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BIOETHICS AS SOCIAL PHILOSOPHY

By Kevin Wm. Wildes

I. Introduction

When many people think of bioethics, they think of gripping issues in clinical medicine such as end-of-life decision-making, controversies in biomedical research such as that over work with stem cells, or issues in allocating scarce health-care resources such as organs or money. The term "bioethics" may evoke images of moral controversies being discussed on news programs and talk shows. But this "controversy of the day" focus often treats ethical issues in medicine superficially, for it addresses them as if they could be examined and discussed in isolation from the context in which they are situated. Such a focus on the latest controversies fails to take into account that medicine is a social institution and that the controversies in bioethics often reflect deeper social and moral issues that transcend the boundaries of medicine and ethics. If one moves beyond the issue-of-the-day approach to bioethics, one can see that the field must address these deeper issues.

The ethical issues in medicine and health care can only be addressed adequately if they are understood in the social context of the practice of medicine. One of the reasons that we often have such a limited view of bioethics is that we have a limited understanding of medicine, which is frequently seen as merely applied science. This essay, however, will argue that medicine is, in many respects, a social science.

Bioethics is an interdisciplinary field that has emerged to address normative ethical issues in medical practice, research, and policy. The next section of this essay will outline the development of the field. For the moment, however, it can be stipulated that bioethics is distinct from traditional "medical ethics," which was primarily concerned with the conduct of *physicians*. The emergence of bioethics, as distinct from traditional medical ethics, was due in part to medical advances and the realization of the important roles of nonphysicians in the ethical choices present in medicine. The ethics of the guild was no longer adequate to address the ethical questions involved in medical practice and research.

Contemporary, industrialized societies have constructed multiple bureaucracies to enable, govern, and regulate human life. Systems of medicine and health-care delivery are one of these crucial bureaucratic structures.[1] These structures help to define human life and often act as a

[1] Robert B. Pippin, "Medical Practice and Social Authority," *Journal of Medicine and Philosophy* 21, no. 4 (1996): 417–37.

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form of social control.[2] This essay will argue that if one examines the emergence of bioethics as a field, along with the context of contemporary medical practice, one must see bioethics as a form of social philosophy that can provide key insights into a particular society. For example, one can view the contemporary questions concerning managed care in the United States as one instance of controversy about authority over health-care resources and patient care. Other industrialized nations have faced similar questions. However, these questions raise, in turn, more fundamental questions about how medicine is understood within a society.[3] For example, what is the purpose of medicine? Who is the object of medical care (e.g., individual patients or populations)? To what extent should medicine be a form of social control? Many of these questions show the relationship of bioethics to the philosophy of medicine, a field of philosophical inquiry concerned with medical epistemology, metaphysics, teleology, and, of course, ethics. Many of the questions of bioethics cannot be adequately addressed without some assumptions drawn from these areas of philosophy of medicine.

II. The Emergence of the Field

To understand the claims that I will make about bioethics, it is important to understand my views on both how and why the field of bioethics emerged. In recent years there have been numerous discussions of the development of bioethics as a distinct field.[4] These discussions, though from diverse sources, can serve as a basis for this essay since many of them have also assessed the field and its weaknesses.

If someone knew nothing about the history of either medicine or bioethics, that person might wonder about the relationship of ethics and medicine before the emergence of the field of bioethics in the late 1960s.[5] Discussions of bioethics can sometimes make it seem as if there were no ethical reflection before the emergence of the field. Of course, this is an easy point to which to respond. Philosophy and medicine have been associated with each other since the time of the ancient Greek schools of medicine, and much of this association has concerned ethics. In the ancient world, there were several different schools of philosophical reflection about medicine: one thinks of the works of Hippocrates, Galen,

[2] John K. Iglehart, "Physicians as Agents of Social Control: The Thoughts of Victor Fuchs," *Health Affairs* 17, no. 1 (1998): 90–96; Michael M. Burgess, "The Medicalization of Dying," *Journal of Medicine and Philosophy* 18, no. 3 (1993): 269–79.

[3] See Mark J. Hanson and Daniel Callahan, eds., *The Goals of Medicine: The Forgotten Issue in Health Care Reform* (Washington, DC: Georgetown University Press, 1999).

