Promoting active killing of ill people without a hint of irony as an embrace of life's sanctity has had some of the force of Bill Clinton's "It depends on what the meaning of 'is' is." For Dworkin, the "sanctity of life" is not a principle but a mere contingency, defined essentially by where a person stands in his or her life at any given moment. Such a porous concept is incapable of protecting the weak and vulnerable from medical discrimination or killing; and that—as with the distinction between human beings based on personhood criteria—is exactly the point.

Dworkin argues that since the deaths of some people cause more grief and a greater sense of tragedy than the deaths of other people, it is justifiable to view the inviolability of individual human lives in relative terms. He writes:

Most people's sense of that [death-caused] tragedy, if it were rendered as a graph relating the degree of tragedy to the age at which death occurs, would slope upward from birth to some point in late childhood or early adolescence, then follow a flat line until at least very early middle age, and then slope down again toward extreme old age. ... [Thus] the death of an adolescent girl is worse than the death of an infant girl because the adolescent's death frustrates the investments she and others have made in her life.

Determining the value of life with such an emotional yardstick is a quixotic enterprise. One could just as easily argue that the newborn's life is more valuable because it is all potential—a blank slate—while the adolescent has already acquired a character and experiences that limit her range. Such arguments are, at best, an underwriter's version of morality, and not worth the time it takes to make them.

**Euthanizing Hippocrates**

"To regard life as sacred," Leon Kass has written, "means that it should not be violated, opposed, or destroyed, and that positively, it should be protected, defended and preserved." These precepts are especially important in medicine, considering the power accorded physicians to cut, poke, drug, and manipulate the bodies of their patients. Gilbert Meilaender summarizes the obligation of physicians as "to be committed to the bodily life of their patients." A robust belief in the sanctity of life takes these prescriptions one step farther by positing the obligation of physicians to view each of their patients as having equal moral worth. In such an ethical framework, physicians are not free to pick and choose among their patients those to whom they will give optimal care. Every patient deserves the same level of dedication, excellence, loyalty, and fidelity from his or her doctor, regardless of their physical or cognitive condition.

These worthy concepts are famously embodied in the Hippocratic tradition. Indeed, medicine may actually have been the first field in which the underlying principles of the equality-of-life ethic were recognized as applying generally rather than parochially. The oath bearing the name of Hippocrates (ca 470–360 BCE) was created hundreds of years before the advent of Christianity. It required physicians, among other obligations, to "apply dietetic measures for the benefit of the sick according to my ability and judgment" and to "keep them from harm and injustice," and "to give no deadly medicine to any one if asked." The life- and dignity-affirming doctrines of the
Hippocratic Oath are generally summarized by the familiar phrase “do no harm.” These principles were and are upheld by physicians in a myriad of ways, by rendering optimum care to each patient, promoting bodily healing, alleviating pain and suffering, respecting a patient’s dignity, refusing to disclose a patient’s confidences even in a court of law, and refusing to kill a patient even if so requested.

As the twenty-first century dawns, the Hippocratic tradition is ailing. According to the physician and ethicist Edmund D. Pellegrino of Georgetown University, it remains “the moral backdrop against which most American and British physicians made, and still make, their ethical choices.” However, the tradition has been under sustained attack for more than twenty years and is in acute danger of collapse. “It was when bioethics came on the scene that the Hippocratic tradition of the physician/patient relationship started to fall apart,” philosopher Dianne N. Irving told me. “Once it was weakened, bioethics began to replace it with medicine practiced for the greater good of the society rather than for the individual patient. That threatens patient welfare and denigrates medicine into a business, rather than a profession.” What Irving intends as a criticism is embraced as an accurate description by many bioethicists who celebrate their calling as “post-professional.”

A recent study of physician oath-taking published in the Journal of Clinical Ethics illustrated how far modern medicine has strayed from the traditional values of the Hippocratic Oath. The authors analyzed contemporary medical oaths and compared them to the Hippocratic original. In light of Roe v. Wade, it is not surprising that only 8 percent of doctors pledge to forswear abortion; it is surprising that only 14 percent promise not to commit euthanasia.

When I tell my lecture audiences that most doctors no longer take the Hippocratic Oath upon becoming physicians and that many no longer see it as relevant to their profession, they are shocked and disturbed. They believe, quite correctly, that the oath exists for their protection. They want their doctors to practice a “do no harm” style of medicine. “Why have they abandoned a tradition that has served medicine so well?” they ask.

