

**Hidden Persuaders:  
Value Variables in Bioethics**

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The late, great theologian Karl Rahner once noted that moral analyses frequently reflect basic assumptions and the cultural variables that operate behind them. He referred to such assumptions as "global prescientific convictions." We might translate that as massive cultural biases. At any rate, Rahner stated that such convictions are responsible for the impression that certain "proofs" in moral theology assume from the outset the conclusion they purport to establish. In this fashion, the conclusions are "smuggled into the premises of the argument."<sup>1</sup> "*Hineingesmuggelt*" is Rahner's sonorous word. He argued that one of moral theology's important tasks is the exposure and demolition of such prescientific convictions.

What Rahner calls "global prescientific convictions" Harry Stack Sullivan once described as "reasons" that have sunk so deeply into the self that they are implicitly understood. Such reasons constitute the unwitting aspect of a culture and are much more responsible for its tone and direction than explicit laws and policies.

I believe we could find several "global prescientific convictions" in the church's nineteenth century analysis of religious freedom (e.g., certain convictions about the state as ideally Christian). The same could be said of the notions of "natural" and "unnatural" as they weave themselves in and out of discussions of reproductive technology and genetic engineering. The subordinate status of women in society and the church is another such conviction.

My contention here is that bioethical thought -- and indeed, health care planning in general -- can be profoundly influenced by certain cultural assumptions, trends, unexamined attitudes, biases -- what I shall

call "value variables." I will list ten candidates here with the happy admission that more and others might qualify. Two things should be noted about these value variables: They are more or less implicit, and they are intertwined in such a way that they often feed off each other.

### 1. The Denial of Mortality

Of course, it is impossible to deny mortality. What is possible, however, is to organize health care in such a way that it seems to imply rejection of the fact. Daniel Callahan puts it as follows:

Our toughest problem is not that of a need to ration health care, though that will be necessary. It is that we have failed, in our understandable eagerness to vanquish illness and disability, to accept the implications of an insight available to all: We are bounded and finite beings, ineluctably subject to aging, decline and death. We have tried to put that truth out of mind in designing a modern health-care system, one that wants to conquer all diseases and stay the hand of death.<sup>2</sup>

Thus, Callahan continues, "we have defined our unlimited hopes to transcend our mortality as our needs, and we have created a medical enterprise that engineers the transformation." The symptoms of this rejection of the fact of mortality abound.

Item: A wealthy society like ours must not allow anyone to die who can be saved. Witness the end-stage renal disease program of 1972, providing government-paid dialysis for all who need it. Indeed, a 1987 Harris poll revealed that most people (71 percent to 26 percent) believe that "health insurance should pay for any

treatments that will save lives even if it costs one million dollars to save a life."

Item: Intensive care units are overused; too frequently they resemble high-tech hospices. As Joseph A. Califano, Jr., puts it: "A substantial number of patients admitted are elderly, in chronically poor health, with little chance for short-term survival."<sup>3</sup> Many patients are either too sick or not sick enough.

Item: Nearly 30 percent of Medicare's money goes to patients with less than a year to live. This figure has not varied appreciably in the last fifteen years.<sup>4</sup>

Item: Patients in a persistent vegetative state are maintained for prolonged periods by artificial nutrition and hydration (e.g., Nancy Cruzan). Most people judge this prolongation to be needless, heedless and aimless -- indeed, a pursuit of the temporal that potentially blurs the eternal.