[4] See, for instance, Warren Reich, "The Word 'Bioethics': Its Birth and the Legacies of Those Who Shaped Its Meaning," *Kennedy Institute of Ethics Journal* 4, no. 4 (1994): 319–36; and Albert R. Jonsen, *The Birth of Bioethics* (New York: Oxford University Press, 1998).

[5] For this dating of the field's emergence, see Jonsen, *The Birth of Bioethics*.

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Democrates, Plato, and Aristotle.[6] Though these schools differed in many respects, they were all primarily concerned with the conduct of the physician. Furthermore, there has been extensive theological reflection on ethics and medicine in many religious traditions.[7]

In the past, then, there has been no shortage of ethical reflection involving medicine. This being the case, one might ask why there was a need to develop the new area of ethical reflection that has been named bioethics. Why not simply rely on the various traditions of medical ethics that already existed? I would argue that there are at least two developments that influenced the emergence of bioethics as a field distinct from traditional medical ethics. I claim that traditional medical ethics was really "physician ethics,"[8] and that bioethics emerged as a result of the recognition that there are other people, besides physicians, who are involved in medical decision-making. This means that the field of bioethics emerged as a response to the social dimensions of medicine.

The first influence on bioethics was the development of scientific medicine. The nineteenth and twentieth centuries witnessed the grounding of medical epistemology in the basic sciences. The modern understanding of illness is rooted in anatomical, physiological, bacteriological, and—now—genetic causal factors. Changes in medical epistemology in the modern age were tied to new, scientific standards for the acquisition and validation of knowledge. One could argue, accurately, that modern medicine was born when the clinic and the laboratory became conjoined.[9] This union of the clinic and the laboratory transformed medicine in a number of ways. Most importantly, it provided a basis for the development of scientific medical knowledge and related technological interventions. Laboratory research became essential to clinical practice and research.

We often forget the radical impact of the scientific model, and the advances it has made possible, on medical epistemology and medical practice. From the development of effective surgery to the manipulation of human genes, the physician, as medical scientist, has been transformed from an observer to a manipulator of nature and the body. These scientific possibilities have led to dramatic changes in society's expectations and

[6] On these various schools of thought, see Paul J. Carrick, *Medical Ethics in the Ancient World* (Washington, DC: Georgetown University Press, 2001).

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

[8] For more on this point, see Robert Veatch, *A Theory of Medical Ethics* (New York: Basic Books, 1981).

[9] See H. Tristram Engelhardt, Jr., "Recent Developments in the Philosophy of Medicine: The Dialectic of Theory and Practice and the Moral-Political Authority of Bioethicists" (paper presented at the American Philosophical Association's Eastern Division annual meeting, New York, NY, December 28, 2000).

goals concerning medicine. For instance, for most of its history there was very little that medicine could actually do to help patients. Gradually, with each success, social expectations toward medicine altered. People have come to think of medicine as curative.[10] In the past, people looked primarily to God, or the gods, for cures, which were thought to be miraculous.

The changes that have taken place in medicine have not only been driven by the development of medical knowledge and technology. They have also been driven, in part, by development of other technologies, like the automobile, and by the urbanization of society. These technological and social developments have made the new medical technologies accessible to men and women in contemporary society.

While the development of medical knowledge and technology was a necessary condition for the emergence of bioethics, it does not by itself explain the emergence of the field. To understand other elements that contributed to the field's emergence it is important to recall that traditional medical ethics had relied on two sources of moral guidance. One was the tradition of professional physician ethics;[11] the other was the teachings of the aforementioned theological ethics. Why were these sources no longer able to guide medicine once it reached its modern scientific phase? To understand why neither of these sources is sufficient for contemporary medicine, one must, I think, take into account the phenomenon of "moral pluralism," according to which people not only hold different moral views on topics (e.g., abortion), but work out of different moral frameworks and with different moral methodologies.[12]

The development of medical knowledge and technology created real choices and decisions for people, especially patients. As I have mentioned, traditional medical ethics had been focused on *physician* ethics.[13] The development of scientific medicine gave patients choices and options concerning courses of treatments to be pursued or refused. If a physician and patient share the same moral values and way of thinking, such choices may not be all that problematic. However, when patients and physicians hold different views, the understanding of medical ethics must not be seen as reflecting the judgment of the physician alone.[14] Determining what is in the patient's best interest cannot be done solely by the physician. The physician may speak to the *medical* best interest of the patient,

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

[11] Laurence B. McCullough, "Laying Medicine Open: Understanding Major Turning Points in the History of Medical Ethics," *Kennedy Institute of Ethics Journal* 9, no. 1 (1999): 7–23.

