

MOVING BEYOND BIOETHICS

*history and the search for
medical humanism*

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ABSTRACT From both within and without bioethics, growing criticism of the predominant methods and practices of the field can be heard. These critiques tend to lament an emphasis on logically derived rules and philosophical theories that inadequately capture how and why people have the moral attitudes they do, and they urge the use of more empirically grounded social sciences—history, sociology, and anthropology—to draw attention to the complex factors behind such attitudes. However, these critiques do not go far enough, as they do not question why debate over *ethical* categories should have such a central role in voicing concerns about medicine. The importance of using other forms of inquiry, especially that of history, to examine aspects of medical practice and the emergence of bioethics itself is not simply to refine bioethical moral analysis. Instead, history can be employed to counter the preoccupation with translating concerns about medicine into moral terms and to move towards what is more sorely needed: a true medical humanism.

IS BIOETHICS HELPFUL? Does it clarify how and why anxieties about medical progress occur as they do? Does it offer tools to face them better? Are bioethical answers getting the questions right?

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The field is admittedly hard to pin down. The term *bioethics* encompasses a diverse collection of writings, conferences, journals, theories, methods, purposes, committee meetings, consultations, and policy advisories. However, within that diversity is a shared focus on identifying and resolving concerns about medical care by understanding them as ethical problems. The bioethics lens is claimed to reveal how the conduct of medical care and the anxieties and disputes that surround it fundamentally comprise choices and practices best characterized as *ethical* in nature. But there has been growing disappointment with how well-focused that lens can be. Critics have claimed that the predominant theories and uses of bioethics have increasingly reflected narrow, if not superficial, accounts of what is meant by “ethics.”

That critical response does not go far enough. I believe the very focus on concerns about medicine as fundamentally ethical is what distracts and blurs. While there have been attempts to use history to focus the lens—to make bioethics better ethics, and to support a broader claim for bioethics as the exemplar of what is often referred to as a “medical humanities”—more careful use of history points in a different direction altogether. The real value of humanities and social science disciplines may not be to make bioethics better, but to replace it. The problem with bioethics is not just its narrow approach to ethics, but its dramatic reduction of concerns about medicine merely to issues of ethics.

IS BETTER ETHICS ENOUGH?

Bioethics has rightly been criticized (though neither often nor influentially enough) for lacking empiric curiosity about how people actually form ethical beliefs and commitments and about what really troubles and motivates real people. Some anthropologists and sociologists who have ventured to observe bioethics in action suggest that what bioethicists like to talk about often is not what the people they are talking about want to talk about. For example, observers of medical decision-making have studied women as they make decisions based on amniocentesis and genetic screening results, and also women’s attitudes and actions in neonatal intensive care units (Anspach 1993; Beeson and Doksum 2001). Collectively, these studies capture how individual emotional development and personalized experience serve as the prominent source of medical ethical knowledge. They comprise the relevant data with which people answer “What is the *right* thing to do?” regarding their health care. No surprise there. But emotions and personal experiences often bump up against the more formal ethical principles, accepted as part of the culture of a given medical institution, that communicate proper, acceptable, “feeling rules.” Those rule-expectations often conflict with personalized responses. What bubbles up into the open as a so-called “ethical dispute” in these settings may be a clash of cultures around expressing and experiencing emotions in medical settings, rather than a lack of proper ethical insight (Hoffmaster 2001).

Concern about whether bioethics captures the right questions is increasingly palpable from within the field. Daniel Callahan, frequently hailed as one of the founders of the field, has regularly lamented how bioethics has morphed into something done by expert, professionalized *bioethicists*, rather than hewing to his vision of a more general kind of conversation by people with different backgrounds and perspectives. Callahan (1999) has noted the distinction between a discussion focused on protecting rights, autonomy, and the rules that govern them, versus one focused on meanings, experiences of suffering, and medical purposes. It is the latter questions, which he called “cultural,” with which the field has been losing touch.