Christopher F. Koller summarizes as follows: "Health care has much more important things to offer than the false hope of immortality."<sup>5</sup>

### 2. The Eugenic Mentality

By this phrase I refer to positive eugenics, the preferential breeding of superior individuals or genotypes. At the heart of such an attitude is an intolerance of imperfection. I will use two happenings to make my point. The first was the *in vitro* fertilization debate in this country. I was privileged to be on the 13-member Ethics Advisory Board of the Department of Health, Education and Welfare (HEW), which deliberated on this matter for the federal government. While taking testimo-

ny throughout the country, I became aware of an interesting attitude on the part of a considerable number of people. It was the "consumer-item mentality" toward the child -- "Give me blue eyes this time." The second incident was Robert K. Graham's announcement on May 25, 1982, of the establishment of the Repository for Germinal Choice. Graham was seeking out the sperm of superior individuals (e.g., Nobel Prize winners like Dr. William S. Shockley) to produce -- I use the word deliberately -- genetically superior persons. "We only go with the most superlative males," boasted Graham. Since that time, similar repositories (sperm banks) have become quite common, offering brochures that state the donor's race, education, hobbies, weight -- and yes, eye color.

These two events occurred in a twofold cultural context. First, prenatal diagnosis is increasingly sophisticated. We have amniocentesis, chorionic villus biopsy, ultrasonography and maternal serum alpha fetoprotein testing for neural tube defects. Second, abortion is a culturally accepted form of health care.

The consumer-item mentality toward children, combined with sophisticated prenatal diagnosis, will lead to an increasing emphasis on eugenics. Telling symptoms of this mentality are already apparent. We hear people refer to "the right to a healthy child." Implied in such loose talk is the right to discard the imperfect. What is meant, of course, is that couples have a claim to reasonably available means to see that their children are as healthy as possible.

Barbara Katz Rothman has noted the erosion of the unconditional acceptance of the child implicit in "quality" thinking. She asks,

What does it do to motherhood, to women, and to men as fathers too, when we make parental acceptance conditional, pending further testing? We ask the mother and her family to say in essence, "These are my standards. If you meet these standards of acceptability, then you are mine and I will love and accept you totally. After you pass this test."<sup>6</sup>

Furthermore, we have seen several cases of "wrongful life" where the child himself or herself is the plaintiff.<sup>7</sup> Recent neonatal intensive care cases have revealed an alarming attitude on the part of some people, including physicians. The options narrow to a healthy child or a dead child. We have donor insemination. We have pre-implantation diagnosis for some genetic defects. The National Institutes of Health are already involved in genetic correction of some diseases. Someday soon, researchers will contemplate a more thorough cure, that of correcting the defective gene in the germ line cells (ova or sperm). As an editorial in *The New York Times* noted:

Repairing a defect is one thing, but once that is routine, it will become much harder to argue against adding genes that confer desired qualities, like better health, looks or brains. There is no discernible line to be drawn between making inheritable repairs of genetic defects, and improving the species.<sup>8</sup>

"Improving the species" belongs to what we call "positive eugenics." It raises a host of unanswerable questions: What qualities are to be maximized? Who decides? Which defects are too burdensome? Who decides? Every thoughtful commentator runs from questions like these as if they were the plague. These are just some of the dilemmas of positive eugenics. Far

too few people advert to the fact that when we program for high IQ, we can begin to value the person in terms of the quality. In other words, we reduce the whole to a part. People who do that are on their way to doing other things civilized societies should abhor.

This eugenic mentality is powerfully supported by the developing notions of disease and health. The term "disease" has had an interesting evolutionary history, and, therefore, so has the term "health."

The word "disease" first meant an identifiable degenerative or inflammatory process, which, if unchecked, would lead to serious organic illness and sometimes eventually to death. The next stage of development was statistical: At least some diseases were identified by deviation from a supposed statistical norm. Thus we referred to *hyperthyroidism* or *hypcholesterolemia*, *hypoglycemia*, etc. One was said to be unhealthy, to have a disease, if he or she were *hypo* or *hyper* anything. The person was unhealthy not in the sense of an existing, tangible degenerative process, but in the sense that the individual was more likely than others to suffer some untoward event, what my late colleague Dr. André Hellegers impishly called "hyperuntowardeventitis."