[12] See Kevin Wildes, *Moral Acquaintances: Methodology in Bioethics* (Notre Dame, IN: University of Notre Dame Press, 2000).

[13] See Robert M. Veatch, "Doctor Does Not Know Best: Why in the New Century Physicians Must Stop Trying to Benefit Patients," *Journal of Medicine and Philosophy* 25, no. 6 (2000): 701–21; and Veatch, *A Theory of Medical Ethics*.

[14] See Veatch, *A Theory of Medical Ethics*.

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but not necessarily to the *overall* best interest of the patient. To make judgments concerning the patient's best interest, the patient needs to be involved. Furthermore, in secular societies there are likely to be different religious views that shape people's judgments about what is morally appropriate. This is why procedures like informed consent have come to play such a central role in both clinical and research ethics: such procedures allow people to exercise judgment about what is in their best interest.

Moral pluralism affects not only patients and physicians, but the profession of medicine itself. A key part of the classical notion of a profession was that professions had distinctive moral dimensions. Many people still assume that professionals act in ethical ways and that it is reasonable to have fiduciary expectations of professionals. However, with the development of medical knowledge and technology, one finds a wide range of views among physicians—on issues ranging from abortion to physician-assisted suicide and the economic structures underlying medicine—about what is or is not appropriate behavior. As a result, it becomes more and more difficult to sustain claims based on an internal morality of medicine; the notion of an internal ethic of physicians, a cornerstone to traditional medical ethics, becomes less and less tenable.

In a different way, in a secular, pluralistic society, one cannot assume that theological ethics will supply the type of guidance that is needed. As I have mentioned, in several religious traditions there have been long, well-developed reflections on medicine, its uses, and ethics. In light of these traditions, it is not surprising that theologians played such an important role in the development of bioethics. Many who first grasped the profound impact of developing medical knowledge and technologies were theologians. They were often the first voices to raise broader social questions that transcended traditional physician ethics. As the field of bioethics began to emerge, it is readily understandable why many theologians, working out of faith traditions that addressed questions of medical care, would be interested in these broader questions. Given their long-standing reflections on medicine and health care, these traditions were able to easily engage the changes that were taking place in medicine.

Yet, fairly quickly, theology came to play less and less of a public role in bioethics. The role of theology and religious commitments has been a difficult question not only for bioethics, but for many areas of public life in the United States. But, as ethicist Daniel Callahan has argued, bioethics became acceptable in America because it "pushed religion aside."[15] Callahan does not argue that religious thought became irrelevant to medical questions. Rather, he argues that as bioethics became a form of "public" discourse,[16] it moved to the more "neutral" languages of philosophy and

[15] Daniel Callahan, "Why America Accepted Bioethics," *Hastings Center Report* 23, no. 6 (1993): S8–9.

[16] On this point, see Arthur L. Caplan, "What Bioethics Brought to the Public," *Hastings Center Report* 23, no. 6 (1993): S14–15.

law and away from the "closed" languages of the medical profession and theological discourse.[17]

Cultures and communities often embody a common moral vision and share the same basic views and commitments; in such societies, the two traditional sources of ethical reflection on medicine can be very helpful. In secular societies, where there are often many cultures, moral pluralism is very likely. As a result, the two traditional sources of reflection are limited in their effectiveness and are thus much less helpful. Traditional professional classes will be limited in their moral authority in these societies, and religious traditions will have far less claim on the lives of men and women.