This breach between formulaic rules of thumb and deeper, complex cultural debates, dialogues, and meanings has resonated with dissenting voices within bioethics over time. For over a decade, some consistent dissatisfaction has been leveled at the persistent dominance of the so-called school of principlism in bioethical practice (Clouser and Gert 1990). “Care,” “narrative,” and “virtue” schools of bioethics have flourished, at least on paper, asserting that ethical commitments and answers to ethical dilemmas lie in unraveling the context and content of specific relationships, unfolding events, or personal integrity and commitments, rather than derived principles and theories. Yet the very act of making those assertions generates a further proliferation of theories of ethics to support them, even while rejecting logically derived, generalizable rule-making as the path to ethical knowledge. What remains front and center are the processes of unraveling theories of ethics and identifying how the core ethical dilemma in a given situation can be understood so it can be resolved. Should this continue to be the central concern of bioethics?

BETTER ETHICS: PART OF THE SOLUTION, OR PART OF THE PROBLEM?

Critiques aimed at enlivening bioethics to be more empirical and multidisciplinary, observational as well as propositional, are aimed at symptoms rather than at the underlying disease. They may seem to share a more empirical or down-to-earth ethos with sociological and anthropological (and historical and other) critics outside looking in, but they generally don't fully grasp the real implications of seeing ethics in its social and cultural context. Calls for ethnography in the clinic, Callahan's more eclectic conversation, or narrative, care, and virtue in our deliberations over hard choices, are all put forward to enlarge, but not to question, the necessity and value of nurturing techniques that aim to distinguish the “right” from the “wrong” in medicine. These critical perspectives share interest in certain features: personalized meanings and relationships; cultures of practice; psychological development; social achievements and contexts; and historical contingencies and traditions. But taking into account these features does more than just diversify the data of ethics, it eclipses the importance of ethics per se.

Calls for their inclusion in what counts as bioethics should also urge reconsideration of the robustness of the ethics framework itself, of the description of actions and choices through distinctly justified methods that on their face reliably formulate what counts as right and wrong. The mere search for ever-better formulations of ethical conduct may have been oversold as the best route to resolving anxieties about medical conduct.

This is underscored when one takes into account not only the major schools of bioethical thought that tend to map out the field, but how the field has generally succeeded—how it works. Over the past 30 years, bioethics has become a discipline that “bakes bread” for the now obligatory presidential commissions, hospital ethics committees, think tanks, policy boards, etc. In so doing, the discipline has increasingly come to rely upon, and work towards the development of, widely applicable rules. To produce consensus for widespread action, bioethics has had to stake out the minimally necessary ground of ethical commitments.

And that is narrow ground, indeed. Under such conditions, it is unsurprising that a focus on process, or means, has tended to matter more than the meanings of ends. It is easier to police, define, and reach consensus over how to *realize* the ethical than over what it *is*. As the menu of relevant “what to do’s” has narrowed, bioethics has flourished over “how to do’s.” In the context of decades of debate over human genome manipulation, for example, sociologist John Evans (2002) has described how bioethics has been shaped in large part by a self-promoting alliance with government rule-making bodies. It has become a discipline that structures a rather “thin” debate mostly about means, rather than a “thick” one over ends. A rule of thumb to advance and protect autonomous patient choice has courted little disagreement and avoided messy debates over diverse ends, such as the meanings of procreation for identity, the cultural value of biological continuity, or the significance of conception. Bioethical debate has increasingly focused on means, and it has done so in an increasingly technical, distanced manner. No wonder so much ink has been spilled for decades in the service of an obsession over the technique and integrity of the process of informed consent.

But I would go beyond Evans’ critique. After all, the point of view he targets has some rationale behind it. It should not be surprising that agreement over deep issues in a secular democracy is managed by skating on the thin ice that everyone can agree to own (Casanett, Daskal, and Lantos 1998; Moreno 1995; Yoder 1998). The pure procedural justice of John Rawls was attractive to many (including some early figures in the bioethics movement) for compelling reasons—to avoid civil war in a secular state over competing visions of what is “moral.” If we have a less rich culture because of it, we also get more done without violence. Evans rings true with what I have elsewhere described as the appropriation of an ethics discourse in order to further a new technocratic elite—bioethicists—in the name of overthrowing an old one—physicians (Belkin and Brandt 2001). But I think both those who criticize (like Evans) and those who celebrate the way bioethics has secularized, technocratized, and standardized eth-

ical discourse miss an important element. We should be asking questions such as why this kind of unsatisfactory moral-philosophical tradition is at the heart of medical disputes to begin with. How did bioethics and the interests that nourished it get us to believe that debates and anxieties over biomedical technology are primarily ethical ones, or that they are (or should primarily be) debates over ethics itself?

