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And Power Corrupts . . . : Religion and the Disciplinary Matrix of Bioethics

M. Therese Lysaught

Religion and Public Bioethics: Complicating the
Received Narrative

"Public bioethics" is often positioned as a subfield in the discipline of bioethics. It is depicted as a public practice of deliberation or debate among professionals or a plurality of voices about how society should proceed in the face of a particular problem related to health care or biotechnology. Such debate seeks to produce some level of consensus *via* rationally coherent arguments useful for formulating guidelines to be promulgated by policymakers (aka public policy)¹ or for influencing the beliefs and values of the public. Daniel Callahan and others, in fact, differentiate this sense of "public" bioethics from other forms of bioethics that they variously label "foundational," "clinical," "pedagogical," "institutional," "community," "civic," and so on.²

Yet to limit "public" bioethics to the action of public panels, public conversations, or the crafting of government regulation and health policy is somewhat artificial and misleading. For contemporary images of the clinical setting are structured along similar lines. The clinical context is narrated as a pluralistic space where a diverse set of people—patients, physicians, nurses, allied health workers, families—come together as both strangers and moral strangers yet are bound to work together cooperatively. To resolve moral disagreement, various stakeholders must meet and, through reasoned conversation, craft a balance between the strictures of institutional/public authority and individuals' rights to pursue their own goods. In fact, Bette-Jane Crigger notes (with concern) that medicine (by which she means the clinical setting) is well on its way to becoming

"a privileged domain—perhaps the preeminent domain—of public moral discourse in contemporary American society."³ The public, it seems, is everywhere.

One could in fact argue that there is no subcategory of bioethics that is not public. One reason is that the bioethical architecture of what are deemed to be putatively distinct arenas draws on a shared narrative of public space, a narrative whose "core thesis," as Michael Sandel puts it, is this:

Society, being composed of a plurality of persons, each with his own aims, interests, and conceptions of the good, is best arranged when it is governed by principles that do not themselves presuppose any particular conception of the good; what justifies these regulative principles above all is not that they maximize the social welfare or otherwise promote the good, but rather that they conform to the concept of right, a moral category given prior to the good and independent of it. This is the liberalism of Kant and of much contemporary moral and political philosophy.⁴

Again and again, the settings of particular subfields of bioethics as well as the ways in which they locate and choreograph agents within those settings reproduce this narrative.

Not only does this narrative give a particular shape to the practice of bioethics across contexts.⁵ It tells a consistent story about religion. Across the board, from the pluralistic contexts of public to clinic, religion presents a problem.⁶ Religions posit beliefs that are, by definition, not held in common and as such cannot provide a shared basis for moral exchange.⁷ At best, they are denied intrinsic moral value.⁸ At worst, they emerge as one of the primary sources of moral conflict. Belying their apparent neutrality toward religious convictions, Tom Beauchamp and James Childress in their highly influential *Principles of Biomedical Ethics* return again and again to a particular example of self-destructive behavior, "bizarre actions prompted by unorthodox religious beliefs."⁹ One of the few other contexts in which religious convictions are mentioned in their text is in the conflictual situation of refusal of treatment.¹⁰ In a similar fashion, H. Tristram Engelhardt, the once-despairing champion of the Enlightenment project in biomedical ethics, again and again rhetorically equates the terms "particular," "religious," "parochial," and "ideological."¹¹ Examples abound to demonstrate how the dominant mode of bioethics no longer takes theological or other substantively rational authors seriously but rather simply deems them irrational and outside the purview of legitimate argument.¹²

Yet it is not just that religious beliefs confound the canons of moral consensus and rationality. As problematic as religion can be in the clinical setting, to allow participation of religion within the practice of public bioethics can be even dicier. James Childress, in his account of the process behind the NBAC report on human cloning, names the fundamental issue:

Arguments for and against a significant role for religious convictions in public policy appeal to two different fears, which may be

more or less plausible depending on the particular liberal, pluralistic democracy at a particular time. On the one hand, opponents often fear religion's divisiveness. John Rawls begins his book on political liberalism with the story of religious conflict in the West, and we know full well religion's role in conflicts around the world. Many who argue for a reduced role, or no role at all, for religious convictions in public policy share this fear, *and it is not unreasonable*.¹³

Religion, in other words, must be handled carefully vis-à-vis the public sphere because it is inherently dangerous and violent.

Childress's remarks echo one of the foundational myths that undergird the U.S. liberal social vision described earlier by Sandel. As Judith Sklar tells the story:

Liberalism . . . was born out of the cruelties of the religious civil wars, which forever rendered the claims of Christian charity a rebuke to all religious institutions and parties. If the faith was to survive at all, it would do so privately. The alternative then set, and still before us, is not one between classical virtue and liberal self-indulgence, but between cruel military and moral repression and violence, and a self-restraining tolerance that fences in the powerful to protect the freedom and safety of every citizen.¹⁴

The modern state, in other words, arose out of what came to be known as the "wars of religion" of the sixteenth and seventeenth centuries, as that force necessary to make the peace. Behind the pluralist narrative outlined earlier, then, lies a vision of the state as the necessary hedge that protects individuals against the coercive tyranny of religious authority and the inevitable violence inherent in religious difference.

The story of the state as that which saves us from the violence of religious passion, as the agent of peace, has become canonical for both U.S. public policy and bioethics. More important, it is historically and theologically false. Theologian William Cavanaugh carefully displays that the received story that the liberal state emerged as a response to religious violence gets the matter backward.¹⁵ Drawing on the work of social theorists and historians Charles Tilly, Quentin Skinner, and Richard Dunn, Cavanaugh compellingly argues that the modern liberal nation-state began to emerge well in advance of the wars of religion, documents how indeed most of these wars were not fought between Protestants and Catholics but rather between co-religionists (i.e., between Protestants and Protestants or Catholics and Catholics), and shows how emerging religious identities were manipulated as tools of unflinching *Politiques* in their quest for state power.

