The Influence of Bioethics on Moral Theology

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***Joseph E. Capizzi**, Ph.D., is an assistant professor at The Catholic University of America. During the 2002-2003 academic year, he held the Cardinals' Chair of The Intercultural Forum at the John Paul II Cultural Center in Washington, District of Columbia.**

With increasing frequency, moral theologians are finding work as paid consultants to the medical field.(1) This development has been a boon to moral theologians looking for jobs in tight academic markets. Every hospital, research institution, and health-care facility needs a "bioethicist," and a legion of unemployed or employed but underpaid Ph.D.s is ready to serve when called. The contribution of medicine to theology extends beyond philosophers' and theologians' financial well-being. Philosopher Stephen Toulmin argues that medicine "saved the life of ethics" by nudging philosophers away from metaethics and toward casuistry.(2)

The Secularization of Moral Theology

The developing dependency of moral theology on professions like medicine exerts influences that could distort the mission and practice of moral theology, however. I pose a question: Is it possible that the encounter with medicine, and bioethics in particular, is contributing to the secularization of moral theology?(3) At root, the question concerns institutions with increasingly antagonistic values: the church and the medical profession. If, as is claimed, the medical profession (including healthcare and bioethics) has become secular, then its values depart from or minimally are indifferent to the values of the church. The extent of this conflict needs to be assessed if theologians are to remain active in bioethics.

That secularization threatens Catholic healthcare is a common allegation.(4) Increasingly, too, many worry about the secularization of bioethics. The theologians and philosophers who helped develop bioethics worry that medical practice has been unleashed from moral considerations. There are different accounts of the specifics of the secularization, and of what is required to maintain Catholic integrity in healthcare. Some explain secularization by referring to the loss of "Catholic identity," as often described in university education.(5) Preservation of Catholic identity becomes the key to resisting secularization.(6) The association of secularization with diminishing Catholic identity leaves us still short, however, for specifying the criteria of Catholic identity can be as mystifying as describing secularization. Does Catholic identity require merely Catholic inspiration, or also Catholics, as doctors, nurses, staff, and even patients?(7) At other times authors define secularization negatively as the absence of explicitly religious convictions from some field, public, or profession. These convictions are not referred to when justifying certain behaviors (e.g., providing uncompensated care) or prohibiting others (e.g., aborting or euthanizing).(8) Religious convictions are eschewed as divisive or inappropriate. Secularization involves the adoption of the language of public reason and the abandonment of deliberation about the ends of medicine.

The advantage of the secular perspective is its ostensibly non-judgmental angle on issues. Some believe the strategic advantage has theological support. This is especially true for Catholic theologians who argue that Catholicism requires a posture of this kind of openness to the world.(9) Theological discourse must conform to the reason prevailing in public argument.(10) All reasonable

persons should be convinced of the reasonability of theological discourse.(11) Thus theological claims must be reasonable, as Curran writes: "Reasonable people should see the truth in what is proposed and do it."(12) If and when people do not see the truth in the propositions, there is something wrong with the propositions. Explicitly religious perspectives are seen to reflect views without broader cultural warrant and appeal. They produce value judgments masking contingent subjective attitudes and should not be presumed or imposed in public discussion. Public discussion forbids the assumption of the rightness or wrongness of any activity as such.(13)

Even those who commend the use of secular discourse, however, still often fear the loss of Christian healthcare.(14) Almost all who decry secularization see the influence of the business model on Catholic healthcare as negative.(15) They point, in particular, to aspects of the Church's special ministry as threatened by economic considerations.(16) Many who allege these "secularizations" lament the loss of religious intervention in medicine.

Late in his career, Richard A. McCormick, S.J., noted the "profound threat" of secularization to Catholic integrity in healthcare.(17) McCormick was the most prominent Catholic bioethicist of the past twenty years and a role model for many moral theologians interested in biomedical issues. He studied contemporary developments in medicine and theology long enough and deeply enough to identify many areas of promise and challenge. McCormick was especially concerned about the displacement of the mission of service by Catholics themselves.(18) The mission was the *raison d'être* of Catholic hospitals; without a mission, Catholic healthcare would cease to exist. McCormick described the mission of Catholic healthcare in rich language: "Catholic hospitals exist to enact in the healthcare setting what God did in Jesus. Jesus is God's love for us in the flesh. The Catholic hospital exists, therefore, to be Jesus' love for the other in the healthcare setting."(19) The mission McCormick described involves the I-Thou encounter of persons within the framework of agapic love. The encounter is premised by theological commitment to the worth of both caregiver and patient and guided by the action of divine love. Divine and human actions converge in the encounter. For Christians, Jesus' love frames the medical encounter. The medical encounter must be "guided by and generative of the moral dispositions and perspectives implied in Christ's phrase, 'as I have loved you.'"(20) The secularization McCormick lamented objectifies the caregiver, who becomes an instrument of the fulfillment of the patient's desires; and it objectifies the patient, who has only those claims to care that she and her doctor contractually agree upon. Thus patients could demand that doctors and nurses help them die, and doctors could turn away the poor or AIDS patients, for instance. For the theologian these developments were unacceptable, according to McCormick.(21)