The answer to this important question is complex, having much to do with who we are as a culture and a people. According to Edmund Pellegrino, who has spent a long career as a professor of medical ethics, the Hippocratic system came under attack both from without and from within the medical profession. “These constructs first came into question in the mid 1960s as part of the general upheaval of moral values that occurred in the United States,” he writes. “Concomitantly, the character of medicine was being altered by the specialization, fragmentation, institutionalization, and depersonalization of health care. At the same time, the number and complexity of medical ethical issues expanded as the power of medical technology presented new challenges to traditional values.”

These challenges could have been met without destroying the “do no harm” tradition. However, medical professionals, perhaps having lost confidence in their own ethical instincts, turned to bioethicists for guidance. Unfortunately, by this time the most influential practitioners had enlisted in the relativist branch of the field epitomized by Joseph Fletcher, rather than the more traditional equality-of-life approach espoused by Paul Ramsey. In a philosophical milieu in which the most helpless patients were already widely viewed as less than fully human, the Hippocratic tradition didn’t stand a chance. This sad fact is illustrated by the treatment given the tradition in Principles of Biomedical Ethics, first published in 1979, in which bioethics pioneers Tom Beauchamp and James Childress blithely dismiss it as “a limited and unreliable basis for medical ethics.” As for the “do no harm” ethic that the oath nurtured, readers are informed that it is merely a “strained translation of a single Hippocratic passage.”

Bioethics and Religion

The antipathy of relativist bioethics to religion emerged early. It is not coincidental that Joseph Fletcher, “patriarch” of the movement, insisted on forming his views upon the premise that “man is not a worshipper.” In recounting the reasons why he believed that bioethics became so influential in such a short time, Daniel Callahan wrote, “The first thing that . . . bioethics had to do—though I don’t believe anyone set this as a conscious agenda—was to push religion aside.”
Dan Brock, a prominent philosopher and member of the bioethics elite, was similarly blunt in an article urging the legalization of euthanasia: "In a pluralistic society like our own, with a strong commitment to freedom of religion, public policy should not be grounded in religious beliefs which many in that society reject."65

After welcoming theologians in its formative years (ironically, Fletcher himself was once an Episcopal priest although he left the faith prior to his death), bioethics now stresses that morality and proper behavior are best determined through "rational analysis" based on secular philosophical precepts. Theology, religious values, spirituality, faith—these are considered "external" and thus "unconvincing" in determining wrong from right.66 Moreover, unlike most of the general population that bioethics supposedly serves, many (although certainly not all) modern bioethicists are agnostic or atheistic, a factor that colors their entire approach to issues of life and death as assuredly as the Pope's Catholicism does his. Indeed, some bioethicists view religion as mere "mumbo jumbo," to use Peter Singer's pejorative term.67 Even those who maintain strong spiritual beliefs—including some Catholic priests—are so anxiety-ridden about imposing their religion upon secular society that they leave their personal, faith-inspired values at the door when discussing public health policies.

This near-absolute rejection of religious values as a moral framework for debating and creating secular public policies is what isolates bioethics today from the suffering and uncertainty of those it is supposed to serve. If it is true, as Loma Linda University professor of ethical studies James W. Walters writes, that "ninety percent of the population identifies with the Judeo-Christian tradition,"68 then bioethics is not reflecting an evolving ethic to meet changing times, but imposing one on a population that profoundly disagrees with its most basic assumptions.

That is not to say that religion in the public square does not bring problems. [Murdering doctors in the name of "life" is one of them that comes readily to mind.] But it is also true that religion played an indispensable role in creating an ethic of humanity that gentles the savage injustices of life. Consider the modern hospice movement, which owes its origin to the dedication and compassion, rooted in deeply held religious values, of its founder, Dame Cicely Saunders. Dame Cicely was a nurse and devout Anglican who was working as a medical social worker in a London hospital in the years immediately following World War II. She met a Jewish émigré named David Tasma, who had escaped the Warsaw ghetto, only to die in a London hospital at the age of forty. Tasma was alone in the world and Saunders made a special point to visit with him every day. Their friendship changed our world.