The most recent attempt to seek closure for policy over genetic manipulation technology, specifically cloning, began soon after Evans's book ends, with the work of President Bush's Council on Bioethics. The Council's *Report* explicitly described the Council as breaking from a prior tradition of seeking formal rules and procedural consensus by self-appointed experts (Kass 2002). It called for precisely what Evans saw as missing: a more complex discussion, perhaps without short-term resolution, about "thick" topics. The *Report* also lamented, like Callahan, the transformation of bioethics into a more constrained discipline: "For the President's Council on Bioethics, 'bioethics' refers to the broad domain or subject matter, rather than to a specialized methodological or academic approach. It is a Council *on* Bioethics, not a council *of* bioethicists . . . not as 'experts,' but simply as thoughtful human beings" (Kass 2002, xvii). But this document, again, attended to the symptoms. It formulated a list of emotional, political, religious, and self-interests as ethical problems requiring "moral analysis" and repeatedly aspired to provide this moral analysis—whatever it is—not just the views of "thoughtful human beings." While generally loyal to its goal of airing diverse views about life's meaning and purpose, the *Report* attempted to color that spectrum of opinion and the kinds of life experiences and everyday practices they represent through an ethics lens.

Why? Are we simply too scared or too incompetent to hash out differences over visions of the human community and the uses of technology without returning to the final arbiter—without proving that one position or another really is more "moral?" Such proofs hide more than they reveal. Reading the appended statements of the individual Council members to the *Report* itself reveals important diverse considerations: religious beliefs about the nature of conception; personal commitments to the importance of a notion of continuity to unaltered human dignity and respect through the life cycle; technical opinions regarding the actual benefits society can expect from cloning for the purposes of biomedical research; and skepticism about the ability of regulations to prevent cloning approved only for research purposes from opening the floodgates to cloning for reproduction.

These issues, and hierarchies of their relative importance, obviously can be characterized according to their moral or ethical dimensions. But is it most helpful to the robustness and relevance of the debate to do so? Invoking "ethics" conjures a removed objectivity, and the idea that one is engaging in some kind of groundwork necessary for deliberation to proceed. But often other things are more important for laying foundations than conceptual clarity through moral

terms and constructs, such as the study of real experience, or the negotiation—or open contest—of real conflicting interests and commitments. And it might be useful to do so with more than moral arguments and narratives, but with real observations.

Is the contest between wishes for new medical treatments, and outrage over abortion and further tampering with the genome, really best resolved through the claim that what is primarily at stake are dueling moral visions that can be reasoned through by “thoughtful people” and “moral analysis”?¹ Or might such expert councils take these issues more head-on, and when doing so benefit from also bringing more rigorous social scientific, personal, and historical experience to bear on how to weigh the importance and cogency of competing visions of handling our own creation? Are questions like “What is the moral thing to do?” really more important than those like “How can we best know what it is people hope to do and fear being done?” While some attention to these considerations is paid in the body of the *Report*, logical distinctions over moral categories tend to carry the day. These distinctions and clarifications of what might be at stake are obviously helpful to clarify our thoughts as we think through and talk to each other about these issues. But such distinctions may not be the ones around which our conversations should necessarily be structured. Airing common and relevant intuitions, emotions, cultural practices, idiosyncrasies, and powder keg religious differences perhaps are better contemplated and explored, or at least helped by also being explored, via pursuits other than hearing thoughtful people do moral analysis—via ethnography, polling, empirical study of medical transactions, curiosity about the experiences of people facing the decisions at issue, and elections, among other things.