McCormick worried that the business model had almost entirely supplanted the Catholic mission of healthcare.(22) He believed Catholic healthcare once had the power to transform the practice of medicine but was being overwhelmed by other concerns.(23) He noted, too, that bioethics had not slowed the march of healthcare to the beat of secularization. In fact, he attributed the growth of bioethics to its impotence to transform or slow the process of secularization. He wrote, "[indeed] we could mount a fairly persuasive argument that bioethics in the United States in the past twenty years has developed peacefully and serenely *because* it has posed no threat to the major developments in medicine of the past twenty years."(24)

McCormick describes a missed opportunity: Bioethics could have -- should have -- challenged certain medical developments. Instead of providing critique, bioethics became an ally in the

development of a secularized medicine. Eventually, bioethics itself became secular. Other theologians and even non-religious philosophers agree about the secularization of healthcare and bioethics.(25) According to H. Tristram Engelhardt, the commitments of the Christian community oppose the commitments of the secular healthcare institution. The Christian, for instance, views suffering as an avenue to the virtue of humility. Secular medical commitment views suffering as an enemy of the patient's good and a violation of the patient's dignity. The commitments of each institution are increasingly incommensurable. In language consonant with McCormick's description of the Catholic healthcare institution's *raison d'être*, Engelhardt writes:

> The traditional Christian understanding of life collides with the immanent goals of the cosmopolitan liberal. Traditional Christian health care institutions look beyond medical health to focus on union with God as the only goal in terms of which charity, justice, and mercy have their right sense and significance. Secular health care institutions look to the claims of this world. Finally, traditional Christian morality requires setting limits that the liberal cosmopolitan must find offensive. Traditional Christian health care institutions will not only refuse to provide care that many hold to be theirs by right. They also implicitly reprove those seeking such interventions by recognizing those endeavors as immoral.
>
> The raison d'être of traditional Christian health care institutions is in secular terms counter-cultural.(26)

Engelhardt aptly describes the difficulty: In our culture many will claim from medicine certain procedures and treatments as their right. These claims are not arbitrary but emerge from the ethos of the culture. Thus, for instance, when infertile couples (or even individuals) claim as their right the pursuit of children through in vitro fertilization (IVF), adoption, or other means, they understand their claims as matters of justice. Denying them their "right" to children is an injustice, they assert. Traditional Christian morality, as Engelhardt shows, will see these as wrongful claims. Though the claims may often be profoundly moving and comprehensible, they are nonetheless unjust from the perspective of a faith that views children as more than objects of rights claims. The Catholic healthcare provider thus does not merely reject the service; its rejection of the service entails as well a rejection of the claim. Each perspective, then, views the other as unjust. Thus, Engelhardt calls these opposed views "anti-moralities."(27) In this context bioethics must choose sides. The evidence is in -- the side for technology almost always prevails over the side for the limitation of the technology.

The Marginalization of Religious Perspectives

Thus bioethics and theology are increasingly antagonistic. Historically this is surprising, and for some like McCormick or Daniel Callahan, personally disappointing. Theology dominated bioethics at its inception in the 1960s and 1970s.(28) This was due in part to the prominence of Christian theologians and Jewish scholars involved in bioethics, including McCormick, Callahan, Paul Ramsey, Joseph Fletcher, Leon Kass, Seymour Siegel, and David Feldman, and also to the dominance of theological language and methods. Those theologians represent a diverse group, especially considering their moral positions, so the secularization noticed by bioethicists does not presuppose the departure from any particular moral stance. This is a critical point: The former dominance of theology in bioethics did not reduce theology to moral theory.(29) Bioethics was not theological

because it expressed conservative moral positions. Instead, theology contributed, at multiple levels, to views about the ends of healthcare and the goods of the human person to the embrace of a diversity of languages considered appropriate to moral discussion.

The early bioethicists, however, conceived bioethics as an external source of wisdom upon which medicine could draw. This is expressed implicitly in McCormick's comment, quoted above, about the failure of bioethics to challenge developments in medicine. Bioethics works when it challenges and guides medical developments, when it points medicine toward individual and social goods that the business model may not capture, when it insists upon a conception of the person as bodily and spiritual. That is in the past. Now, "The field has moved from one dominated by religious and medical traditions to one now increasingly shaped by philosophical and legal concepts."(**30**) Engelhardt expresses a greater lament: "In bioethics, the journey from the religious orthodoxies of the Middle Ages, through the rationalist hopes of modernity, to the disappointments of post-modernity, spanned less than 30 years. One has during this brief period been brought to look for theoretical and rational guidance, and then one is shown little guidance is in fact available."(**31**) The consequence has been the marginalization of religious perspectives.