Cavanaugh argues that key to emerging states' ability to foment such wars was the very creation of the modern category of "religion." Through the Middle Ages, religion was understood as a virtue, deeply intertwined with bodily practices located within the institutional structure of the Roman Catholic Church. But in the sixteenth and seventeenth centuries, the term "religion" began to

be used in a new way. It begins to refer to a system of beliefs, a set of propositions that could be held by newly minted modern "individuals" and that could exist separately from one's public loyalties to institutions of church or state.¹⁶ Thus, as he notes: "To call these conflicts 'Wars of Religion' is an anachronism, for what was at issue in these wars was the very creation of religion as a set of privately held beliefs without direct political relevance."¹⁷

Cavanaugh convincingly demonstrates that this theoretical reconfiguration of Christianity as a now fractured diversity of religions fit not only with Enlightenment epistemological presuppositions but, more important, was employed as a tool for wresting power from the only institution strong enough to stand against the state, namely the church. "True religion," in Locke's words, found a new home not in a public, communally extended and authoritative institution but rather in the private and solitary confines of an individual's mind and conscience. As such, the medieval configuration of disciplinary authority split between church and state was dismantled: "What is left to the Church is increasingly the purely interior government of the souls of its members; their bodies are handed over to the secular authorities."¹⁸ The state, in other words, assumed unchallenged disciplinary control over individuals' bodies as religion was brought into service of the sovereign.

Cavanaugh's account upends the foundational myth that sets the terms of debate in the conversation on religion and public bioethics. With others, it reveals the problematic nature of the concept of 'religion' as it functions within the field of bioethics.¹⁹ It displays as mythical the fear that Childress identified as *not unreasonable*. And it unmasks the modern state's claim to be the keeper of peace rather than what it is—the purveyor of violence on a scale previously unimaginable.

But Cavanaugh's rereading of the historical record does more than challenge the very way 'religion' is conceptualized within bioethics; more fundamentally, it problematizes the very depiction of bioethics itself. Far from being an open, public deliberative practice that involves reasoning with other citizens or a limited set of procedural norms that facilitate the full range of individual value judgments, bioethics instead has become part of the disciplinary matrix of the modern social order, a key practice in the state's management of bodies within its purview.

For bioethics, like its ally medicine, is about nothing if it is not about bodies. Bioethics does an extraordinarily good job at masking this fact; rarely will one see bodies referred to, even obliquely, within the discipline of bioethics. The various distinctions between subfields of bioethics (especially distinctions between 'clinical bioethics' and other types) are but further attempts to distance the discipline from the bodies that it organizes.

It will be the burden of this essay to make this case, that bioethics ought properly be understood as a disciplinary matrix that serves the modern Leviathan of state and market. The purpose of doing so, of course, is to narrate a rather different vision of 'public bioethics.' For without a more accurate accounting of the nature and function of public bioethics, it will not be possible

to begin to posit how 'religion' might even begin to position itself in relationship to it.

Cavanaugh's account of the reconfiguration of the relationships between religion, bodies, and the state is clearly indebted to the legacy of Michel Foucault, a debt I share. For those who are not familiar with Foucault, I begin with a brief overview of his analytic framework. The major work of the essay will be to display how bioethics fits the Foucauldian paradigm. So as to avoid the appearance of special pleading, I will turn not to theologians to develop this account²⁰ but rather to social scientists and bioethicists.

Bodies and Disciplinary Matrices

Robert Zussman and others have recently argued that bioethics can and ought to learn from sociology.²¹ Foucault might well have concurred, holding as he did that medicine is a mode of applied sociology.²² Although Foucault is not quite what Zussman has in mind, for those who have read his account of medicine as well as his work on power, knowledge, and discipline, it is but a small step from there to the field of bioethics.²³

Central to Foucault's analysis is a recognition of the material reality of bodies and the politics that is nothing other than production and organization of bodies within culture.²⁴ Bryan Turner, one theorist who has attempted to systematize a theory of the body, summarizes Foucault's thesis: "The body as an object of power is produced in order to be controlled, identified, and reproduced."²⁵ Power, for Foucault, is not negative per se. Rather, it is essentially *productive*. As Anthony Giddens notes, "Power is actually the means whereby all things happen, the production of things, of knowledge and forms of discourse, and of pleasure."²⁶ Joanne Finkelstein extends this definition, capturing its more decentered, circulatory, weblike, operational sense:

Power is a strategy of relations that gives some individuals and groups the ability to act and keep acting for their own advantage. Power is also the ability to bring about a desired situation and to prevent the actions of those who would thwart such desires.²⁷

Key to the productivity of such power is the fact that it is wielded not in an overt, coercive manner but rather that individuals come to wield it over themselves. In other words, within a regime of disciplinary power, each person—by internalizing the norms and surveillance of the social order—effectively disciplines her or himself. As such, Finkelstein writes, this exercise of power is "extremely subtle as it can direct individuals toward actions the eventual outcome of which will not necessarily be to their advantage."²⁸ The basic goal of disciplinary power is to produce persons who are docile—persons, in other words, who do not have to be externally policed.²⁹

But how does this occur? How does it happen that individuals—or rather

individuals vis-à-vis their bodies—become formed in such a way as to internalize the agenda of the wider social order? What, in other words, are the mechanisms of governmentality?³⁰ Bodies are constituted, Foucault and others argue, via disciplinary matrices consisting of the intersection of three key elements: discourses, practices, and institutions.³¹

A *discourse* is that body of concepts and statements that make possible the appearance of objects at a particular historical moment and provide a language for talking about them. Discourses define and produce objects of knowledge, governing the ways a topic can be meaningfully talked about and reasoned about. Various put, nothing that is considered meaningful exists outside discourse, nothing has any meaning outside of discourse, and nothing outside of discourse is considered meaningful.³²

Social theorist Arthur Frank pushes this definition one step further, noting how deeply allied discourses are to bodies. Discourses, he notes, are:

cognitive mappings of the body's possibilities and limitations, which bodies experience as already there for their self-understanding. . . . These mappings form the normative parameters of how the body can understand itself. . . . Discourses only exist as they are instantiated in on-going practice or retained by actors as "memory traces."³³

One example of such a discourse would be the modern scientific account of anatomy. Arising in part out of the structures of the human body, it equally arranges, depicts, defines, and describes the way in which inhabitants of Western culture literally "map" their bodies; bodies no longer consist of humors or mime the structures of the heavens, but instead are composed of organs, systems, tissues, cells, DNA, and so on. Equally, the languages of disease and illness are discourses mapping bodies' self-understandings.³⁴

Dorothy Smith refers to discourses as "extralocal texts—texts created elsewhere—that organize action and relationships in local settings by instructing actors in those settings as to what they should do and perhaps proscribing what they cannot do."³⁵ Frank elaborates on Smith's reading of discourse with the example of DRGs:

In medicine, diagnostic-related groups (DRGs) . . . are a prime example of discourse. . . . DRGs are written documents, created by a group of specialists working on the basis of individual clinical experience and aggregate data but working apart of any specific scene of clinical practice. These specialists produce a code of diagnosis—all illness must map into DRG categories to be treated—and detailed specifications of what count as reimbursable services for each category. DRGs, as a textual code created elsewhere, thus organize activity in local clinics. People in local settings still make decisions and deliver care, but the text limits and directs what they can do.³⁶

This particular example highlights a key feature of discourses—that the content of the "extralocal text" is understood as technical or formal knowledge, knowl-

edge that is increasingly esoteric, the purview of specialists and elite professionals.