Truly moving prose in the *Report* about the continuity of life, the implications of being biological beings, and about fears of tampering with fundamental beliefs about ourselves all resonate, but also give pause. What do those claims really mean? What specifically about people’s lives are we talking about? Playing the moral vision card cannot excuse us from the hard work of convincing and demonstrating and making the day-to-day life and experience of living—for which the card is a mere stand-in—real and attractive. The situation is analogous to the difference between preaching the virtues and logic of democracy, and the hard work and heavy investment in making democratic practices and life-worlds real and compelling. Cloning, like voting, is wise or not based more on what we can reliably say with regards to what it will do for or to me and others, than on what it can somehow be argued and proven to morally *mean*.

How is it that ethical expertise has become something specialized and dispute-regulating over issues in biomedicine? We appoint ethics panels to obses-

¹Most general moral statements of the Council would indicate an objection to genetically modified foods. In Europe, this issue is approached much more in those terms. Is this how it should be resolved?

sively review ever more hair-splitting questions, such as how to distinguish “minimal” from “minor increase over minimal” risk in the area of human experimentation. But we do not look to ethics panels to ponder why American society expands its dependency on fossil fuels or adopts a preemptive rather than an imminent threat war doctrine. Biomedicine owns no unique corner on the market of consequential choices that are translatable as ethical ones. Why and when is such translation helpful, encompassing, relevant, decisive? That question has to be a central part of the work that claims the appellation *bioethics*, especially as the imprimatur of disciplinary expertise that label carries gains increasing authority.

HISTORICAL QUESTIONS AND THE SEARCH FOR A MEDICAL HUMANITIES

Defining *humanism* or “the humanities” is a slippery task, but I understand it here as the study and experience of the possibilities of human expression and purpose as manifested in another slippery word that describes uniquely human production of meanings: *culture*. Humanism is less concerned with generating rules of conduct than with deepening and enriching the self-understanding and perspective brought to bear when people confront choices and each other. And a humanistic ongoing engagement and routine self-reflection can make medicine more deeply ethical than can duels over methodologies of ethics per se. Bioethics has narrowed how reflection in medicine about medicine takes place and has inhibited rather than rescued a medical humanism by an overrated focus on restrictive reduction to “the ethical.”

Bioethics has yet to consistently open itself up to the same kinds of questions and analyses it uses to understand the world. Bioethicists have not generally included in their work questions such as “How is it that I am in a position to address these particular kinds of questions in the forms and approaches I do, and to the audience and with the authority and sponsor I have?” “How am I heard by others and how does the way I divide up what is important to know about the human condition have one impact or another?” Answers to those kinds of questions are part and parcel of humanistic understanding itself, of explaining how in a context of time and place certain questions become more relevant than others.

History can shake up how bioethics conceives of its methods, principles, and purposes. Inward-looking questions become possible, if not compelling, within a rigorous historical inquiry of ethical discourse in medicine. What larger cultural purposes are served by bioethics? What impact has it had on medical institutions? How does its work participate in shaping and using medical knowledge? Are people better off with processing ever more minute medical decisions through analysis of underlying assumptions regarding moral theory? How did a notion of ethical medicine or medical humanities take that sort of predominant form? What other forms are, or were, possible? What can be learned from stories

about prior attempts, far more numerous, rich, and varied than bioethics has tended to acknowledge, to make health care “moral”?