It is also important to understand that the field of bioethics emerged in the era of civil rights in the United States, a time when there was a greater awareness of individual rights and choices and mounting emphasis on protecting individual freedoms and liberties. Minorities and women were arguing for, and achieving, greater and greater legal protection. Thus, at a time when more and more options for medical treatment were emerging, patients were becoming more and more aware of their own liberties and protections. During this time period, many groups, such as women and minorities, found a voice in society and in their lives; patients found a voice then as well.

In summary, then, bioethics emerged as the result of several developments in medicine and society; two in particular stand out. First, the development of medical knowledge and technology created real choices in medical care. Second, the moral pluralism and multiculturalism in secular societies like the United States led to the existence of different moral voices and views. This in turn meant that there would be differing views on appropriate medical care. Bioethics arose as a way to help people from different moral views navigate these choices and cooperate together. The field provides a window into the social and cultural settings of medical practices, and as such provides a way to understand a society. It can help a society, or cultures within one, examine basic questions of health, disease, sickness, and death. It can also enlighten the way a society thinks about moral authority and how it is exercised. In studying the emergence of bioethics, then, one can make the claim that bioethics provides an insight into the life and practices of a society.

III. Social Construction and Medicine

There are other reasons, beyond those that emerge when we consider the development of bioethics as a field, to conceive of bioethics as a form of social philosophy. One such additional reason is the nature of medicine

[17] On the same point, see McCullough, "Laying Medicine Open."

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itself. As people talk about and imagine medicine, medical science, and medical practice, they often envision medicine as "applied science." That is, they think that what physicians and health-care workers do is apply scientific and medical knowledge that has been discovered in the laboratory. There is little, if any, acknowledgment that science, especially medical science, is not value-free. Medical science is embedded in the values of a society or culture. The scientific norms of medicine, such as health and disease, are often influenced by the social and moral values involved in their specification.

The case for arguing that bioethics should be thought of as a form of social philosophy is strengthened, I think, by a view of medicine as a social construction. These days, a philosopher should use the term "social construction" with caution; philosopher Ian Hacking has pointed out that the term suffers from overuse and is incoherent.[18] Given the ambiguities and confusions surrounding the term, one might ask what value it will have for understanding medicine. The term "social construction" is helpful because it recognizes that the practices and goals of medicine are contextualized and specified within particular societies. Hence, medical practice is not simply the imposition of applied science on society; the practice of medicine is influenced by a society's values. The specification of the meaning of key medical concepts like "health," "disease," and "standard of care" is socially influenced in many instances. While there are universal elements in medicine, such as healing and health, there are many local elements involved in the specification of these universals. It is in this sense that one can speak of medicine as a social construction.

How one understands and practices medicine will turn, in large measure, on what one assumes about the nature of medicine and the nature of knowledge. There is a common perception that medicine is applied science and that the philosophy of medicine is about models of explanation. However, to think of medicine as a science, or as scientific, one needs to articulate the assumptions that are held about the model of science that is being deployed. Medical knowledge is scientific in that it is statistically based, empirical, verifiable, and generalized. A scientific model alone, however, does not capture our experience or expectations about medical practice, for such a model does not appreciate sufficiently how medicine acts as a social structure and set of practices within a given society. The relationship between the values of a society and its medical practices can be discerned by examining how the concepts of medicine, such as the concept of disease, are specified in that society.

Some thinkers understand medicine only through the lens of the physician-patient encounter.[19] However, the contemporary model of med-

[18] See Ian Hacking, *The Social Construction of What?* (Cambridge, MA: Harvard University Press, 1999).

[19] See, for example, Edmund Pellegrino, "What the Philosophy of Medicine Is," *Theoretical Medicine and Bioethics* 19, no. 4 (1998): 315–36.

ical care cannot be fully understood if one only looks at this relationship. Such a "physician-patient model" is too narrow in that it ignores the reality that medicine is set in a social context. The horizons in which the physician and patient encounter one another are shaped by important social forces. For instance, societies often define what medical procedures will or will not be allowed (e.g., abortion or physician-assisted suicide), and insurers generally decide what procedures will or will not be paid for. When they meet in the clinic, then, the physician and the patient are not alone.[20]