As such, knowledge associated with discourses becomes a mode of social power. As Finkelstein notes:

Where knowledge becomes a source of power, as it does with technical or formal knowledge, it is the technocrat, the owner, the controller of knowledge, who gains social power. Significantly, when technical knowledge is the basis of power, the inequalities between provider and consumer are frequently concealed by the idea that a professional service is offered. . . . Indeed, the inherent power and domination of the situation are disguised insofar as the monopoly created by specialist knowledge has been legitimated by the sanction of law and professionalism.³⁷

Disciplinary identity and professionalization are key markers of the development of discourse.

Discourses, of course, cannot float free. In order to do the work of constituting and disciplining bodies, of inscribing the meanings of the social order into bodies, they must be incarnated in social *practices*. Discourses and practices stand in reciprocal relationship: discourses define the rules for practices, which in turn embody those discourses.

Discourses, then, are reproduced into the social world by techniques of discipline, by the practices of bodies on which they are inscribed. As Frank notes:

Theory needs to apprehend the body as both medium and outcome of social "body techniques," and society as both medium and outcome of the sum of these techniques. Body techniques are socially given—individuals may improvise on them but rarely make up any for themselves—but these techniques are only instantiated in their practical use by bodies, *on* bodies. Moreover, these techniques are as much resources *for* bodies as they are constraints *on* them; constraints enable as much as they restrict.³⁸

In other words, through their enactment these techniques produce bodies that embody the commitments of the wider social order; they produce "docile bodies." And it is through the creation of such bodies, that then go on to act in the world in self-motivated ways, that practices further realize (make real) and reproduce the commitments of the discourses in the world.

Discourses are legitimated in part by being embedded in *institutions*, social organizations which have attained sufficient power to render their discourses true. Institutions, Frank writes, "have a specificity within both space and time. A discourse can only be spoken or enacted; it is nowhere but in that act or speech. An institution is a physical place where one can go, which may or may not be there any longer."³⁹

Institutions, then, provide both a centralized social space for exponential

consolidation of productive power as well as visible social sanction for the truths put forward in a particular discourse. Such institutionalization, at least in our culture, further reinforces the "scientific" character of the discourse's growing body of knowledge.

Further, institutions enable methods of surveillance that are crucial to the mapping of the bodies within their population as well as the process of normalization. Via disciplines like medicine, certain attitudes and practices come to prevail as normal and acceptable. Institutionally sanctioned discourses both define the "normal" and, through techniques and practices, encourage individuals to regulate and achieve her or his own conformity with the established rules.⁴⁰

Disciplinary matrices of discourses, techniques, and institutions are able to exercise power in this decentralized manner insofar as the discourse is able to sustain a *regime of truth*. "Truth" in this sense points to the creation of knowledge as a function of power (power, as noted above, which is understood not negatively but as productive). Truth is a product of discursive practices understood to emerge only within a structure of rules, practices, and institutions that control the discourse and collaborate to establish a given claim as "true." Knowledge shaped by discourses, empowered by institutions, and wielded through techniques and practices thus has the power to make itself true.

Truth then is embodied and reproduced through "rituals of truth," practices shaped according to the rules of the discourse which then, not surprisingly, reinforce the truth claims of the discourse (one might think, for example, of the "truth" of the anthropological claim that we are autonomous individuals embodied and reproduced through the practice of advance directives). Through these many factors, the networks of productive power serve to produce, via inscribed bodies, particular styles of subjectivity. Subjects are both produced within discourses and simultaneously subjected to discourses. Such subject production is one component of the process of normalization.

These, then, are the components of a Foucauldian disciplinary matrix. By not allowing attention to be diverted from bodies, such an analysis seeks to unmask how particular discourses—particular fields of knowledge and truth claims—are used in conjunction with institutionalized practices to effect social and political ends, even while rhetorically claiming to be apolitical, neutral, and objective. It turns attention not to abstract ideas or disembodied "wills" but rather to the usually covert operations of productive power, power that produces particular kinds of embodied subject-citizens and in doing so reproduces the body of the state.

The Disciplinary Matrix of Bioethics

Equipped with an outline of disciplinary matrices and how they function, we can turn now to the field of bioethics itself. One might counter that the connection between bioethics and the state is already inferred in the phrase "public

bioethics."⁴¹ This analysis seeks not only to establish that fact but to display the intricate connections between the various types of bioethics, suggesting that they ought rather be understood as coordinated aspects of an overarching matrix rather than as conceptually and practically distinct activities. By narrating bioethics as an institutionally located set of discursive practices, its function as a normalizing discipline in service to state and market becomes disturbingly clear.

Bioethics as Discourse

In historical perspective, discursive formation entails a discontinuous trajectory in which one can plot the emergence of a new discourse and the decline of an old one. Although such a history will often be recounted as seamless, more often it is one of ruptures and radical breaks. As history is written by the winners, so "the persons and professions that rose to prominence will tend to write the history of the debate in a way that makes their rise seem somehow natural."⁴²

Such a pattern indeed characterizes recent histories of the development of the field of bioethics. As per the standard narrative of the genesis of bioethics, its earliest origins lay among theologians, but substantive theological discourse was quickly replaced by the more advanced discourse of philosophy. Kevin Wildes narrates this standard account, that bioethics emerged because of the increased technologization of medicine in the 1960s and that theological ethics was pushed aside because "philosophical ethics offered the hope of resolving such questions without appealing to the faith of a particular community."⁴³ Wildes further proclaims the canonical narrative, highlighting the transition from theology to (in his own words) secular or civil religion:

Bioethics has emerged as a field that is distinct from theological ethics and traditional physician ethics even though both disciplines were important to the development of the field. . . . [O]ne needs to understand why theological voices receded from the field. . . . The turn toward a secular bioethics became a search for a secular or civil religion that might bind the sentiment of citizens who were at least nominally divided by religions, cultures, or other differences.⁴⁴

The transition here is cast as seamless, logical, necessary.