Interestingly, it is precisely in trying to secure bioethics as the inheritor, if not the true innovator, of efforts to develop a vigorous medical humanities—to do what a recent issue of the *Kennedy Institute of Ethics Journal* called “laying medicine open”—that the bioethics literature has recently turned more to history (McCullough and Reich 1999). In general, though, such turnings have been disappointing, perpetuating the problems history should instead help address. The goal, in short, should be to use history, as Laurence McCullough (2000) put it, to help make bioethics a “mature” discipline. But in order to do that, what I grant McCullough with one hand I will have to take away with another, as I feel his and others’ uses of history within bioethics are often too narrow. A growing crop of histories of bioethics are available, mostly published by leading figures of the field and those intellectually shaped within it: *A History and Theory of Informed Consent* (Faden, Beauchamp, and King 1986), *Strangers at the Bedside* (Rothman 1991), and *The Birth of Bioethics* (Jonsen 1998) are prominent among these. But within these and other works is a tendency, echoed in the countless historical characterizations of the appearance of bioethics within work in the field itself, to use history to celebrate, rather than examine, the field. Even work critical of bioethics, such as Tina Stevens’s *Bioethics in America* (2000), shares that tendency. Such histories for the most part portray bioethics as a needed rescue of patients by philosophers (in Stevens’s case, a not robust or radical enough rescue) and/or an attempt to set and reinforce boundaries.

So, figures such as prominent 18th-century physicians and commentators on medicine John Gregory and Thomas Percival are read by their 20th-century critics primarily for the purpose of pointing out that these earlier medical figures were not like them. Prior figures, it is stressed, did not represent true ethical expertise but really only furthered parochial professional aspirations (unlike the work of bioethicists, of course), thus underscoring the need for a true ethical expertise. Robert Baker (1993) and I (Belkin 1998) have challenged these characterizations by considering how such figures, when looked at in their historical context, were quite conversant with the intellectual world and moral philosophical writings of their day. They did ethics too! Interestingly, this reversal has caught on, and individuals such as Robert Veatch and Laurence McCullough have seized on this alternative narrative to support a new narrative for bioethics.

Rather than emphasize its revolutionary uniqueness, work in bioethics can instead be portrayed as the continuation of a more extended tradition, thus lending legitimacy for the field through the noble role of reviving interactions between medicine and humanities. This portrayal strikes me as a rearguard action in response to the voices of skepticism aimed at the bioethics mentioned here. Furthermore, however much I welcome seeing prior figures as more than caricatures, such a use of history still remains focused on validating rather than exploring, and on consolidating rather than revealing, the practices of bioethics and

the evolution of attitudes about medicine. This is a point McCullough (2000) has also made. But, at the same time, he has also approvingly analogized Gregory's wise "laying open" of medicine to public scrutiny to recent practices of evidence-based medicine and managed care. This move returns once again, then, to the kinds of celebratory rather than exploratory uses of history with regards to ethics and medicine. Here the point is to use history to secure bioethics as real "laying-open" humanism, and to secure things like evidence-based medicine as part of a progressive tradition, rather than posing more critical questions about what that humanism should look like (or what managed care and evidence-based medicine may be about).²

In this case, Gregory provides poor support for either agenda—that is, for claiming an old heritage of humanistic inquiry for a new bioethics, or for analogizing Gregory's penetrating "laying open" of medical practice with evidence-based medicine or managed care. Gregory was certainly fluent with the philosophers of his day. His major work, the *Duties and Offices of a Physician*, which first appeared anonymously in 1770, uses Scottish Enlightenment notions of perception, psychology, and sympathy. But his "opening up" of medicine is hard to summarize as a philosophical treatise, or as a precursor to a managed-care "opening up" of medicine. Its mixed perspectives reflect quite specific 18th-century purposes. This work, to my reading, was primarily an effort to engage the highly uncertain nature of medical knowledge and to spell out how physicians who take on the careful responsibility of learning and applying such knowledge require certain qualities. As part of that effort, Gregory elaborated and defended a new kind of gentleman who embodied the qualities necessary to capably acquire and use vexing, contingent, and consequential medical knowledge and experience.

This invocation of gentlemanly discretion and virtue hits contemporary ears as anachronistic, but for Gregory and his contemporaries, it was radical and provocative. Throughout his book, such as in the discussions of treating hypochondriacs or maintaining a presence with the dying, Gregory specifically took aim at practices he identified as widely and wrongfully perpetrated. The Preface to the first edition characterizes the book as "crushing" the arrogance that characterizes the profession, replacing it with the "ingenuous part of mankind," those gentlemen of "erudition and genius" (Gregory 1770, iv–v).³ The gentlemen were part of a vanguard, distinguished by openness rather than the use of knowledge and authority to obscure and hide. Such gentlemen were a corrective to

²Others writing within the bioethics literature acknowledge the need for more careful uses of history, such as seeing that bioethicists may not be unique in advocating practices such as "true" informed consent over the centuries (Powderly 2000). Tod Chambers (1998) has pointed out that the seminal writings of different philosophical schools of bioethics themselves contain and rely upon quite different, unexamined, historical assumptions about the modern condition.