It is in this very encounter, in the clinic, that one finds the dimensions of social construction in contemporary medical practice. In contemporary medical practice, with its research and technological infrastructure, the physician-patient encounter involves other health-care professionals, insurers, clinical or hospital administrators, legislators, and regulators. This means we must reject the physician-patient model of the practice of clinical medicine for a more expanded view of the practice, one with a very different sense of medicine. Medical practice cannot be adequately explained as the encounter of the physician and patient, nor can medicine be adequately explained as the application of scientific knowledge. Medical knowledge is deployed in a set of social circumstances where the circumstances and values that help people to interpret reality and society are involved in establishing the norms of medicine.[21] There is something of a circle here. Medicine is shaped by the values of a culture, and medicine then helps to reinforce and control the values of that culture.

Most physicians and patients would agree that medicine is not just a set of technical skills. It involves, at some level, a moral vision of how the practitioner ought to act. To understand medicine as a practice opens a set of philosophical questions about the nature of a practice. Here one can borrow from Alasdair MacIntyre and argue that a practice is a coherent method of achieving socially established goods that are internal to the practice.[22] Practices are public. They are not the habits of individuals, nor are they to be confused with the place or role of institutions that support practices but also support goods external to those practices. So, for example, while medicine is a practice, hospitals and delivery networks, institutions that support medicine and other goods as well, are not. A practice is part of a way of life, which is reminiscent of Wittgenstein's view that rules are part of a way of life. The crucial point is that medicine, as a practice, is socially constructed. As Wim J. van der Steen and P. J.

[20] Allen Buchanan, "Trust in Managed Care Organizations," *Kennedy Institute of Ethics Journal* 10, no. 3 (2000): 189–212.

[21] R. M. Hare, "Health," in Hare, *Essays on Bioethics* (New York: Clarendon Press, 1993), 31–49.

[22] See Alasdair MacIntyre, *After Virtue* (Notre Dame, IN: University of Notre Dame Press, 1981).

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Thung write, "[A]ny attempt to completely divorce medicine from other domains of culture would be futile, even foolish."[23] To say that medicine is socially constructed is to recall that medical practice is influenced by the values, moral and otherwise, of the culture and society in which it is situated. This influence is evidenced again and again in bioethics, where the issues and controversies of the field often reflect differing assumptions about health, disease, illness, and the goals of life.

Some thinkers worry that if one holds the view that medicine is in part a socially constructed practice, then the door to relativism and the "Nazi problem" is wide open. That is, if medicine is constructed socially, how can it be argued that the medical practice of the Nazi physicians was wrong? There is a response to this criticism, however. Medical practices, like all practices, have moral boundaries. These boundaries are not unique to the profession, or part of any special morality for professionals generally. What the Nazi doctors did to patients and research subjects was morally wrong for *anyone* to do. One therefore does not need a morality unique to the medical profession to criticize ethically the practices of the Nazi doctors. One can argue, for instance, that the Nazi doctors, irrespective of their profession, had no *moral authority* to do what they did. In ethical perspectives concerned with moral authority—a concept that is generally applicable and not limited to situations involving professionals or physicians specifically—the most foundational moral authority relevant to the performance of an action rests on the consent of those involved in that action (patients or research subjects, in the case of the Nazi doctors). The Nazi doctors never got consent from the people they acted upon, and in many cases were consciously attempting to do harm.[24] As a result, we can, holding this sort of ethical perspective, claim that the actions of the Nazi physicians were wrong, yet still understand that medicine is a social practice with socially constructed elements.

If one takes the social and cultural turn in trying to understand medical practice, then one will have to accept a more expansive understanding of bioethics. This is because bioethics is not a field only devoted to the resolution of moral controversies. In many cases, the underlying issues in bioethics are issues in the philosophy of medicine and provide insights into the social context of medical practice. From this more expansive view, it can be argued that bioethics can be a coherent and increasingly important field in helping us understand the social context of medicine.

In contemporary medicine, the scientific aspects of medicine have become increasingly important for medical practice. The development of scientific research and treatment, along with the use of statistical and

[23] Wim J. van der Steen and P. J. Thung, *The Faces of Medicine: A Philosophical Study* (Boston: Nijhoff, 1988).