But is this the only way to reconstruct this history? Is this the most accurate way to tell this story? John Evans, in fact, narrates the same history quite differently.⁴⁵ He helpfully debunks the dominant myths that shape the recent histories of bioethics, including those that suggest that the principles' approach to bioethics was necessitated by expanding commitments to democracy or stories that plot such developments as "natural" progressions. Over against the accounts that claim that the dominant approach to bioethics is necessitated by the pluralistic nature of contemporary U.S. society, Evans convincingly demonstrates that the growth and institutional embodiment of bioethics in the

United States, via government advisory commissions, took shape precisely as a way to circumvent pluralism, to "avoid more direct democratic control."⁴⁶ As he demonstrates, the pluralist model of democracy was in fact "unacceptable to the scientists, who feared that an 'excitable' public would shut down not only [human genetic engineering] research, but other research in their home jurisdiction that the public did not understand."⁴⁷ They were fearful, in other words, of funding cuts,⁴⁸ pointing to the hidden economic substrate of all these discussions.

Bioethics, then, emerged as a mechanism for shaping and controlling the *hoi polloi*. A first step toward such an end would be to create a body of esoteric, technical, formal knowledge that would be portrayed as inaccessible to the common person while simultaneously constituting objects of knowledge and defining the acceptable parameters for discussion. Although many bioethicists protest the characterization of their field as one of specialized knowledge (a claim made most often by detractors) one finds such descriptions with relative frequency. Most often such claims arise within conversations about hospital-based ethics consultation. David Casarett and his colleagues note that some "contend that the ethicist is a specialist who possesses expertise in moral theory . . . [that] ethicists, like physicians possess a unique fund of knowledge, problem-solving techniques, experience and techniques that allows them to solve complex moral problems."⁴⁹ Nancy Dubler paternalistically states the claim in a *via negativa* when she maintains: "It is simply not within the purview of most patients and family members to understand the complex nature of the moral judgments facing them."⁵⁰

Though the precise content of this knowledge base remains contested within the realms of hospital-based ethics consultation, it has become well established within the realm of public bioethics. Bioethics' specialized knowledge defines the acceptable parameters of discussion, prescribing certain ways of talking about topics and excluding others (i.e., rules of inclusion and exclusion). Substantively rational arguments and religious language have been systematically excluded, or at least carefully positioned so as to be mostly irrelevant within public bioethics. While dominated by a formal, instrumental rationality,⁵¹ public bioethics privileges a particular point of view, a particular conception of "the good" and of the ends that society and individuals within it must necessarily pursue and preserve.⁵² Evans captures it well when he notes that it operates "with a very constrained list of universal, commensurable ends that have become institutionalized by the dominant profession in the debate."⁵³ These ends are, of course, the principles of autonomy, beneficence, nonmaleficence, and justice.⁵⁴

As the above accounts make clear, specialized, technical knowledge is inextricably intertwined with professionalization, the creation of experts or specialists.⁵⁵ Professions are defined, in fact, by their role as those who apply a distinct system of knowledge to a well-defined set of problems delimited within a particular jurisdiction. Insofar as such knowledge is abstract, professional training is necessary to know how it is to be applied.⁵⁶ That bioethics has

become a "profession" is little contested.⁵⁷ Evans fleshes out the demographics of this shift:

While the bioethics profession has been strengthening its jurisdiction over ethical decision making in public bioethical debates, it has grown even stronger in its other jurisdiction of decision making in hospitals (clinical bioethics). The bioethicists have also increasingly taken on the trappings of a classic profession, with a professional association of 1,500 members; 200 centers, departments, and programs; an academic degree (a master's in bioethics from the University of Pennsylvania and a Ph.D. in bioethics from various other universities). There is even a debate about licensing: who is qualified to be a clinical bioethicist and to offer ethical judgments in hospitals? Licensing, and other internal and external controls over who is a legitimate member of the profession, is the hallmark of an increasingly successful profession. The organization that accredits hospitals has required since 1998 that every hospital have a mechanism for resolving ethical problems that arise.⁵⁸

In the words of Henk ten Have: "In a certain sense, ethics has become part and parcel of the technological order. It has been professionalized as an autonomous discipline external to medical practice. It is dominated by an engineering model of moral reasoning and impregnated with the idea of a technical rationality, applying principles to practices."⁵⁹

In an interesting twist on the standard discussions of professionalization, Tod Chambers insightfully recounts how central the image of "centering" has been to the internal contests shaping the field over the past thirty-five years.⁶⁰ Centering narratives trace the "migration" of the practice of bioethics from the academic realm to that of the hospital or clinic; from the realm of "theory" into the realm of "action"; from philosophical training to medical training, with the rise of clinical bioethics. His story closes with more recent attempts to wrest bioethics from both philosophy and medicine by sociologists.⁶¹ With each move, such centering strategies have functioned as attempts to establish authority, legitimacy, and jurisdiction within the field by defining which conceptual tools shape the field and who ought rightly be included as a conveyor of bioethical power.⁶²

As Chambers notes, all these scholars and more use the metaphors of inside-outside to describe this shift in their work.⁶³ Intriguingly, the same metaphors shape the discussion on religion and bioethics. The conversation revolves around phrases such as whether religions should be "included" in public bioethics, how they might "contribute to" the debate, "how a religious community might enter into the discussions in bioethics,"⁶⁴ or how they might "influence" public bioethics. True to the founding myth, religion and theology must be located "outside" the public sphere in such a way that they must "enter" it, be "included" or "influence" it, as if from a distance. Yet perhaps a mark of how completely irrelevant theology has become to bioethics, the re-

centering of the field away from theology does not even enter into Chambers's account.