³The author of this Preface is not clear; it is not Gregory.

those who exploited patients with “an affectation of mystery in all their writings and conversations relating to their professions; and affectation of profound knowledge; inscrutable to all, except the adepts in science” (Gregory 1770, 3–4). Gregory’s gentleman-scientist was a carefully asserted social identity through which he claimed that hard work, interest, seriousness, proven ability, and active discourse with fellow men, rather than breeding, rank, or privilege, should justify knowledge and power.

Gregory was a reformer and an expert. He replaced at least as much authority as he dispelled but argued that the replacement was a more reliable, diligent, and beneficial arbiter of knowledge.⁴ The physician-gentleman identity locates Gregory in a social and intellectual space that defines changes in British society and whose interests were reflected in the pages of the *Gentleman’s Magazine*. First published in 1731, the *Gentleman’s Magazine* was filled with political news, summaries of trials and debates in Parliament and American colonial assemblies, political analyses, theological discussions, reports from exotic countries, reviews of serious books ranging in subjects from botany to history, debates over historical interpretations, and the publication of original poetry and music. The magazine appears as a testament to the belief, as one letter to the magazine described it, that “worldly-minded men are commonly the most successful” (*Gentleman’s Magazine* 1770, 362). Central to this worldliness was a background in science, and the pages of the *Gentleman’s Magazine* were filled with technical scientific papers, including regularly published meteorological tables, morbidity and mortality reports, and articles on topics ranging from astronomy and archaeology to zoology. Medical topics were particularly prominent (Porter 1985).

Scientific work reinforced social identities. The late 18th century saw a proliferation of scientific societies. As Arnold Thackray (1974), in his study of the early Manchester Literary and Philosophical Society observes, this “proliferation points to fundamental shifts in the meaning of science as a cultural activity”:

From this analysis it will appear that an adequate understanding of the society hinges on the question of the social legitimation of marginal men, on the adoption of science as the mode of cultural expression by a new social class, and on generational patterning in intellectual life. . . . Natural knowledge thus seemed an appropriate, suitably distinct center around which a new, marginal group could build its own separate and progressivist philosophy and cultural system. (674, 678)

⁴An interesting expression of this position that confounds the clear boundaries between beneficent paternalism and respect for autonomous others often made by contemporary bioethical writings, is the position Gregory’s son, James, took after his father’s death regarding the use of increasingly distinct and prominent teaching wards. James was sensitive to the possibility of teaching cases receiving poorer care or being subject to experimentation and argued for public scrutiny and peer supervision of this service (Risse 1986, 249–52).

“Most important,” Thackray concludes, “was the ability of natural knowledge to function as ratifier of a new world order” (686).

Isn't this the kind of scientific chauvinism in the name of asserted social progress that bioethics emerged in the 1970s to *reject*, not *resume*? Bioethicists seeking connections to this past cannot have their cake of seeking legitimacy through history without eating as well the critical questions that may come as a result of a more balanced history. The beginnings of bioethics are to a large degree traceable to efforts to reject the very pretensions of someone like Gregory to think of moral issues in medicine as necessarily understood within a quite historically specific merging of scientific and social purposes. History here questions rather than confirms bioethical claims to inheritance of his arguably far more complex expression of medical humanism, one that would be cramped in the space of moral reductionism carved out by much of bioethics. Gregory's vista was broader: he encompassed what was thought known about the psychology of patienthood, the social value of professionalism, the difficulties of using and acquiring of medical knowledge, and the place of scientific inquiry in culture.