As Saunders and Tasma spoke of his impending death, she began to comprehend "what he needed—and what all of the other dying patients and their families needed." She told me, "I realized that we needed not only better pain control but better overall care. People needed the space to be themselves. I coined the term 'total pain,' from my understanding that dying people have physical, spiritual, psychological, and social pain that must be treated. I have been working on that ever since." [Tasma left Saunders £500 to begin her work, telling her, "I will be a window in your home." Saunders said to me, "It took me nineteen years to build the home around that window."69]

Dame Cicely Saunders' epiphany was not "rational," but spiritual, coming from a deep empathy inspired by her religious faith. Her work was a "personal calling, underpinned by a powerful religious commitment,"70 wrote David Clark, an English medical school professor of palliative care and Saunders' biographer. So strong was Saunders' faith in what she perceived as her divine call, she began volunteering as a nurse at homes for the dying after work.71 Urged on by her deep desire to help dying people, she went to medical school at the age of thirty-three, at a time when there were few female doctors, not to mention medical students her age.

Saunders focused her medical practice on helping dying people and alleviating pain. She obtained a fellowship in palliative research and began work in a hospice run by nuns, where pain control was unevenly applied, a nearly universal problem at the time, causing much unnecessary misery. Saunders conceived of putting patients on a regular pain control schedule, which, in her words, "was like waving a wand over the situation."72
Saunders' faith pushed her toward founding a hospice based on her concept of treating the total patient. Believing firmly that "the St. Christopher's project [was] divinely guided and inspired,"73 she became an activist, energetically raising money for the new project, and in the process, raising the consciousness of the medical establishment. Saunders' initial idea was for St. Christopher's hospice to be a "sequestered religious community solely concerned with caring for the dying." But the idea soon expanded from a strictly religious vision into a broader secular application, in biographer Clark's words, a "full-blown medical project acting in the world."74

Saunders succeeded beyond even her own wildest hopes. St. Christopher's opened in a London suburb in 1967 and jump-started the modern hospice movement. In 1971, Saunders sent one of her team doctors to New Haven, Connecticut, to help found the first modern hospice in the United States, whence the movement spread nationwide. Hospice has been a certified medical specialty in Britain since 1987.75

There is a direct line of compassion, succor, and love from David Tasma in 1948 to the millions of others who have benefited from hospice care since 1967. None of this would have happened without religious values manifesting in the secular milieu of medicine through Dame Saunders: specifically, the belief that no matter what our state of health, no matter our age, no matter how much help we need, no matter how we look or smell, we all have equal moral worth.

To promote such values is not to support theocracy. It does not divide a pluralistic society by imposing religion on an unwilling public. Rather, it is a secular application of a religiously based view of the inherent worth of all human life. How sterile and harsh the world would be if the values that inspired Dame Cicely were barred from the public square, as many bioethicists wish, simply because they are founded in religious faith. How dangerous to approach issues of public health policy and clinical medical ethics solely from the perspective of amoral "moral philosophy." It is true that religion untempered by secular restraint and rationalism can lead to tyranny. But it is also true that secularism unenriched by the values of spirituality will lead to the creation of "hierarchies of human worth," which are really nothing more than the building blocks for a culture of death.76

Brave New Bioethics

Having rejected the core values of Western civilization as a basis for determining what is moral and good, relativistic bioethics turned to secular moral and analytical philosophy for the answers. This approach accepts no moral standard or ethical rule, no matter how deeply valued, as a self-evident truth. Every moral principle must be reassessed and deemed "rational" if it is to pass muster. Not surprisingly, the people bioethicists deem best able to perform this exercise are themselves, especially those trained in the arcane schools of secular philosophy.

Ironically, mainstream bioethics, which explicitly eschews religious values in public policy and medical ethics discourse and proudly proclaims itself the epitome of rationality, has itself become something of a secular faith among its adherents. As Renee Fox notes, "Bioethics uses medicine as a metaphor for discussing with each other issues of ultimate values and belief, questions that are as religious as they are ethical."77 And Leon Kass adds, "While bioethics is not formally a religion, it is absolutely faith-based and is equally indemonstrable. They purport to grapple with First Principles. Yet, they step into the public square with no greater claim to wisdom than does someone who believes in the Resurrection or in the revelation of the Law at Sinai."78

Bioethicist Daniel Callahan clearly perceives his calling in quasi-metaphysical terms. "Above all," he wrote in 1994, "bioethics needs to develop the capacity to help individuals make good moral decisions in their own lives and to do so in the context of the most basic moral questions: how ought I to live my life? The health of the soul (as they might have put it in an earlier day) is even more important than the health of the body."79 Thus, it seems that bioethics didn't actually "push religion aside," as Callahan wrote elsewhere, it merely changed the venue of belief.