The third notion defines disease as inability to function in society. For instance, a good deal of surgery is being performed to enlarge breasts, to shrink buttocks, to tuck tummies, to remove wrinkles -- in brief, to conform to someone's notion of the attractive and eventually of the tolerable. We live in a society that cannot tolerate aging. At some point, then, this question arises: Who is the patient here? Who is sick--the individual, or society? I mean, of course, that this

broad understanding of "health" can too easily reflect the sickness in society's judgments about the meaning of the person. In our time and in some societies, people are hospitalized because of nonconformity. That suggests that the notion of "health" is becoming increasingly nonsomatized and getting out of control.

The final stage of development is the definition of health popularized by the World Health Organization. According to WHO, health is a "state of complete physical, mental, and social well-being, not simply the absence of illness and disease." This description of health was adopted in the 1973 abortion decisions of the U.S. Supreme Court. The Court stated that the "medical judgment may be exercised in the light of all factors -- physical, emotional, psychological, familial, and the woman's age -- relevant to the well-being of the patient."<sup>9</sup>

Through the expansion of the notions of health and disease, contemporary medicine is increasingly treating people's desires in a move toward a society without discomfort. In the process, some basic human problems are being medicalized.

### **3. Good Health Care = Efficient Rescue Medicine**

When people think of health care, they usually think of sick care. Joseph Califano puts it this way:

Heart disease is America's number-one killer. Daily newspapers and television dramas give the impression that coronary bypass surgery, modern cardiopulmonary techniques, miracle hypertension pills, human heart transplants, and in the future, animal and artificial heart transplants are the way to battle heart disease.

Right?

Couldn't be more wrong.

Since 1970 our nation has experienced a dramatic 25 percent decline in deaths from coronary heart disease. The major reasons? Improved eating habits -- the reduction in cholesterol -- accounted for almost one-third of the drop. The decline in cigarette smoking was responsible for another quarter. So individuals, by changing personal habits, were responsible for more than half the decline in deaths from heart disease. In contrast, coronary care units accounted for only 13.5 percent; cardiopulmonary resuscitation, 4 percent; bypass surgery 3.5 percent; and the widely used hypertension pills only 9 percent. Deaths from stroke are also sharply down for much the same reasons.<sup>10</sup>

Califano goes on to point out that virtually all the factors that substantially increase the likelihood of heart disease are in the patient's control, not the physician's.

But on we go. Our bias toward acute care means not only neglect of health care, but a one-sided emphasis on cure to the neglect of care, and that in an aging society at the very time when what is needed is *more* caring. Christopher Koller states: "Clinically, patients and providers alike often forsake the collective art of caring for the individualized science of curing."<sup>11</sup> And why not? After all, as Dr. Timothy Quill notes, "We overtrain

doctors to extend life. We undertrain them to address human suffering."<sup>12</sup> His example: the attempt to resuscitate an 80-pound, 80-year-old man ravaged by lung cancer whose bones fracture under the pressure of CPR.

Daniel Callahan points out that caring is not emphasized for physicians in the way that medical knowledge and technical skills are stressed. "The ability to care requires a capacity to acknowledge our own mortality and our common vulnerability as well as to understand the privacy and hiddenness of much pain and suffering in others, an understanding that requires imagination."<sup>13</sup>

#### 4. The Absolutization of Autonomy

Until the last few decades, medicine was practiced in a highly paternalistic way. Paternalism refers to a system in which treatment decisions are made against the patient's preferences or without the patient's knowledge and consent. The past twenty years have seen a reaction against paternalism and the flowering of patient autonomy.

What can easily be missed is that reactions have a way of becoming overreactions. In the religious sphere, a reaction against authoritarianism can usher in anarchy. In an overreaction against paternalism, autonomy has been absolutized. The symbolic cheerleader for this absolutization is Dr. Jack Kevorkian, who states:

In my view the highest principle in medical ethics -- in any kind of ethics -- is personal autonomy, self-determination. What counts is what the patient wants and judges to be a benefit or a value in his or her own life. That's primary.<sup>14</sup>

Period.