We should do history of medicine not to once again dwell on whether bioethics and its aspiration as medical humanism is something legitimately old or necessarily new, but to point out broader vistas for us as well, and to multiply the frameworks within which we analyze and talk about hard medical choices in general. Other histories—of capitalism and urbanization, of professionalism and consumerism, of science and technology, of the popular experience of illness and patienthood—can add new dimensions to the weathered pages of Gregory's *Observations*, as well as to debates over the development of medical practice and technology since. Gregory's work was a conversation about medical identity, the conditions of exercising medical knowledge, the consequences of making expert claims in a particular social context, and the implications of the instability and horror of patient experience. Rather than shoehorning Gregory's work into a philosophical school or moral theory, we should see in it a range of historical circumstances, purposes, and analytic approaches at play in pursuit of humane, progressive, medicine.

The tendency to look to the past primarily to mine analogies with which to validate present efforts is what allows claims like McCullough's and others, aimed at buttressing the legitimacy of managed care or evidence-based medicine. How tight, though, can those connections be made? The contribution of history to these questions should be carefully considered. Scholars are increasingly interested, for example, in the accelerating degree to which claims to scientific objectivity through standardized measures have combined with the commodification and homogenization of production and the demand to transform many sectors of the economy. Many 19th and 20th century expansions of economic activity, the development of highly capitalized industry, and the diffusion of dispute over public expenditures have been moralized as progress through

their marriage with claims to scientific objectivity and measurement, a phenomenon historian of science Theodore Porter (1995) calls “trust in numbers.” Advocates of managed care in particular have wrapped themselves within the rhetoric of evidence-based medicine to lend legitimacy to its restructuring of medical practice, if not medical knowledge itself (Belkin 1997). The “McDonaldization,” rather than the humanistic laying open, of medicine may be a more apt characterization of the changes some would want to consider progressive. (For a more encouraging view, see Timmermans and Berg 2003.)⁵ History provides caution and questions about either claim. Many other issues approached one-dimensionally as ethical look different under a historical gaze. History, for example, can flesh out and make more concrete what people mean when they appeal to enduring “norms and traditions,” as is frequently the case in defenses or criticisms of the practice of physician-assisted suicide. To deeply engage something as complex as the doctor-patient relationship—how it is dynamic and changing yet persistently sacralized, socially complicated but personally accountable, morally demanding and morally ambiguous—history is a worthy tool.

Such tools are sorely needed. I fear a lack of historical consciousness blinds bioethicists to the ways in which ethics-talk is appropriated as an arbiter of change in the health care system. It aggravates the larger disease—the distracting reliance on moral language as the ultimate route to humanistic practice. History properly understood and employed can help anchor a more useful medical humanism (Belkin 2001). Too much is at stake as medical technology and discourse increasingly define who we are and how society will develop. Reducing these consequences to moral categories may allow us to tell moving stories, but maybe not the really revealing and challenging stories that count to those listening.

REFERENCES

- Anspach, R. R. 1993. *Deciding who lives: Fateful choices in the intensive-care nursery*. Berkeley: Univ. of California Press.
- Baker, R. 1993. Deciphering Percival's *Code*. In *The codification of medical morality*, ed. R. Baker, D. Porter, and R. Porter, 179–211. Dordrecht: Kluwer Academic Publishers.
- Beeson, D., and T. Doksum. 2001. Family values and resistance to genetic testing. In *Bioethics in social context*, ed. Barry Hoffmaster, 153–79. Philadelphia: Temple Univ. Press.

⁵Timmermans and Berg's case studies (though somewhat problematically selective) argue that standardized practice will eventually tend to focus on coordinating the large-scale, multiple-actor, industrial production medicine has become. But it will do so in ways that may not lead to “McDonaldized” medicine (their term as well), but to the protection of physicians' expertise, guided to meet the needs of unique individuals. They approach this claim with some well-deserved caution but outline a useful research agenda. Nonetheless, the point remains that the historic economic, institutional, managerial, bureaucratic, etc., changes behind the astounding changes in the medical marketplace since the early 1990s in America are poorly grasped or usefully engaged through an ethics lens, or through “Gregorian” analogies.