The work of sociologist John H. Evans supports the narrative of bioethics' secularization.(**32**) Evans describes how a theologically shaped discussion about the ends of medicine "thinned" to a formal discussion about means, primarily in terms of risks and benefits. This was caused by many factors, but Evans and others describe a historical process that saw the diminishment of theological language and its replacement by formally rational discourse.(**33**) The victory of bioethics over substantial theological contributions to the field is total, if not permanent. Thus, Evans asserts:

> The growing institutionalization of the bioethicists' form of argumentation is suggested by the continued growth in the number of bioethicists in this debate. When scientists were being challenged by theologians for jurisdiction in the 1960s, bioethicists and theologians had equal numbers of influential authors, but among the common authors there were many more theologians than bioethicists. By the mid-1980s this had changed, and bioethics was second only to science in producing influential authors. By the time period considered in this chapter [1992-1995], bioethics had the greatest number of influential authors, followed by science, philosophy, law, and finally, theology, which had only one.(**34**)

Thus the thin discourse of science displaced the thick discourse of theology. Thin discourse prevailed because it was much more suitable to public policy discussion. This presents theologians with a choice: Either they accept their irrelevance,(**35**) or they adopt bioethics' thinner mode of discourse. That adoption, however, it would seem, amounts to what the theologians describe as secularization.

The Influence of Bioethics on Moral Theology

Here arises the difficulty for moral theology. Many theologians agree with and contribute to this description of healthcare's and bioethics's secularization, yet how many are asking about the influence of bioethics on moral theology? If McCormick provides reason to doubt the influence of theology on medicine, if in fact moral theology was powerless before developments in medical science, might there not have also been, and continue to be, negative influences on moral theology?

The supposition of the narratives we have seen is that moral theology witnesses this unfortunate division of itself from medicine and bioethics; but, that is too simplistic an understanding of the relationship of these disciplines. Theologians are called upon by medicine and the healthcare industry to serve them as bioethicists, so moral theology has not separated from bioethics.(**36**) Are they doing so in ways that raise challenges McCormick thought nonexistent, or must they accept the new rules of bioethics that jerry rig outcomes in favor of the unchallenged march of medicine? Furthermore, as we shall see, it is naïve to continue thinking that moral theology is immune from its social context.

Stanley Hauerwas has written the most extensive critique of theologians' involvement in bioethics. In *Suffering Presence: Theological Reflections on Medicine, the Mentally Handicapped, and the Church*, and elsewhere, Hauerwas criticizes all the participants (singling out Fletcher and Ramsey as representative) for not showing "how their religious convictions have made a difference for the methodology they employ or for their response to specific quandaries."(**37**) The jerry rigging, according to Hauerwas, occurs across the gap separating theology from ethics. Thus, Hauerwas writes: "What is interesting about the debate between Fletcher and Ramsey is that it could have been carried on completely separate from the theological premises that each side claimed were involved." According to Hauerwas, the moral commitments of the participants appear to have no connection to asserted theological conviction.(**38**) In other words, Hauerwas believes the theologians built the process of secularization into their contributions.

Evans' research shows how bioethics exploits the gap Hauerwas describes. According to Evans, bioethicist John Fletcher translated Ramsey's and Kass' arguments into language amenable to the nonpartisan language of bioethics advisory commissions. Evans writes,

> The translation is signaled in a subtle way: 'Even though these views [of Kass and Ramsey] are premised on theological, philosophical, and ethical beliefs *that many do not hold*, the objections contain a *core* that should and can be addressed.' That is, the 'ethical beliefs' or ends that are not universal and commensurable will not be further discussed, and the parts of Ramsey's and Kass's arguments that conform with [*sic*] the bioethicists' form of argumentation will be treated as representative of all their arguments. Needless to say, if Ramsey's and Kass's arguments are limited to those used by bioethicists, the two will eventually be described as agreeing with bioethicists.(**39**)

This argument works hand in hand with Hauerwas's: If theologians want to remain part of the discussion, either their efforts will be exploited in the way Kass's and Ramsey's were, or the theologian preemptively will have to translate his or her views into the accepted language of bioethical argumentation. In other words, contemporary bioethics forces theologians to recast some questions, and even to preempt others, if theologians want to remain relevant. Hauerwas thus augments McCormick's insights. Where McCormick noticed the slight or nonexistent influence of bioethics on medicine, Hauerwas noted the diluting influence of bioethics on theologians.

Hauerwas knows, of course, that at least some of those he criticizes would respond that their religious convictions allow or even compel them to employ the methodologies he disdains.(**40**) Many Christians have provided theological rationales for adopting what Evans calls a thin form of rationality. Hauerwas has devoted much of his work to rejecting that view; it is not self-evidently

wrong. Hauerwas' insights, however, cannot be dismissed by positing as alternatives either full engagement along the terms set currently by bioethics, or retreat.(41) Hauerwas forces all those interested in bioethics to notice -- as McCormick seemed to -- the costs of full engagement. How long can Christian healthcare remain the type of mission McCormick described when severed from Christian language and ritual? It makes believer and non-believer alike subject to the misconception that the good news about Christ's resurrection has little to do with the substance of Christian living. *That* is a position no Christian should welcome, and if bioethics requires us to contribute to that misconception, then we have a sufficient argument against Christian participation in bioethics, as McCormick seemed to realize(42) One of the ironies of all of this is that McCormick, who late in his career expressed such deep frustration at the impotence of bioethics and the secularization of Catholic healthcare, consciously chose to participate in the process that Evans and Hauerwas believe partially responsible for the impotence and secularization. Take, for instance, McCormick's own analysis of his participation on an Ethics Advisory Board. McCormick wrote in the early 1980s:

> The Ethics Advisory Board ... was established at the behest of the National Commission for the Protection of Human Subjects. It included physicians, geneticists, lawyers, lay people, and two of us in the field of ethics. We chose to begin by considering this question: Is in vitro fertilization (IVF) with embryo transfer ethically acceptable? We defined ethically *acceptable* as ethically *defensible*, although not necessarily ethically *right*. Some 14 months later, we concluded that IVF was ethically defensible even though controversial, because the heart of it involves an evaluation that can't be proved.(43)

McCormick focuses on the formation of the question. Arriving at the right question upon which to proceed was critical and already reveals the translation process Hauerwas and Evans describe. The question, like any question, sets the possibilities of its legitimate answer and cuts off access to other questions. As McCormick notes, the choice to pursue the ethically *acceptable* differs markedly from the pursuit of the ethically *right*. McCormick does not explain the distinctions between acceptable, defensible, and right, leaving it to his readers and the public to fill in the blanks. I shall assume without argument that ethically acceptable views are those meeting the standards of public rationality. That is, they express views that are not fanatical but are reasonable along the lines of reasonability described by the philosophers Robert Audi and John Rawls.(44) If that is so, the convergence of this way of forming the question with Evans' and Hauerwas' analyses ought to be obvious. In choosing to ignore the question of the rightness of IVF, the Board effectively agreed to adopt a jerry rigged discussion. Once the question was so put, any conclusion other than the one they reached was unfathomable.(45) McCormick agreed to the translation of his theological perspective into the accepted language of bioethics and abetted its almost complete inability to influence the outcome.(46)

McCormick could have used his faith community's rejection of IVF as a position toward which to argue. Instead, the Catholic Church's rejection of IVF was irrelevant. He could have adverted to Christian anthropology, or a conception of creation, but instead he allowed that the fundamental "evaluation" about embryonic life could not be proved. "In moral matters you can't prove evaluations."(47) Thus, the pursuit of the ethically defensible was reduced to considerations about possible states of affairs: Does IVF produce excess embryos? Would the destruction of excess embryos be abortion? What are the risks to the children created by IVF? Will severe defects result? Can IVF be contained?(48) These are, of course, important questions once one disregards the prior

moral analysis of the procedure, a moral analysis that includes especially the doctrinal basis of a distinction between procreation and reproduction.(49) Considerations of Christian doctrinal issues are of course not welcome on most advisory committees, but one does not have to reference them explicitly to raise questions internal to IVF, such as: What does it teach us about biological parenthood? What does it display about our views of children as products of technology? All such questions are preemptively forbidden. Why questions that do arise count at all is also unclear, however. What does it matter that IVF produces excess embryos? Why do severe defects count? Are we not making evaluations here, too? Nothing is said by the Board about the moral significance of the questions they regard as morally significant. Can the Board, for instance, assume an answer to the rightness of abortion to reject IVF on the grounds that the destruction of excess embryos is abortion? McCormick does assume the wrongness of abortion (he writes, "abortion should not be part of the contract"[50]), but why he chooses to assume this but not the wrongness of IVF is unclear. Except, of course, if he had assumed the wrongness of IVF, he probably would have been asked to leave the Board. Had he assumed the wrongness of IVF, as he did abortion, the institutional visions of the Catholic church and the medical community would have clashed over the question of the right, for the Catholic church clearly rejects IVF.(51)

Lessons Learned

What lessons are we to draw from McCormick's experience in and reflections on bioethics and healthcare? The evidence that McCormick and others provide of an increasing institutional antagonism between medicine and theology is moving theology to reintegrate with morality. The momentum of this movement is undeniable, and many from varying perspectives within Catholic moral theology have taken note.(52) Strategic and theological grounds increase the momentum. If McCormick's self-assessment of the experience of bioethics is accurate, the strategic engagement of theology and medical science has been negative. Science effectively claimed exclusive jurisdiction over medicine; theology was incapable of slowing technological advances increasingly threatening to certain categories of persons (the very young, the very old, the very ill); and now theological interventions in bioethics seem just like that -- extrinsic and arbitrary constraints foisted upon an unwitting partner.

The theological argument for engaging science in the manner of the bioethical consultation suffers from this experience as well. There are different ways to assess the theological view that Catholic discourse is public discourse. Of course, the strategic argument is not irrelevant, for one of the claims of those defending this view is that it works; and when it does not work, a possible conclusion is that there is something wrong with the theory.(53) There are more fundamental reasons, however, to depart from that approach. Hauerwas has argued against that approach for decades, of course, but more and more Catholics see theological grounds for being explicitly theological.