[24] See H. Tristram Engelhardt, Jr., *The Foundations of Bioethics*, 2d ed. (New York: Oxford University Press, 1996).

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scientific knowledge to determine guidelines for treatment, reimbursement, and the allocation of resources, has accentuated the scientific side of medicine and limited the role of physician judgment. This emphasis on the "scientific" model contributes to a view of medicine as being transcultural and objective. The quantitative and qualitative development of the scientific dimensions of medicine have led to a forgetfulness of the *art* of medicine.

It is this art of medicine that guides the interpretation of scientific facts in individual cases. Facts need to be understood in relationship with other facts and assumptions. These relationships are what give the facts meaning and structure. Philosophers such as Paul Feyerabend, Thomas Kuhn, Imre Lakatos, and Alan Musgrave brought to our understanding of the formation of facts a deeper awareness of both the sociology of knowledge and the role of cultural values and social constructs. Medicine is not just a set of techniques or skills. It is "philosophy in action," as philosopher H. Tristram Engelhardt, Jr., says.[25] Medicine seeks to remake the human in certain ways and for certain purposes. As one thinks about medicine, one is well advised to remember the words of Rudolf Virchow, a nineteenth-century figure in the philosophy of medicine who said that "medicine is a social science in its very bone and marrow."[26]

In the past, the art of medicine essentially involved the physician's judgment in relationship to individual patients. However, in an age that is increasingly aware of cultural and moral pluralism and of the role of patients in medical decision-making, there is an expanding dimension for medicine's artistic side. The very concepts that frame the practice of scientific medicine—concepts like "health," "disease," and "normalcy"—are greatly influenced by surrounding cultural and social assumptions, and those assumptions are in need of interpretation. The art of medicine helps the physician apply scientific medical knowledge to particular contexts and patients.

The relationship between medicine and social values is borne out in many issues in bioethics. For example, one way to examine many issues about end-of-life care and physician-assisted suicide is by treating them as bioethical issues that involve scientific facts as well as moral and cultural attitudes concerning the meaning of life and death. These questions in bioethics also raise further questions about the purposes of medicine and the appropriate role of health-care professionals. The different responses to these various bioethical issues reflect differing views on the philosophy of medicine, which are influenced in turn by the cultural views of those involved. (Indeed, within the field of bioethics there is a

[25] H. Tristram Engelhardt, Jr., "The Philosophy of Medicine: A New Endeavor," *Texas Reports on Biology and Medicine* 31 (1973): 451.

[26] Rudolf Virchow, "Scientific Method and Therapeutic Standpoints," in Virchow, *Disease, Life, and Man*, ed. and trans. Lelland J. Rather (Stanford, CA: Stanford University Press, 1971), 48.

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literature from Europe, Asia, and Latin America on the need to develop a bioethics that is not so "American.")[27] Within the field of bioethics, then, one can examine broader questions about the social nature of medicine.

As hinted at in the previous paragraph, issues in bioethics often involve issues in the philosophy of medicine (which, as I stated in Section I, deals with elements of medical epistemology, metaphysics, teleology, and ethics). One reason that bioethics may not have evolved as a distinct discipline is that questions in the philosophy of medicine are woven deeply into it. Clashes about reproductive medicine, for example, signify the existence of different underlying views of medicine that are influenced by differing cultural values. Arguments about abortion often involve metaphysical questions concerning the standing of early human life. In addition, as genetic knowledge continues to expand and the technologies for manipulating genetic structures increase, there will be important bioethical questions tied to these scientific advances. Though broad, the field of philosophy of medicine can play an important role in our assessments of these various bioethical questions by helping us identify and map the different issues and views relevant to those questions. Through such philosophical cartography, the philosophy of medicine can help clarify bioethical debates and discussions.

IV. Health Care and Public Authority

Let me briefly summarize the discussion thus far. Medical practice finds itself with new opportunities and new questions. As previously mentioned, these questions occur at the same time that several traditional sources of moral insight and knowledge are more limited than they have been traditionally. The internal morality of medicine (e.g., physician ethics or nursing ethics) is no longer sufficient for medical choices. Medical decision-making involves not just medical practitioners, but patients and a host of others. Furthermore, the new opportunities and questions have also emerged in a time when nations such as the United States are more and more aware of internal cultural and moral diversity. Religious voices, once prominent in the public realm, now command less and less authority. Amidst this diversity, however, there is still a need to find a common moral language to guide decisions in health care.