- Belkin, G. S. 1997. The technocratic wish: making sense and finding power in the managed medical marketplace. *J Health Polit Policy Law* 22(2):509–32.
- Belkin, G. S. 1998. History and bioethics: The uses of Thomas Percival. *Med Humanities Rev* 12(2):39–59.
- Belkin, G. S. 2001. Towards a historical ethics. *Camb Q Healthc Ethics* 10:345–50.
- Belkin, G. S., and A. M. Brandt. 2001. Bioethics: Using its historical and social context. *Int Anesthesiol Clin* 39(3):1–11.
- Callahan, D. 1999. The Hastings Center and the early years of bioethics. *Kennedy Inst Ethics J* 9(1):53–72.
- Casanett, D. J., F. Daskal, and J. Lantos. 1998. The authority of the clinical ethicist. *Hastings Cent Rep* 28(6): 6–11.
- Chambers, T. 1998. Retrodiction and the histories of bioethics. *Med Humanities Rev* 12(1): 9–22.
- Clouser, K. D., and B. Gert. 1990. A critique of principlism. *J Med Philos* 15: 219–36.
- Evans, J. H. 2002. *Playing God? Human genetic engineering and the rationalization of public bioethical debate*. Chicago: Univ. of Chicago Press.
- Faden, R. R., T. L. Beauchamp, and N. M. P. King. 1986. *A history and theory of informed consent*. New York: Oxford Univ. Press.
- Gentleman's Magazine*. 1770. 40:362.
- Gregory, J. 1770. *Observations on the duties and offices of a physician; and on the method of prosecuting enquiries in philosophy*. London: W. Strahan and T. Cadell.
- Hoffmaster, B., ed. 2001. *Bioethics in social context*. Philadelphia: Temple Univ. Press.
- Jonsen, A. R. 1998. *The birth of bioethics*. New York: Oxford Univ. Press.
- Kass, L. R., et al. 2002. *Human cloning and human dignity: The report of the President's Council on Bioethics*. New York: Public Affairs.
- McCullough, L. B. 1993. John Gregory's medical ethics and Humean sympathy. In *The codification of medical morality*, ed. R. Baker, D. Porter, and R. Porter, 145–60. Dordrecht: Kluwer Academic Publishers.
- McCullough, L. B. 2000. Holding the present and future accountable to the past: History and the maturation of clinical ethics as a field of the humanities. *J Med Philos* 25(1): 5–11.
- McCullough, L. B., and W. T. Reich. 1999. Laying medicine open: Innovative interaction between medicine and the humanities. *Kennedy Inst Ethics J* 9(1):1–5.
- Moreno, J. D. 1995. *Deciding together: Bioethics and moral consensus*. New York: Oxford Univ. Press.
- Porter, R. 1985. Lay medical knowledge in the eighteenth century: The evidence of the *Gentleman's Magazine*. *Med Hist* 29:138–68.
- Porter, T. 1995. *Trust in numbers: The pursuit of objectivity in science and public life*. Princeton: Princeton Univ. Press.
- Powderly, K. 2000. Patient consent and negotiation in the Brooklyn gynecological practice of Alexander J. C. Skene, 1863–1900. *J Med Philos* 25(1):12–27.
- Risse, G. B. 1986. *Hospital life in Enlightenment Scotland*. New York: Cambridge Univ. Press.
- Rothman, D. J. 1991. *Strangers at the bedside: A history of how law and bioethics transformed medical decision making*. New York: Basic Books.
- Stevens, M. L. T. 2000. *Bioethics in America: Origins and cultural politics*. Baltimore: Johns Hopkins Univ. Press.

- Thackray, A. 1974. Natural knowledge in cultural context: The Manchester model. *Am Historical* 79(3):672–709.
- Timmermans, S., and M. Berg. 2003. *The gold standard: The challenge of evidence-based medicine and standardization in health care*. Philadelphia: Temple Univ. Press.
- Yoder, S. 1998. The nature of ethical expertise. *Hastings Cent Rep* 28(6):11–19.