For instance, in an important article on the changing self-understanding of the moral theologian, Peter Black and James Keenan show that the development of moral theology in the twentieth century includes increased appreciation for the reintegration of moral theology into theology.(54) Moral theologians, they write, "rediscover the theology of their discipline: the truth as it is in God and as manifested in Jesus Christ."(55) They note, as others have, that the manualist tradition separated moral theology from theology and to some extent mimicked canon law, and further divided moral theology into two parts: fundamental and special moral theology.(56) All

commentators appear to agree that these divisions were unfortunate. John Mahoney is especially critical:

> [T]he mentality stimulating such over-systematization, and then in turn feeding on it, has impelled moral theology to view sin as above all a transgression of law, and has inculcated concepts of divine justice and retribution, and of God himself, which have bitten deep into the spiritual lives of millions.(57)

Though perhaps we should not uncritically accept Mahoney's negative view, he draws our attention to the inseparable relationship of ethics to doctrines of God.

Black and Keenan's argument on behalf of theological reintegration is necessary to overcome an over-reified view of moral theology. Their analysis shows the fungibility of moral theology: Moral theology changes in its inevitable interactions with the world. We should expect, then, that interaction with medicine and healthcare will influence moral theology. We can press their point, however, even further.(58) Karl Barth argued that ethics "belongs to the doctrine of God."(59) Barth rejects the easy distinctions in our categories, curricula, and departments that entail the division of doctrine from ethics.(60) We cannot resolve the problems he associates with this division merely by reattaching ethics to doctrine. He urges the acknowledgment of the sinfulness involved in the way we pose ethical questions:

> [Man] wants to be like God. He wants to know of himself (as God does) what is good and evil. He therefore wants to *give* this answer himself and of himself. So, then, as a result and in prolongation of the fall, we have 'ethics,' or, rather, the multifarious ethical systems, the attempted human answers to the ethical question.(61)

Barth's point resonates with but also deepens Black and Keenan's. Where "ethics" or "moral theology" is conceived as responses to questions detachable from theology, we lapse into error and even sin. When, in Black and Keenan's term, moral truth becomes "ontological," manifested in the person of Christ,(62) theology repossesses ethics as the pursuit of knowledge of God. Barth writes: "The man Jesus, who fulfills the commandment of God, does not *give* the answer, but by God's grace He *is* the answer to the ethical question put by God's grace."(63) God both poses and answers the ethical questions.

Daniel Callahan has argued "the most striking change over the past two decades or so has been the secularization of bioethics."(64) A field once dominated by "religious and medical traditions" is now "shaped by philosophical and legal concepts. The consequence has been a mode of public discourse that emphasizes secular themes: universal rights, individual self-direction, procedural justice, and a systematic denial of either a common good or a transcendent individual good."(65) As McCormick's analysis implies, theologians have abetted these developments.

They abetted, and continue to abet, the secularization of bioethics by adopting a mode of discourse that implies the division of doctrine from ethics. If theologians want to remain bioethicists, they shall have to follow Black and Keenan's insistence that moral theology become more theological. Thus they will transform their questions and not just their answers. Moreover, the moral theologian

may be forced to acknowledge that at some point he or she no longer can transform the question sufficiently to allow his or her cooperation with its resolution.

The implications of the foregoing should be clear. McCormick correctly saw that the threats to Catholic healthcare are internal as well as external. The threats to Catholic healthcare, however, exist in part because of prior damage to the practice of moral theology. Moral theology must reassess its role in the enterprise that seeks knowledge about God. It cannot simply "apply" that knowledge to medicine, but it must allow persons who are disciples to transform healthcare in the manner McCormick suggested toward the end of his career. Early in his admittedly pessimistic essay on the end of Catholic hospitals, McCormick quoted the late Cardinal Joseph Bernardin. The emphasis of the cardinal's passage is not on the practice of Catholic medicine as *techne*, but as an expression of Christian allegiance to suffering presence that McCormick placed at the heart of the Catholic hospital's mission. The cardinal's words are an appropriate place to end this essay and to begin reconstructing a Catholic bioethics that can replace McCormick's pessimism with hope, for, as the cardinal states well, Catholic distinctiveness rests not in any technical capacity, but in bringing Christ's comfort to those especially in need.

> As Christians, we are called, indeed empowered, to comfort others in the midst of their suffering by giving them a reason to hope. We are called to help them experience God's enduring love for them. This is what makes Christian health care truly distinctive. We are to do for one another what Jesus did: comfort others by inspiring in them hope and confidence in life. As God's ongoing, creative activity in the world and the love of Christ make it possible for us to continue to live despite the chaos of illness, so too our work in the world must also give hope to those for whom we care. Our distinctive vocation in Christian health care is not so much to heal better or more efficiently than anyone else; it is to bring comfort to people by giving them an experience that will strengthen their confidence in life. The ultimate goal of our care is to give to those who are ill, through our care, a reason to hope.
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> Let me be clear what I mean by 'hope.' It is not a hope for something. It is not the expectation that something will happen. Although some people hope for a physical cure, not everyone does. Often people believe that a cure is not possible, or they are too tired to hope to be restored to their former state of health. But, even when a cure is not to be expected, one can still hope. The hope of which I speak is an attitude about life and living in God's loving care. Hope, rooted in our trust of God's love for us in Christ, gives us strength and confidence; it comforts us with the knowledge that, whatever is happening to us, we are loved by God through Christ.(**66**) •

Notes

1. Throughout, "moral theologians" shall serve as shorthand for moral theologians and Christian ethicists. On the rise of paid bioethical consultation, see Baruch Brody and Nancy Dubler et al., "Bioethics Consultation in the Private Sector," *Hastings Center Report* 32, no. 3 (May/June 2002): 14-20.