The offshoot of this absolutization is that very little attention is given to the values that ought to guide the use of autonomy. The sheer fact that the choice is the patient's is viewed as the sole right-making characteristic of the choice. This attitude has impoverished the presentation of the pro-choice position on abortion. Choices, however, may be good or bad, and unless we confront the features that make choices good or bad, autonomy usurps the evaluation. When it trumps every other consideration, autonomy has been overstated and distorted and leads to what Bruce Jennings calls "the terrible singularity, the chilling aloofness of the sovereign moral will."<sup>15</sup>

## 5. Dignity as Independence

We often hear people, especially the elderly, declaring, "I don't want to be a burden." The idea of depending on others seems almost un-American. Depending on others is foreign to our notion of human dignity. Human dignity means independence, much as national dignity is anchored in the Declaration of Independence.

Witness this clip from *USA Today*:

Cynthia Powelson knew it was time to die. She'd tried surgery, chemotherapy, acupuncture and meditation. She couldn't eat or drink. And her gastric tumor had grown so large she appeared six months pregnant. Doctors said she wouldn't live a year. The graduate student, 37, gathered family at her suburban Rochester, New York, home, married her longtime love, then had her feeding tube removed. She died 12 days later. Life was out of control. Death was on her terms. Having some say in death, as Powelson did, has become a national obsession.<sup>16</sup>

I am not criticizing Cynthia Powelson's decision, not at all. Nor is it appropriate to glamorize dependence. Our discomfort with dependence is quite understandable. But for too many people dignity is *totally* incompatible with dependence. Thus dignity -- as in death with dignity -- means death in my way, at my time, by my hand.

All I would argue here is that our notion of dignity must incorporate the reality of dependence. Christians realize that Christ displayed great dignity in dependence: "Not my will but thine be done." Christians do not view dependence as depriving us of our dignity, but as a sacrament of our openness to and dependence on God. In the fragility of dependence, we are invited to cling to and trust in a power beyond our control. In this sense, a rejection of interdependence is closely tied to rejection of creaturehood and mortality. An Anglican study group put it this way:

There is a movement of giving and receiving. At the beginning and at the end of life receiving predominates over and even excludes giving. But the value of human life does not depend only on its capacity to give. Love, *agape*, is the equal and unalterable regard for the value of other human beings independent of their particular characteristics. It extends especially to the helpless and hopeless, to those who have no value in their own eyes and seemingly none for society. Such neighbour-love is costly and sacrificial. It is easily destroyed. In the giver it demands unlimited caring, in the recipient absolute trust. The question must be asked whether the practice of voluntary euthanasia is consistent with the fostering of such care and trust.<sup>17</sup>

## 6. The Secularization of Medicine

By "secularization," I refer to the divorce of medicine from the values that make it a service-oriented profession. Put differently, secularization refers to an increasing preoccupation with payers, liability, competition, compensation -- in short, the business aspects of medicine. The average physician spends 7.5 hours a week on utilization review problems, nearly nine full work weeks a year. Physicians increasingly regard their expertise as their own possession to be dispensed in the marketplace on their terms. Thus, 30 percent have said that, were they free to choose, they would not treat AIDS patients. Sixteen percent of physicians now advertise, thus reinforcing the impression of medicine-as-business.

One result of this transformation is that physicians are leaving the profession. As Dr. Raymond Scalettar, chairman of the AMA Board of Trustees, put it: "You never used to hear of a physician retiring

unless he was ill or disabled. This wasn't work. This was a calling. Now it has changed."<sup>18</sup> The nature of that change is captured by Seattle physician Michael McCarthy: "I like the emotional side of medicine. But this isn't about emotion anymore, it's a business."<sup>19</sup> No wonder that a Gallup poll conducted for the American Medical Association found 67 percent of the 1500 persons polled saying that doctors are too interested in making money, and 57 percent responding that "doctors don't care about people as much as they used to."