Evans's sociological analysis of the growth of bioethics also demonstrates how the discourse of bioethics clearly functions as an "extralocal text," in Smith's sense of the term. As he documents, once the Belmont principles were established, bioethicists began to apply them and their form of argumentation beyond their original focus in the ethics of human experimentation.⁶⁵ Capturing the work of Belmont in textbook form, Beauchamp and Childress's *Principles of Biomedical Ethics* expanded the form and content of this approach to apply to almost all ethical issues in science, medicine, and society.⁶⁶ The twin sanctions of public approval and an authoritative textbook fueled principlism's growth, creating an "enormous demand" for ethics training, spawning a new and ongoing industry of books, workshops and courses "designed to make 'the theories and methods of ethics' 'readily available to more people in a shorter period of time.'" ⁶⁷ As a result, this particular method increasingly shaped bioethical discussion across localities—in the academy, the literature, the public forum, the media, and the clinic. As David Rothman notes, "the new rules for the laboratory permeated the examining room, circumscribing the discretionary authority of physicians. The doctor-patient relationship was modeled on the form of the researcher-subject; in therapy, as in experimentation, formal and informal mechanisms of control and a new language of patients' rights assumed unprecedented importance."⁶⁸ The long arm of state policy reaches into all levels of the social body.

Techniques and Practices of Bioethics

As James Lindemann Nelson notes, bioethicists "wield explicitly normative techniques."⁶⁹ The discipline of bioethics, in other words, comprises a distinct set of practices, techniques by which discourses are enacted, inscribed onto bodies, and thereby reproduced as truthful in the world. These techniques mediate the "extralocal texts" of the bioethics canon into local settings.

Bette-Jane Crigger, in her account of hospital-based ethics consultation, provides one of the most straightforward accounts of bioethics as a practice. Noting from the outset that bioethics has become "established as a particular form of practice," the intent of her essay is to explore the ways in which "bioethics does a further sort of cultural work that tends not to be recognized."⁷⁰ Although working with a slightly different sense of local and extralocal knowledge, Crigger's account of bioethics reflects Frank's account of how practices mediate extralocal texts, making it possible for abstract norms to shape local actions, to interpret individual bodies. Speaking first of medicine, she notes:

Medicine operates as a paradigm of meanings on at least two levels: as a system of concrete, local, ready-made meanings, and as a system of abstract, global, negotiated meanings. As a system of local, that is clinical, meanings, medicine construes individuals' privately experienced sensations as symptoms and signs upon which to base

diagnosis, recommend treatment, and assess prognosis. That is, medicine names and thus confers a particular kind of socially recognized significance ("illness" or "disease" of a given sort) on personal bodily experience. . . . There is a fixed set of indicators to be deployed in construing embodied experience. . . . Overlaying this "local knowledge" of the clinic, however, is a system of more abstract and far-reaching meanings that link medicine—or better perhaps, patients' embodied relationship with medicine—to the wider social order.⁷¹

These higher order meanings, she notes, are "abstract and self-consciously normative" as well as "profoundly social."⁷² Each moment of clinical practice—be it a practice of medicine or bioethics—realizes these higher order meanings in the world and serves to reproduce them, slowly working to transform the world into its image: "Each clinical encounter offers the prospect of incrementally transforming the set of meanings upon which not simply the immediate participants, but also the wider culture, may draw, refashioning the universe of discourse within which the next encounter will take place."⁷³ Ethics consultation stands as a vehicle for negotiating between the local and higher order meanings, offering, "the potential not only to 'discover' normative meanings in clinical decisions, but also actively to create new norms and values in the process of making those decisions."⁷⁴

Such a dynamic could be displayed for each bioethics practice. One will suffice for our purposes. Consider the practice of informed consent. Rothman, above, has noted how the practice of informed consent has reshaped the clinical encounter in the direction of the politics of the laboratory; the patient-physician relationship now more closely resembles the subject-researcher relationship. Drawing on the normative anthropology captured in the primary end of bioethics—the principle of autonomy—the practice of informed consent constructs the patient as first and foremost, primarily, essentially an autonomous subject, even though the patient's autonomy may be severely compromised by illness or even though their own anthropology—should they hail from a non-Western culture—provides no space for contemporary U.S. concepts of autonomy. The practice of informed consent shapes patients by persuading them (or coercing them, since most medical procedures will not be performed without a signed document) to locate themselves under the rubric of autonomous consent, to understand their relationship with the physician as somewhat contractual (based on a signed document, one which waives many of their rights), as consumers who are "choosing" a particular course of medical treatment, having weighed the advantages and disadvantages of the options.

Institutionalization

Institutions, as noted earlier, are social organizations that have attained sufficient power to render their discourses true. The institutional dimension of bioethics takes two main forms. Clearly, the main institutional form of bioeth-

ics has been the U.S. government, in the form of government advisory commissions. Evans traces the dominance of principlism to the increased scope of state intervention in issues related to science and medicine. Pointing to an obvious but often overlooked fact: "A blunt indicator of this spread in state interest are the titles of the first and second government bioethics commissions. The 'National Commission' was 'for the Protection of Human Subjects of Biomedical and Behavioral Research.' The 'President's Commission' was 'for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.'" ⁷⁵

Evans establishes the crucial role played by these commissions in establishing the parameters of truth. First, they determined which arguments would count as legitimate, thereby granting jurisdiction to some professions over others.⁷⁶ The replication of this mode of reasoning in subsequent government commissions reinforced those truth claims. Second, these parameters for argumentation were codified into law via government regulations. As Evans notes:

The influence of this new profession grew rapidly. Through the influence of the first government advisory commission, its form of argumentation was written into public law as the proper method of making ethical decisions about research involving human subjects. Henceforward all researchers at institutions that receive federal funds would have to learn and adopt this form of argumentation.⁷⁷

It is important to note that the power of law was reinforced by force of economics. The Belmont Report, by translating its reasoning into government regulation, which was tied to government funding, rendered the principles' approach and its formal rationality to be the 'truth' vis-à-vis public bioethics. This is the case now not only for human subjects research but for the clinical sector as well.⁷⁸ Indeed, bioethics has become a primary agent of the presence of the state in the practices of research and medicine.