2. Stephen Toulmin, "How Medicine Saved the Life of Ethics," *New Directions in Ethics: The Challenge*

of Applied Ethics, ed. Joseph P. DeMarco and Richard M. Fox (New York: Routledge and Kegan Paul, 1986), 265-81.

3. Another way to put the question would be to focus on the increasing "professionalization" of moral theology, as it parrots the practices of the professions. These practices would include *inter alia* the dissemination of an increasingly esoteric knowledge judged only by members, as well as the adoption of codes of ethics and the formation of and attendance at annual and biannual professional conferences. The "professional" finds oneself with allegiances to the profession that may contradict or exclude the demands of one's church. Professional standards of scholarship may resist, be indifferent to, or exclude certain types of commitments required by belief. So, for instance, a member of a society of Christian ethics imperils oneself not by refusing to acknowledge that Christ is Lord, but by plagiarism or the unwillingness to recognize the social and political rights of members with different sexual orientation. (See the Bylaws of the Society of Christian Ethics, Article III, section 3.)

4. See Charles E. Curran, "The Catholic Identity of Catholic Institutions," *Theological Studies* 58 (1997): 90-108; J. Bryan Hehir, "Identity and Institutions," *Health Progress* 76, no. 8 (November-December 1995): 17-23 (also available through the archives at the Catholic Health Association's website, <www.chausa.org>).

5. See Christopher Tollefson, "The Importance of Begging Earnestly," *Christian Bioethics* 6, no. 3 (2000): 267-80; H. Tristram Engelhardt Jr., "Roman Catholic Social Teaching and Religious Hospital Identity in a Post-Christian Age," *Christian Bioethics* 6, no. 3 (2000): 296. For an excellent and detailed historical account of Catholic healthcare, see Christopher J. Kauffman, *Ministry and Meaning: The Religious History of Catholic Health Care in the United States* (New York: Crossroad, 1995).

6. See Ana Smith Iltis, "Institutional Integrity in Roman Catholic Health Care Institutions," *Christian Bioethics* 7, no. 1 (2001): 95-103. Also, see Joseph Boyle, "Collaboration and Integrity: How to Think Clearly About Moral Problems of Cooperation," and Anthony Fisher, O.P., "Is There a Distinctive Role for the Catholic Hospital in a Pluralist Society?," in *Issues for a Catholic Bioethic*, ed. Luke Gormally (London: The Linacre Center, 1997), 187-230.

7. See Tollefson's important comments on Catholic identity in "The Importance of Begging Earnestly."

8. Daniel Callahan, "Religion and the Secularization of Bioethics," *Hastings Center Report*, Special Supplement (July/August 1990): 2-4.

9. See for instance David Tracy, *The Analogical Imagination: Christian Theology and the Culture of Pluralism* (New York: Crossroad, 1981); also Charles E. Curran, *The Catholic Moral Tradition Today: A Synthesis* (Washington, DC: Georgetown University Press, 1999), 1-25.

10. See also David Tracy and John B. Cobb Jr., *Talking About God: Doing Theology in the Context of Modern Pluralism* (New York: Seabury, 1983), esp. chap. 1.

11. See ibid., chap. 2.

12. Charles E. Curran, *Catholic Social Teaching, 1891-present: A Historical, Theological, and Ethical Analysis*

(Washington, DC: Georgetown University Press, 2002), 88.

13. See H. Tristram Engelhardt Jr., "The DeChristianization of Christian Health Care Institutions, or, How the Pursuit of Social Justice and Excellence can Obscure the Pursuit of Holiness," *Christian Bioethics* 7, no. 1 (2001): 152, where he remarks that at best the remaining prohibitions of certain practices will seem like "external constraints over against the actual life of the [healthcare] institution."

14. See note 4.

15. In addition to those cited in notes 4-8, see also Kevin O'Rourke, O.P., "Catholic Healthcare as 'Leaven,'" *Health Progress* 78, no. 2 (March-April 1997), online at <www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP9703&ARTICLE=D>; Bishop Donald W. Wuerl, "Catholic Health Ministry in Transition," *Health Progress* 80, no. 3 (May-June 1999): online at <www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP9905&ARTICLE=E>.

16. See for instance the essays by Scott E. Daniels, Sandra Ely Wheeler, Edmund D. Pellegrino, and Arthur J. Dyck in *The Changing Face of Health Care: A Christian Appraisal of Managed Care* (Grand Rapids, MI: Eerdmans, 1998).