When medicine becomes a business, the physician-patient relationship is eroded by being made a means to a further end.

## 7. The Interventionist Mentality

This value variable is very close to the emphasis on "rescue medicine" discussed under Number 3 above, but it is somewhat broader. Corporately, we Americans are *Homo technologicus*. We believe that the best solution to the dilemmas created by technology is more technology. Thus, Glennon Hospital in St. Louis spends \$400,000 to treat lead poisoning rather than attempting to correct the problems in the homes where lead poisoning originates. We use pesticides and discover only later that they are carcinogens. We tend to eliminate the maladapted condition (disabled, retarded, etc.) rather than adjust the environment to it.

The high-water mark of the interventionist mentality was the declaration of the late Joseph Fletcher that "laboratory reproduction is radically human compared to conception by ordinary heterosexual intercourse."<sup>20</sup> The surest symptom that

something is awry here is that the fun has gone out of things.

## 8. Confusion of the Legal and Moral

It is the temptation of the Anglo-American tradition to identify legal and moral issues. We are a pragmatic and litigious people for whom law is the answer to all problems, the only answer and a fully adequate answer. Thus, many people confuse morality and public policy. If something is removed from the penal code, it is viewed as morally right and permissible. And if an act is seen as morally wrong, many want it made illegal. Behold the "there ought to be a law" syndrome.

When these two spheres, interrelated as they are, are confusedly identified, then the moral arguments establishing the one or the other also are confusedly identified. Since public policy must be sensitive to a whole host of pragmatic considerations (e.g., enforceability, pluralism of conviction, social costs, social priorities) collectible under the term "feasibility," it is possible for moral argument to be affected -- indeed, corrupted -- by such considerations. Furthermore, it is possible that the tactics used so often to move public policy can come to be regarded as "moral arguments." An example can be drawn from the late 1960s and early '70s when "gut feelings," confrontation, symbolic acts of protest, and other forms of

nondiscursive exchange prevailed over analytic discourse and were frequently regarded as adequate warrants for *moral* stances. The prophet was confused with the philosopher. As a result, we experienced a loss of accountability to reason.

## 9. Morality as Purely Personal

We often hear such declarations as: "It is not my concern what another does." "Each person must decide for him or herself." "Who am I to determine another's morals?" Or again, "I do not myself accept abortion, but I do not want to impose my morality on others." Such statements spring from a lonely individualism that supposes that you and I are islands, individual and isolated from the society and atomized within it.

One of the major mischiefs of this individualism is our failure to see the social dimension of many problems (physician-assisted suicide, abortion, reproductive technologies, human sexuality). A view of abortion as a matter of individual choice, for example, divides people, while abortion seen as a social problem could bring people together. Nearly everyone would agree that the conditions that lead to abortion (poverty, lack of education, broken families, lack of recreational alternatives, etc.) should be corrected.

Or again, sexual activity is often viewed as a purely private matter. Robert McAfee Brown recently underlined how false that view is.<sup>21</sup> Sexual relationships are microcosms of society. A loving atmosphere in the home can flow out into society. An inhumane and violent social atmosphere can turn on the family and shatter it. Sexual and social issues are

inseparable. Or better, sexual issues are social issues.

### **10. Functional Assessment of the Person**

I believe it safe to say that many Americans unwittingly operate from a rather crude utilitarianism in many of their moral judgments. "If it produces good results, what can be wrong with it?" This bias toward producing results will naturally lead to an evaluation of people as producers. They will be regarded, supported, protected in terms of their functionality or value to society. If that is the silently operating criterion, it is clear who will suffer.