We have seen what the new secular faith of bioethics rejects; what, then, does it embrace? Again, it is important to concede that the field is not monolithic. Not everyone who claims to be a bioethicist necessarily accepts all or even some of the concepts I will discuss below, just as not every Christian adheres to the same tenets of
faith. That being duly noted, I think it is fair to say that most prominent contemporary bioethicists adhere to a general belief system whose dominant features are as follows:

Utilitarianism: Whether explicit or implicit, utilitarianism is one of the primary themes of the ideology. “All [leading] bioethicists,” claims author and bioethics critic Anne Maclean, accept “some version of utilitarianism.” John Keown of Cambridge University told me similarly, “Much of modern bioethics is largely utilitarian. Utilitarianism is fast establishing itself as the new orthodoxy.” Renee Fox and co-author Judith P. Swazey write in a book about bioethics that since the mid-1970s, “moral philosophy has had the greatest molding influence on the field,” especially “analytic philosophy—with its emphasis on theory … and its utilitarian outlook.”

Generally stated, utilitarians hold that “what people want is the ultimate measure of right and wrong.” Joseph Fletcher, a doctrinaire utilitarian, wrote that “a moral agent’s business is to maximize good,” which he defined as “happiness.” He went on to say, “Whatever increases human happiness is good; whatever reduces human happiness is evil.” Peter Singer, one of the world’s foremost contemporary utilitarians, is less concerned with happiness than with whether the “interests” of those affected (which in his view includes animals) are furthered or hindered. Singer himself admits that “ethical ideals, like individual rights, the sanctity of life, justice, purity, are incompatible with utilitarianism.” Thus, to the utilitarian, there is neither objective right nor objective wrong: actions are measured subjectively based on desired or actual outcomes and on ends that justify means.

Lacking a firm commitment to the sanctity of human life, utilitarians may justify profoundly dangerous and immoral schemes and not even blush. As described by Anne Maclean in her book *The Elimination of Morality*, the British bioethicist John Harris proposed eliminating the shortage of transplant organs by a scheme in which the few would be murdered to benefit the many:

> [E]veryone [shall] be given a sort of lottery number. Whenever doctors have two or more dying patients who could be saved by transplants, and no suitable organs have come to hand through ‘natural deaths,’ they can ask a central computer to supply a suitable donor. The computer will then pick the number of a suitable donor at random and he will be killed so that the lives of two or more others may be saved.

To the radical utilitarian Harris, saving two or more lives at the expense of one murder would bring greater overall happiness than the suffering caused by the killing of one man or woman. And since under utilitarianism, no individual possesses human rights per se, why not go ahead and perform the human sacrifice?

Obviously, this proposal will never become public policy. Nor, I hope, will most bioethicists secretly applaud Harris’s “audacious” ideas. Still, the fact that such ideas could be presented as a respectable point of view in an important philosophy primer (*Applied Ethics*, edited, not surprisingly, by Peter Singer) illustrates much of what has gone so dreadfully wrong in bioethics discourse.

The Quality of Life Ethic: If bioethicists are skeptical about “sanctity/equality of life,” they certainly have no such doubts about “quality of life.” What do they mean by this phrase as applied to health policy and medical practice? In *Clinical Ethics*, a bioethics book designed for everyday clinical use by working medical professionals, Albert Jonsen and his co-authors write, “In general, the phrase expresses a value judgment: the experience of living, as a whole or in some aspect, is judged to be ‘good’ or ‘bad,’ ‘better’ or ‘worse.’”