From policy through law and economics, this new regime of truth has been further reinforced by the institutionalization of the theoretical apparatus supporting the discourse via the production of knowledge within the academic realm. The 'truth' of Belmont was first expanded—almost evangelically—by Beauchamp and Childress's *Principles of Biomedical Ethics* and its aftermath. Yet this dissemination, of course, was not accidental. As James Lindemann Nelson notes: "The birth of principlism itself is intertwined with the advent of state intervention in ethics. . . . It is also well known that the Belmont principles were created at the urging of the state, and enacted as regulations, with the help of Kennedy Institute members who were simultaneously writing *Principles of Biomedical Ethics*."⁷⁹

One can trace additional links between the quiet hand of the state and the culture of academic bioethics. As Evans notes:

Since journals refuse to publish results from research not reviewed by IRBs [Institutional Review Boards], the principles became the

standard not only for federally funded research, but for privately sponsored research as well. This was a huge resource given to the new profession of bioethics in its competition with other professions: the government was essentially requiring researchers at every research institution and hospital in the nation to learn its form of argumentation.⁸⁰

The linkage between the institutions of state, clinical research, and the academy render a clean distinction between "public bioethics" and other realms of ethics (i.e., foundational, clinical, institutional, community, etc.) problematic. Here we see the reification (one could say, the fetishization) of the substance of bioethics: its content and parameters "do not seem to have been created by anyone but is just 'common sense' or even 'fact'—and takes on a life independent of its creator."⁸¹

Thus, tracing the institutional infrastructure of bioethics begins to unmask the intimate relationship between bioethics and the state. Even if one was narrowly to construe public bioethics as concerned with the crafting of public policy, etymology would lead to the same conclusion. As Ruth Malone notes, the Greek origins of the word *policy* "link it to citizenship, government, polity, citizen, city. That is, the idea of policy arises originally from the relationship of citizens to one another in a common public space."⁸² Indeed, as the literature on the rise of formal rationality indicates, the state is one of the foremost proponents of formal rationality.⁸³ Thus, the state appears not only as an historical factor in the rise of bioethics but indeed as so critically constitutive of the discourse itself that bioethics might rightly be construed as itself an apparatus of the state.

The State, Bioethics, and Normalization

Foucault's account of disciplinary matrices seeks in part to demonstrate how the state/social order effectively shapes the subjectivities of citizens within their purview to embody that social order's normative claims, in order to reproduce those norms toward the end of maintaining, furthering, or reproducing that state/social order.⁸⁴ As mentioned earlier, this process of producing docile bodies is known as normalization.

Evans, as we observed, debunks the claim made in the recent histories of bioethics that the principles approach was required by our society's increasing recognition of pluralism or what he calls the "expanding democracy" explanation.⁸⁵ Rather, as he notes, this story masks a deep disconnect between the objectives of the allied scientific-government complex and the populace. The first government advisory commission, the National Commission (1973), he argues, was "instructed by Congress to create a set of ends," ends that "had to be portrayed as universally held by the citizens, but had to be applied without a method of determining empirically what the ends of the citizens were."⁸⁶ Its subsequent task, as outlined in the previous section, was to establish these ends as truth, to diffuse them throughout the institutional infrastructure of

research and patient care, and through the practices of bioethics to persuade the citizenry to adopt these as their own ends.

Crigger captures this normalizing function in the practice of hospital-based ethics consultations. For Crigger, bioethics consultation poses a paradox. On the one hand, bioethics' "peril" is that it may "work toward imposing on patients a particular, content-laden vision of what the dominant culture perceives to be morally most significant and most appropriate."⁸⁷ Yet its peril is equally its promise, as she notes.

The practice of bioethics consultation in clinical settings not only guides individual decisions, but just as importantly announces the dominant culture's commitment to fashioning a common moral order in a pluralistic society. That commitment and the practices in which it is inscribed in the clinic hold both promise and peril.

Promise in that ethics consultations may indeed promote a common moral idiom, if not also a stronger commonality of norms . . . [Bioethics] work(s) toward shaping some significant portion of a shared moral order.⁸⁸

Indeed, for Crigger, "the moral and *political* authority of ethics consultation on this model are seen to derive from a societal mandate to foster shared decision making."⁸⁹

Yet can this promise be fulfilled without imposing culturally dominant views of the good on patients? It is hard to see how it will be avoided. In fact, Casarett et al. obliquely point to this inevitability: "It is rare," they note, "that an ethics consultant can simply hand down an opinion. In fact, that typically happens only when the primary issue has been legally resolved, or, to put it another way, *when a national discourse has produced a consensus that is then imposed by the state.*"⁹⁰

Thus, the normative claims of the liberal political philosophy that shapes the social order are, through the practices of bioethics, subtly prioritized. More powerfully, although claiming that particular goods are permitted to exist in their private spaces, an important component of the normative infrastructure is that such particular convictions ought not be held too tightly; all commitments must ultimately be negotiable. Casarett et al., in their reflections on the process of ethics consultation, highlight this dynamic:

Often, the immediate obstacle to consensus is unwillingness to engage in dialogue. . . . Consensus is fragile and is easily disrupted when one or more participants hold tenaciously to a principle or value. The fragility of consensus requires that *all* participants, including the ethics consultant [though equally this would include the patient or physician], be willing to reconsider their own normative claims. Indeed, this is the only way normative validity can be evaluated. . . . Genuine understanding of the issues involved may threaten

deeply held beliefs about the values that make collaborative social life possible. Just as allocation decisions frequently require us to make choices that call into question certain fundamental values that hold society together, moral argumentation in clinical ethics highlights troubling choices that we might prefer to keep hidden. Ethical deliberation requires participants to examine deeply held values such as the sanctity of life, the primacy of autonomy, and the commonly held view that lives do not have a dollar value. These threads make up the fabric of our social existence. To bring them to the surface in order to examine and weigh them threatens the integrity of the view we have of ourselves and our society.⁹¹

In the end, all particular commitments must bow to the overarching norm of consensus.

But it is no longer only the common moral idiom of autonomy that bioethics serves to normalize among the citizenry through its practices; bioethics more recently appears to be serving as an agent for the increasingly powerful alliance between state and market. The standard portrayal of public interaction around questions of bioethics is one of discourse, argument, persuasion, and consensus. Yet often this image is bolstered by that bizarre fiction of "the marketplace of ideas" (a metaphor rendered even more absurd in these days of global capitalism). Can the capitalist resonances be accidental?⁹²

Troyen Brennan abandons any pretense of bioethics' neutrality and maintains that the future of the field lies in embodying more consistently the commitments of political liberalism and, indeed, the market. Brennan calls for a new medical ethics that reflects "the public morality of liberalism" and respects the resource constraints of "market justice."⁹³ But although Brennan issues this as a call for bioethics to move toward, others acknowledge how deeply bioethics is indebted to and allied with market economics.⁹⁴ Ruth Malone focuses on the economic infrastructure of bioethics, noting that although medicine and bioethics once framed its discourse in military terms, more recent metaphors have shifted to the language of the market.⁹⁵ As she notes:

The market metaphor has assumed a prominent place in U.S. discourse on medicine and health policy, displacing an earlier military metaphor ("battling disease," "doctor's orders") still in use but now considerably less prominent. . . . [T]his shift in language has been extremely effective in promoting a different understanding of medicine and health care. . . . [T]he metaphor has been taken up readily, perhaps due to its compatibility with the economism of much health services research methodology, such as cost-benefit and cost-effectiveness studies.⁹⁶

Metaphors, of course, do not merely label things; they form our concepts, create the parameters for action, define what can even be seen as a problem

or issue.⁹⁷ Market metaphors within bioethics function as extralocal texts, enhancing bioethics' ability to mold health care institutions, practitioners, and patients as increasingly ideal consumers. Market metaphors embody particular philosophical presuppositions about the nature of the person and the nature of social interaction:

In markets, the relationship to the other is primarily, if not solely, instrumental: the other is necessary only as a means to the end of purchase or sale of products. Buyers' and sellers' relations are based in contractual obligations of business that do not extend to concern for or dependence on one another. . . . The product-market metaphor relies on the self-interested utility-maximizer view of human agents that is congruent with neoclassical economics, in which individuals make choices based on their perceptions of what will benefit them most. Agency is reduced to rational choices made to buy or to sell, a matter of exerting preferences rather than of acting in accordance with constitutive values or concerns.⁹⁸

Market metaphors are likewise deeply enmeshed with the images that shape standard displays of public bioethics. As Malone notes:

The product-market metaphor works for talking about policy in several important ways: we understand policy at least partially in terms of political negotiation, which bears more than a passing resemblance to negotiations for market goods. And we view the practice of policymaking as one in which choices must be made among different ideas or viewpoints, much as a shopper in a market must choose among competing brands of soap. Also, we sustain the cultural myth of "objectivity" as a desirable and achievable goal in policymaking, congruent with the moral impassivity of the market.⁹⁹

Malone sees deep incongruities between such an anthropology and health care policy, which at least in theory "addresses how we as a society will deal with sick and injured people who must depend on the care and concern of others. . . . This view of human agency as instrumental rationality leaves little space for the kinds of actions that embody different values—for example, generosity, mercy, or solidarity."¹⁰⁰

In reality, however, this is not an incongruity but rather a Foucauldian window into the operative but obscured foundations of bioethics, a window that Malone's own words suggest:

The product-market conception of health policy (and health care) also helps to keep the experience of suffering safely at bay for us. . . . Sickness, as others have noted, represents a challenge to the social order. If the perceived need for policy solutions to social problems may be understood as a confrontation with uncontrolled elements, the product-market metaphor suggests a restoration of order: a rule-

based mechanism (the market) that both preserves and controls the autonomous self. In the quite recent past, this has been largely a function of medicine: we have a vast and illuminating literature on the medicalization of social problems. . . . The market has begun to supplant even medicine as a dominant mechanism of social control.¹⁰¹

Not coincidentally, Evans (evidencing his debt to Weber) traces the dominance of principlism to the development of double-entry bookkeeping in 1494, which paved the way for modern capitalism and formal rationality. The logic of principlism, he argues, is isomorphic with the logic of accounting. The principles of bioethics function as units of commensuration—akin to other commensurable metrics such as utility, risk-benefit analysis, profit, and money.¹⁰²

In short, much of public bioethics functions as a normalizing practice that masks the economic interests and dynamics that are the real forces that shape public policy. As Ed Pellegrino notes: "In stem cell research, for example, commercial and technological imperatives dominate the decisions under the guise of a value-free agreement among 'reasonable' people who will not be so benighted as to invoke some transcendental source of morality in support of their position."¹⁰³ How metaphorical is it, we might ask, when Albert Jonsen refers to the principles of bioethics as "the common coin of moral discourse"?¹⁰⁴

Theology and the Disciplinary Matrix of Public Bioethics

More could be said, but for now, we come to the end of a rather different narration of the practice of public bioethics.¹⁰⁵ Where, then, does this leave the question of religion? Clearly, a thoroughgoing constructive account of the relationship between religion and public bioethics would take me beyond the limits of this chapter. Let me indicate, instead, the direction such an account might take.

Over against standard responses to the question of religion and bioethics, this alternative construal of bioethics forces a question: Is it the proper task of religion to contribute to, support, undergird, disseminate, and so on, the disciplinary matrix of the modern social order? Is it the job of religion to assist the state in the management of bodies within its purview? Is it the task of Christianity to assist the state in normalizing its citizens according to particular canons of philosophical and economic "truths," especially norms such as autonomous individualism, adversarial rights, or utility, which are deeply at odds with the central truths of the faith? Is it proper to Christianity to aid the state in producing docile citizens, those who have internalized market paradigms of consumer choice so deeply that they apply them to all aspects of their lives, including the realm of moral discernment?

It is not clear that many authors—theologians and scholars of religion included—would not assent to the above questions, at least in their broad outlines. Time and again, religion is cast as instrumental to the ends and needs

of bioethics.¹⁰⁶ Too many accounts of how to “relate” religion to public bioethics end up being little more than attempts to make a kinder and gentler Leviathan. But Leviathan it remains. And theologians do little to challenge the idolatrous and heretical claims of the state.¹⁰⁷

To answer “no” to the above questions will be to issue a radical call. For to answer “no” will be a call to orient religion (or, more accurately, theological reflection on medicine and healing) toward a different social body. If Foucault’s account is valid, truths (as known, as productive) do not exist apart from the discourses in which they are embedded, discourses that inscribe bodies into certain visible practices which are institutionally extended. Truth, in other words, sits in a complex relationship to power—the power to produce bodies and, more important, to reproduce particular social bodies. Theology, indeed, is such a discourse—a field of knowledge that forwards a regime of truth by aiming toward the reproduction of the social body of the church through concrete, embodied disciplinary practices. To answer “no” to the above questions is to issue a call for the church.