### **The Implications of Value Variables**

If I am correct in identifying these value variables, then it is clear that they will profoundly affect how we think about

bioethical problems, and especially health care reform. When these variables are shaken and mixed, I strongly suspect that they will yield thought patterns that will overvalue and overstate longevity, independence, autonomy (of both patient and physician), technology, curing (to the neglect of caring), youth, individualism, doing (vs. being), and competition. Correspondingly, they will yield thought patterns that undervalue and understate mortality, dependence, caring, the social dimension of choices, limits of technology, aging, being (vs. doing and producing), and cooperation (vs. competition).

I expect such hidden persuaders to generate stiff resistance on the part of patients, physicians and hospitals to the type of sacrifice that will be required by true health care reform. The wagons are already circling. Indeed, if such reform is to occur, it will require something akin to a cultural conversion. If you are optimistic, you will believe that such conversion is possible without the turbulence of catastrophe. But if you are pessimistic. . .

## NOTES

1. Karl Rahner, "Über schlechte Argumentation in der Moral-theologie," in H. Boehlaars and R. Tremblay, eds., *In Libertatem Vocati Estis* (Rome: M. Pisani, 1977), p. 249, cited in Philip Rieff, *The Triumph of the Therapeutic* (London: Chatto and Windus, 1966), pp. 2-3 and 5.
2. Daniel Callahan, *What Kind of Life: The Limits of Medical Progress* (New York: Simon and Schuster, 1990), p. 23.
3. Joseph A. Califano, Jr., *America's Health Care Revolution: Who Lives? Who Dies? Who Pays?* (New York: Random House, 1986), p. 104.
4. James D. Lubitz and Gerald F. Riley, "Trends in Medicare Payments in the Last Year of Life," *New England Journal of Medicine* 328 (No. 15, April 15, 1993): 1092-96.
5. Christopher F. Koller, "Health Care Priorities: Four Things to Keep in Mind" (An Open Letter), *Commonweal*, April 23, 1993, p. 6.
6. Barbara Katz Rothman, "The Products of Conception: The Social Context for Reproductive Choices," *Journal of Medical Ethics* 11 (No. 4, December 1985): 188-92, p. 190.
7. *Turpin v. Sortini* 119 Cal. App. 3d 690; *Harbeson v. Parke Davis* 746 Fed 2d 517; 656 P 2d 483; 98 Wash 2d 460.
8. *The New York Times*, "Whether to Make Perfect Humans" (Editorial), July 22, 1982, p. A22.
9. *Doe v. Bolton*, 410 U.S. 179, 192 (1973).
10. Califano, *America's Health Care Revolution*, p. 187.
11. Koller, "Health Care Priorities," p. 6.
12. Nicole Carroll, "On Death and Dignity: Patients Seek Control Over Their Lives," *USA Today*, February 23, 1993, p. 1D.
13. Callahan, *What Kind of Life*, pp. 147-48.
14. *Free Inquiry* Interview, "Medicide: The Goodness of Planned Death," *Free Inquiry* 11 (No. 4, Fall 1991): 14-18, p. 14.
15. Bruce Jennings, "Active Euthanasia and Forgoing Life-sustaining Treatment: Can We Hold the Line?" *Journal of Pain and Symptom Management* 6 (Number 5, July 1991): 312-316, p. 316.
16. Nicole Carroll, "On Death and Dignity," p. 1D.
17. General Synod Board for Social Responsibility, Church of England, *On Dying Well: An Anglican Contribution to the Debate on Euthanasia* (London: Church Information Office, 1975), p. 22.
18. Melinda Beck, "Doctors Under the Knife," *Newsweek*, April 5, 1993, p. 28.

19. Lisa Belkin, "Doctors in Distress: Many in Medicine See Rules Sapping Profession's Morale," *The New York Times*, February 19, 1990, p. A1.
20. Joseph Fletcher, "Ethical Aspects of Genetic Controls: Designed Genetic Changes in Man," *New England Journal of Medicine* 285 (September 30, 1971): 776-83, p. 781.
21. Richard Scheinin, "Love, Justice, Sex: These Three," *San Jose Mercury News*, Oct. 31, 1992, p. 10.