There are at least two ways in which public authority has been involved in bioethics. First, and most obviously, public authority has been called upon to address the developing questions concerning contemporary medical practice. Understanding the need for public and common

[27] See, for example, James F. Drane, "Bioethical Perspectives from Ibero-America," *Journal of Medicine and Philosophy* 21, no. 6 (1996): 556–69; Eugenia Porto, "Social Context and Historical Emergence: The Underlying Dimension of Medical Ethics," *Theoretical Medicine* 11, no. 2 (1990): 145–65; and Klaus Leisinger, "Bioethics Here and in Poor Countries: A Comment," *Cambridge Quarterly of Healthcare Ethics* 2, no. 1 (1993): 5–8.

moral authority is crucial to understanding the development of bioethics. There are many areas in the conduct of human life where there are different views of what is morally appropriate. In a secular society, many of these differences are worked out by appealing to limited government and rights to privacy and self-determination. Health care, however, provides secular societies a special challenge. Medicine touches on sexuality, reproduction, death, suffering, and soon, the very design of human life. These topics are understood within a moral context—that is, within the context of moral values and commitments. The delivery of contemporary health care is not possible without the cooperation of men and women who often have different moral values and commitments. As a result, there will be an ongoing need to find ways to cooperate across moral differences if contemporary medical care is to continue to develop.

In secular, diverse societies like the United States, the disciplines of law and philosophy have become central to crafting the field of bioethics. The important roles of law and philosophy in this realm are highlighted in secular societies that give the government a central role in the infrastructure of health-care research and delivery. Law is thought to transcend the concerns of particular groups, and to address society as a whole; it provides a way to regulate the structures and the organization of medicine. Philosophy, for its part, has been thought to be the discipline that can establish the content of ethical claims without appealing to a specific culture or view.

There is a second way in which public authority is involved in bioethics. Public investment helps fund medical research, medical education, and the development of medical facilities, and also supports numerous programs that are directly involved in health-care delivery. In the United States, there are numerous examples of such programs, including the National Institutes of Health, the Department of Health and Human Services, the Veterans Administration, and the Food and Drug Administration, just to name a few. There is also indirect public involvement in health care through structures like the tax code.

As a brief example of how public authority controls specific aspects of health care, consider budget decisions about research. These are not purely scientific choices—they are often politically driven. Diseases that primarily affect the poor, for example, often have less priority in national research agendas, in part because those afflicted have less of a voice. Furthermore, decisions about certain types of research, such as embryo research or stem-cell research, are driven as much by political concerns as by scientific ones. For example, how would one answer the question of what is the "right" amount to spend on stem-cell research? The answer is not a medical or scientific decision. Rather, it is a political decision that requires practical judgment and a balancing of various goods.

Because public authority has all this importance in health care, there has been public participation in the development and regulation of health

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care through agencies and commissions. One has only to think of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, the President's Commission on Biomedical Ethics, or the current National Bioethics Advisory Commission. The directives established by these commissions are examples of the "regulatory ethics" that Callahan thinks has come to define the field of bioethics.[28] One can argue, following the point I made above, that bioethics has served to support this sort of public involvement in health care by providing a common moral framework in which these commissions can operate.

V. Conclusion

This essay has argued that bioethics, as it has emerged, must be understood, in part, as a form of social philosophy. Bioethics provides a lens through which one can examine secular societies. Faced with new ethical challenges emerging as a result of developments in modern medicine, bioethics seeks ways in which people in secular societies can work together in the provision of medical care and research. The field provides insight into issues of moral community, and into how a society understands political authority and its appropriate exercise. Bioethics also involves social philosophy because the basic concepts of health care (concepts like "health" and "disease") are socially constructed categories. Finally, bioethics's connection to social philosophy is cemented by the fact that central questions in clinical medicine—questions concerning the allocation of resources, for instance—are questions of social philosophy and ethics.

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[28] See Callahan, "Why America Accepted Bioethics."