17. Richard A. McCormick, S.J., "The End of Catholic Hospitals?" *America* 179, no. 1 (July 4-11, 1998): 6.

18. See Michael R. Panicola's suggestive "A Cautionary Tale: Can Catholic Health Care Maintain Its Identity and Integrity While Meeting the Challenges of the Marketplace?," *America* 186, no. 14 (April 29, 2002): 13-15.

19. Richard A. McCormick, S.J., "Beyond Principlism is Not Enough: A Theologian Reflects on the Real Challenge For U.S. Biomedical Ethics," in *A Matter of Principles? Ferment in U.S. Bioethics*, ed. Edwin R. Dubose, Ronald P. Hamel, and Laurence J. O'Connell (Valley Forge, PA: Trinity International, 1994), 348.

20. Ibid., 358.

21. Ibid., 352, 358, 359. Another way of stating the special mission of the Catholic hospital consonant with McCormick's description would be to focus on its preferential option for the poor. See Tollefson's "The Importance of Begging Earnestly."

22. McCormick, "Beyond Principlism," 346-7.

23. Anthony Fisher, O.P., "Is There a Distinctive Role for the Catholic Hospital in a Pluralist Society?" *Issues for a Catholic Bioethic*, ed. Luke Gormally (London: The Linacre Center, 1999), 200-230, is compatible with McCormick's analysis of the commercial or business threats to Catholic healthcare. Fisher explains that many Catholic hospitals are faced with a dire choice: "offer top-quality healthcare on competitive terms, but at some cost to 'Catholic identity,'" or "[maintain] religious traditions and particular, often fairly low-tech, forms of care, but at the expense of becoming rather marginal" (204); but see Albert Jonsen, *The Birth of Bioethics* (New York: Oxford University, 1998), for a more positive appraisal of bioethics than Fisher's or McCormick's.

24. McCormick, "Beyond Principlism," 345 (italics in original).

25. See Callahan, "Religion and the Secularization of Bioethics," 2-4; Callahan, "The Social Sciences and the Task of Bioethics," *Daedalus* 128, no. 4 (Fall 1999): 275-94, esp. 279-84; John H. Evans, *Playing God: Human Genetic Engineering and the Rationalization of Public Bioethical Debate* (Chicago and London: University of Chicago, 2002); Kevin O'Rourke, "Catholic Hospitals and Catholic Identity," *Christian Bioethics* 7, no. 1 (2001): 15-18; H. Tristram Engelhardt Jr., "Can Philosophy Save Christianity? Are the Roots of the Foundations of Christian Bioethics Ecumenical? Reflections on the Nature of a Christian Bioethics," *Christian Bioethics* 5, no. 3 (1999): 203-12; Engelhardt, "The DeChristianization of Christian Health Care Institutions"; and Jonsen, *The Birth of Bioethics*.

26. See Engelhardt, "The DeChristianization of Christian Healthcare Institutions," 154.

27. Ibid.

28. See note 25.

29. See Engelhardt, "Can Philosophy Save Christianity?" 203-4.

30. Callahan, "Religion and the Secularization of Bioethics," 2. See also Gilbert Meilaender, *Bioethics: A Primer for Christians* (Grand Rapids, MI: Eerdmans, 1996), x.

31. H. Tristram Engelhardt Jr., "Creating a Discipline: Theory" (paper read at the Birth of Bioethics Conference, Seattle, WA, September 23-24, 1992), quoted in Jonsen, 345 n. 76.

32. Evans, *Playing God*.

33. Evans relies heavily on Max Weber and Jürgen Habermas to distinguish formal from substantive rationality. Formal rationality proceeds from generally accepted ends, limiting itself to assessing means. Substantive rationality does not presuppose an end, but focuses on the compatibility of certain ends with fundamental values. Thus ends themselves are the subject of debate. See Evans, *Playing God*, 13-21.

34. Ibid., 153.

35. In Evans' terms, they accept that the scientists successfully took from theologians jurisdiction over bioethics.

36. To some extent and in ways that cannot be explored here, this provides reason to scrutinize the adequacy of Evans' generalizations.

37. Stanley Hauerwas, *Suffering Presence: Theological Reflections on Medicine, the Mentally Handicapped, and the Church* (Notre Dame, IN: University of Notre Dame Press, 1986), 70, 72.

38. In other words, Hauerwas would deny that bioethics has become more secular. It was secular, according to Hauerwas, from the beginning.

39. Evans, *Playing God*, 146.

40. See for instance Curran, "The Catholic Identity of Catholic Institutions."

41. The retreat option invoked to present one with a Hobson's choice (an apparently free choice that actually offers no real alternative): Either we get involved, as we Catholics always have, or we get out completely, which Catholics have never done. See Curran, "The Catholic Identity of Catholic Institutions," 92; and O'Rourke, "Catholic Healthcare as 'Leaven.'" O'Rourke writes, "some followers of Christ have determined that the world belongs to the devil and that the only way to follow Christ faithfully is to retreat from society . However, this is not the vision of apostleship which expresses the self-understanding of the Catholic Church" (online). Because the choice is forced, Hauerwas rightly claims never to have advocated retreat as so described.