Such issues are, of course, a proper part of medical decision making. For example, several years ago I snapped a knee ligament while skiing. My orthopedist told me that I could have it repaired surgically, but that it would be a delicate and painful process that would take more than a year to heal. My other option was simply to quit skiing and avoid other sports requiring quick lateral movements. I decided to give up the slopes because I believed that choice best protected my life’s quality, although I probably would have made a different decision if I had been in constant pain. The same kind of cost/benefit analysis goes into more serious medical decisions, such as whether to accept a last-ditch round of chemotherapy or ask for medical technology to extend life.
CULTURE OF DEATH

The problem with the concept of quality of life arises when it ceases to be a factor in medical decision making and instead becomes the factor. The "quality of life" ethic is described by Peter Singer, in his book *Rethinking Life and Death*, as follows:

We should treat human beings in accordance with their ethically relevant characteristics. Some of these are inherent in the nature of being. They include consciousness, the capacity for physical, social, and mental interaction with other beings, having conscious preferences for continued life, and having enjoyable experiences. Other relevant aspects depend on the relationship of the being to others, having relatives for example who will grieve over your death, or being so situated in a group that if you are killed, others will fear for their own lives. All of these things make a difference to the regard and respect we should have for such a being.

The danger of Singer's approach should be obvious to every reader. The standards Singer uses to measure human worth are his standards based on what he considers important and "relevant." And therein lies the heart of the problem. Subjective notions of human worth, in the end, are about raw power and who gets to do the judging. In our not-so-distant past, for example, decisions denigrating the moral worth of a subset of people, specifically blacks, were made to justify their oppression and exploitation. The quality-of-life ethic is no different—only the "relevant characteristics" have changed, not the wrongness of the approach. Quality of life, as a moral measure, strips worth and "dignity from people based on health or disability, just as surely as racism does based on skin pigment, hair texture, or facial characteristics.

Not surprisingly, disabled people are especially worried about using quality of life as a yardstick of moral worth. "Many in society consider disability as worse than death and a drain on our limited resources," says Diane Coleman, a disability rights activist and the founder of Not Dead Yet, a national organization that battles medical discrimination against disabled people and resists the legalization of assisted suicide. "There is a great revulsion against disabled people that is visceral. This disdain is masked as compassion but many people believe that in an ideal world, disabled people wouldn't be there."

Harsh Medicine

That being true—and who can deny it—what would happen to the rights of disabled people if the quality-of-life philosophy consolidated its hold over contemporary medical ethics? Coleman worries, Anti-disabled bias would become especially dangerous. If it becomes even more respectable to label us "inferior" or even "less human" based on perceptions of the quality of our lives, it will become acceptable to oppress, exploit, and even kill disabled people. To some degree, this is already happening. People with disabilities are seriously discriminated against in health care as well as in other areas of life.

*The Georgetown Mantra:* Having rejected the equality of all human life, the Hippocratic tradition, religious values in public policy decision making, and the very idea of objective right and wrong, bioethicists realized they needed to forge new analytical guidelines that would "be respected unless some strong countervailing reason exists to justify overriding them." This need was filled, beginning in 1979, by the philosophy professors and bioethics pioneers Tom L. Beauchamp and James F. Childress in their book *Principles of Biomedical Ethics.* Beauchamp and Childress posited four primary guidelines that have generally directed bioethics analysis ever since:

- **Autonomy:** "respecting the decision making capacities of autonomous persons."
- **Beneficence:** "providing benefits and balancing benefits against risks and costs."
- **Nonmaleficence:** "avoiding the causation of harm."
- **Justice:** "distributing benefits, risks, and costs fairly."

Since bioethics is a relativist pursuit, these four principles are, according to the authors, not cast in stone but merely "general guides that leave considerable room for judgment in specific cases and that provide substantive guidance for the development of more detailed rules and policies." Still, they are taught in medical schools, nursing schools, medical professional continuing education courses, short bioethics courses given to members of hospital ethics committees, community patient ombudsmen, hospital administrators, and health...
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insurance executives—indeed, to almost everyone who has taken a course in bioethics in the last twenty years. "The four principle tradition is now so widely accepted," Dr. Edmund Pellegrino wrote, "that some of its more whimsical critics have labeled it a mantra, implying that it is often supplied automatically and without sound moral grounding." The influence of the "Georgetown Mantra" (so called because of the authors' affiliation with Georgetown University) in the application of bioethics in health policy and clinical decision making is hard to overstate.

There is of course nothing inherently wrong with any of the four guidelines that make up the Georgetown Mantra and very much that is right with them. But in the relativist context in which they exist, unanchored in morality, these guidelines are entirely malleable and subject to manipulation in order to obtain a desired outcome. Thus, rather than being proper guides for principled decision making, as envisioned by their creators, the elements of The Mantra are often reduced to mere outcome-justifiers: a bioethicist or medical clinician decides what action or inaction to take in a particular situation and then selects the particular guideline that best justifies the previously made decision. Thus, the four guidelines can justify nearly any ends.

The ultimate amorality of the Georgetown Mantra is amply illustrated by an article written by K. K. Funk, in the American Journal of Economics and Sociology, entitled "Dying for Money." Funk, a professor of economics, recommended allowing seriously ill and disabled people to convert their health insurance benefits into a lump sum cash payment—at less than the market exchange rate—if they agree to commit assisted suicide. How did Funk justify such a proposal? Why, with the Georgetown Mantra of course:

Benefit conversion coupled with dignified death go a long way towards resolving these conflicting principles [of the Mantra]. Because resources released from one patient's refusal of medical treatment [autonomy] can be specifically requested to be used for other patients or beneficiaries with greater need [full beneficence], autonomy and full beneficence need not conflict. Once the patient is allowed to choose death, the caregiver does not have to impose treatment for fear of malpractice liability. Thus, patient-centered beneficence is satisfied. Since benefit conversion is equally available to all who are insured, and the amount of converted benefits varies only with the severity of the illness, justice is also served. All that remains to be done is to educate the terminally or chronically ill how to allocate their converted benefits once death is chosen. Because these four ethical principles [of the Mantra] are largely taken care of, the sense of tragedy connected with the death and denial of treatment to the hopelessly ill can be mitigated.

As to the abuses that would inevitably follow if his proposal were accepted, Funk shrugs, "the world is full of slippery slopes."

Bioethicists are fond of pointing out that there is no going back to the era when the West was culturally homogeneous and primarily Judeo-Christian in outlook, or to a time in which health care decisions were relatively simple. For better or worse, they note correctly, the United States, Canada, and Western Europe are now fundamentally heterogeneous societies, racially and culturally mixed, and fundamentally secular in civic and public policy outlook. Moreover, they argue, the era in which medicine was primarily concerned with keeping people alive for as long as possible, and public health policy sought essentially to uphold a (misapplied) religious approach to the sanctity of human life, is gone forever. And perhaps, they believe, it is even a case of good riddance, since the sanctity/equality-of-life ethic is archaic in a Darwinian world with too many people competing for too few resources.

It is true that the purposes of modern medicine have expanded appropriately to include important services such as maintaining a good quality of life and achieving individual life goals, in addition to
merely preserving lives. And, yes, we now contend with more complicated ethical issues than our forebears faced: cloning, genetic medicine, the societal and individual consequences of increased life expectancies, the impact of permitting wide latitude in individual medical choices.

But this doesn't mean that ethical decisions need be as complex as bioethicists make them, nor that modern bioethics ideology has the best answers to these emerging moral problems. In a question that evokes the case of the emperor's new clothes, Anne Maclean cogently asks, "Why should we attach more weight to the pronouncements of philosophers on moral issues than to those of other people?"97

"Three generations of idiots is enough," United States Supreme Court Chief Justice Oliver Wendell Holmes infamously declared in authorizing the involuntary sterilization of Carrie Buck, age twenty-one, in Virginia.1

What had Carrie done to deserve this fate? She was born poor and powerless, the daughter of a prostitute. In 1924, at the age of seventeen, she became pregnant out of wedlock, apparently after being raped by a relative of her foster father. To cover up this heinous act, Carrie's foster family had her declared morally and mentally deficient, after which she was involuntarily institutionalized in an asylum.

Adding to Carrie's woes, in 1924 the State of Virginia enacted a law permitting "mental defectives" to be involuntarily sterilized for the betterment of society. Asylum doctors decided that Carrie was a "human defective" and therefore a good candidate for the procedure. Her mother was institutionalized, after all, and her baby, age seven months, did not look "quite normal."2 Thus, they figured, society would be best served if Carrie's genes were removed from the human race.

Carrie's guardian tried to stop the involuntary surgery in court. But the trial judge instead ordered that the sterilization proceed, relying on "experts" who testified that Carrie had unfit genes. The case