42. These comments relate to a discussion that much animated moral theology in the 1980s, the "specificity" or existence of a *Christian* ethics. The discussion produced copious literature, of very mixed quality and seemingly little agreement. Vincent MacNamara's *Faith and Ethics* (Washington, DC: Georgetown University Press, 1985), does a very nice job surveying the discussion and untangling some of the conceptual confusion.

43. Richard A. McCormick, S.J., "In Vitro Fertilization," *On Moral Medicine*, ed. Stephen E. Lammers and Allen Verhey (Grand Rapids, MI: Eerdmans, 1987), 333-5; originally in *Contemporary OB/GYN* 20 (November 1982): 227-32.

44. See Robert Audi, *Religious Commitment and Secular Reason* (New York: Cambridge University, 2000); John Rawls, *Political Liberalism* (New York: Columbia University, 1993); and Rawls, "The Idea of Public Reason Revisited," *The University of Chicago Law Review* 64 (1997): 765-807.

45. In fact, of course, it is hard to imagine any moral position that is not "defensible" when one excludes consideration of what is right. Think, for a moment, about the issue of slavery in the United States prior to the issuance of the Emancipation Proclamation. If one genuinely attempts to understand the mindset of a nineteenth-century American citizen, would not abolition be closer to indefensible than support of the status quo? Recall that we have to bracket the question of the right. Which would have had more immediate negative social consequences: abolition of slavery or its retention?

46. Catholic theologians often justified this type of translation by invoking a conception of the natural law, emergent in the seventeenth century, according to which independent reason was capable of arriving at the principles of morality. That notion of the natural law has been under revision since before the Second Vatican Council. On the varieties of the natural law and the necessity of retrieving a more theological version, see Jean Porter, *Natural and Divine Law: Reclaiming the Tradition for Christian Ethics* (Grand Rapids, MI: Eerdmans, 1999).

47. McCormick, "In Vitro Fertilization," 334.

48. These are the questions McCormick reports the Board to have discussed. See ibid.

49. See Meilaender, *Bioethics: A Primer for Christians*, 11-21.

50. Ibid.

51. See Catholic Church, *Catechism of the Catholic Church*, 2nd ed. (Vatican City: Libreria Editrice Vaticana, 2000), nos. 2373-79, on the Church's understanding of fertility, sterility, and the inappropriate means adopted to overcome the latter.

52. See Servais Pinckaers, *The Sources of Christian Ethics*, trans. Sr. Mary Thomas Noble (Washington, DC: Catholic University of America, 1995), and Curran, *The Catholic Moral Tradition Today*.

53. There would also be an historical argument: Have these proponents of public theology adequately represented the tradition's understanding of the natural law? Is it reducible to reasonability, as the proponents suggest? Jean Porter's work is a good place to begin questioning this assumption. See Jean Porter, *Natural and Divine Law*.

54. Peter Black and James Keenan, "The Evolving Self-Understanding of the Moral Theologian: 1900-2000," *Studia Moralia* 39 (2001): 291-327.

55. Ibid., 303.

56. See Pinckaers, *The Sources of Christian Ethics*; and *Morality: The Catholic View*, trans. Michael Sherwin, O.P. (South Bend, IN: St. Augustine's, 2001), as well as John Mahoney, *The Making of Moral Theology* (Oxford: Clarendon Press, 1987) and John Gallagher, *Time Past, Time Future: An Historical Study of Catholic Moral Theology* (New York: Paulist, 1990).

57. Mahoney, 35.

58. They refer to Charles Curran's study, *The Origins of Moral Theology in the United States: Three Different Approaches* (Washington, DC: Georgetown University Press, 1997).

59. Karl Barth, "The Doctrine of God," *Church Dogmatics* II/2, ed. G. W. Bromiley and T. F. Torrance, trans. Bromiley et al. (1957; Edinburgh: T & T Clark, 1987), 512, 515. The original is Barth, *Die Kirchliche Dogmatik, II: Die Lehre von Gott* 2 (Zürich: Theologischer Verlag, 1942, 1988). The section of this material (no. 36 in the German) is titled "Ethik als Aufgabe der Gotteslehre," which the translators render as "task" but which implies "mission" as well.

60. Barth's rejection of these distinctions explains why John Webster calls the *Church Dogmatics* "a work of moral theology as well as a systematics." Webster, *Barth's Ethics of Reconciliation* (Cambridge: Cambridge University, 1995), 1.

61. Barth, 517 (italics in original).

62. Black and Keenan, "The Evolving Self-Understanding," 302-3.

63. Barth, 517.

64. Callahan, "Religion and the Secularization of Bioethics," 2.

65. Ibid.

66. Cardinal Joseph Bernardin, "A Sign of Hope," *Pastoral Letter on Healthcare* (October 18, 1995), as quoted in McCormick, "The End of Catholic Hospitals?," 6.

*Biographical information is true at time of publication.