And this, of course, is why bioethics has left theology behind. For inextricable from substantive theological discourse is the one social body with the real potential to challenge the unbridled authority of the state, the one that the state has, since the sixteenth century, been trying to render powerless.¹⁰⁸ Is it indeed a coincidence that shortly after medical ethics emerged within theological circles, the state-biotech-market complex quickly mobilized to consolidate disciplinary oversight, deftly circumscribing religion to the sphere of autonomy/informed consent, thereby evacuating it of any independent power?¹⁰⁹

Forty years later, any pretensions on the part of the church to encroach on the disciplinary authority of the state meets with fierce resistance. As Catholic hospitals find, their attempt to embody in their institutional practices particular visions of the good or common good (such as the sanctity and dignity of life) via a refusal of certain practices is increasingly considered unacceptable. The scathing invective with which Catholic hospitals are derided by organizations such as “MergerWatch” and the recent legislative assaults on Catholic hospitals’ practices regarding emergency contraceptives (which are largely misrepresented in the popular press) and “conscience clauses” for health care professionals evidence that, indeed, bodies are the site upon which power is contested.¹¹⁰

In the end, the relationship between theology and the disciplinary matrix of public bioethics must remain both critical and constructive. If Christianity is to be truthful and liberatory, it must first “query and unmask the dynamics of power” embedded in the discipline of bioethics. The important critical task is to uncover the hidden processes—in its discourse, in its practices, in its institutional affiliations—by which medicine and bioethics seeks to normalize us not toward freedom and autonomy (as the rhetoric would suggest) but rather toward the ends of the state/biotech/market. Such was the work of this chapter.

And second, it must construct alternatives. In other words, the task of Christian theology is to help people live as Christians through illness, healing,

dying, and medical care. Its task is to forward the countercultural claim that Christian convictions make a difference for who one is, for how one lives (i.e., how one is produced)—in short, to maintain the truthfulness of Christian convictions. To do so will require practical, visible, institutional embodiment—an embodiment in a church, not the state. To do so will require robust theological language, alternative discourses wedded to alternative practices and regimes of understanding self/body directed toward and sustained by a church that is able to produce bodies which embody these truths. Such a claim will, indeed, strike fear into the hearts of those James Childress mentioned at the outset. Yet such fears would indeed, I abjure, be unfounded. In the words of William Cavanaugh:

If we understand the unity of body and soul, we must understand that what is really at stake is not body-power versus soul-power, but competing types of soul/body disciplines, some violent and some peaceful. Christians must understand that the state's control of the body is a control of the soul as well. The church must see that its own disciplinary resources—Eucharist, penance, virtue, works of mercy, martyrdom—are not matters of the soul which may somehow "animate" the "real world" of bodies, but are rather body/soul disciplines meant to produce actions, practices, habits that are visible in the world. For the church to be a true social body it must reclaim not only its body but its soul from the state, and institute a discipline which is truly Christlike—a power based in compassion and martyrdom, suffering, and reconciliation, and not in a revived Christendom.¹¹¹

Through the disciplines of the Christian tradition, bioethics could find in theology a very different kind of power, not the power of state violence but the power of peaceableness, a power made perfect through weakness. How fitting this is for a practice whose center is sick and broken bodies.

NOTES

1. Lisa Sowle Cahill at one point equates the two: "Public bioethical discourse (or public policy discourse) is actually a meeting ground" ("Can Theology Have a Role in 'Public' Bioethical Discourse?" *Hastings Center Report* 20, no. 4 [July–August 1990, special suppl.]: S11).

2. Daniel Callahan, "The Social Sciences and the Task of Bioethics," *Daedalus* 128, no. 4 (1999): 297; and Courtney S. Campbell, "Bearing Witness: Religious Resistance and Meaning," in *Notes from a Narrow Ridge: Religion and Bioethics*, edited by Dena S. Davis and Laurie Zoloth (Hagerstown, Md.: University Publishing Group, 1999), pp. 21–48.

3. Bette-Jane Crigger, "Negotiating the Moral Order: Paradoxes of Ethics Consultation," *Kennedy Institute of Ethics Journal* 5, no. 2 (1995): 90.

4. Michael Sandel, *Liberalism and the Limits of Justice* (London: Cambridge University Press, 1982), p. 1.

5. The vision of bioethics, and indeed of moral interaction, that emerges from this narrative is conflictual, intellectual, and pluralistic. Bioethics exists because of conflict of opinions among diverse and possibly irreconcilable points of view. The "stuff" of bioethics is primarily ideas and beliefs that are packaged into reasoned arguments and traded until one side is persuaded, consensus is reached, or an impasse is met. Moral reasons put forward must be accessible to all parties of the conversation (both as a matter of courtesy and as a matter of persuasion). And all meet on equal ground; the presumption is that "in [secular pluralist societies] there cannot be a privileged moral position or a dominant moral view. The realities of moral and political life demand that we respect the moral claims of others even when they differ fundamentally from our own" (David J. Casarett, Frona Daskal, and John Lantos, "Experts in Ethics? The Authority of the Clinical Ethicist," *Hastings Center Report* 28, no. 6 [November–December 1998]: 7).

6. In 1989, the Hastings Center held a symposium titled "Religion and Bioethics," the proceedings of which were subsequently published in a "Special Supplement" to the *Hastings Center Report* (July–August 1990). The fundamental perspective shaping the conversations asked, "What significance, if any, does [religion] hold for the ways we now do bioethics? What difference, finally, do religious perspectives make for bioethics?" (Daniel Callahan and Courtney S. Campbell, preface to "Theology, Religious Traditions and Bioethics," in *Hastings Center Report* 20, no. 4 [July/August 1990, special suppl.]: 1 [emphasis added]). Although rabbis and theologians asserted the indispensability of religious perspectives, many participants demonstrated a marked antagonism toward any religious influence on the field of biomedical ethics, hailing the "exorcism" of the theological as "rational" and realistic "progress."

7. In light of the foregoing analysis in this paper, it is interesting how religious and moral "beliefs" have come to be described in economic terms—as quantifiable, productlike propositions that are or are not "commensurable." We cannot have real moral discourse between particular communities, it is claimed, absent a more overarching transactional system which can determine the moral "exchange rate." In other words, we will get nowhere as long as we bring francs and lire to the table; what we need is a moral Euro.

8. In Tom L. Beauchamp and James F. Childress's classic *Principles of Biomedical Ethics*, religious beliefs are situated as "non-moral" (2nd ed., New York: Oxford University Press, 1983), pp. 6, 48.

9. *Ibid.*, pp. 72, 175, and 295. See also Ruth Macklin's essay "Ethical Relativism in a Multicultural Society," *Kennedy Institute of Ethics Journal*, 8, no. 1 (1998): 1–22, which offers many examples of conflict that center on religion. It is instructive that in this essay, religious beliefs are conceptually equated with foreign "cultural" beliefs and practices.

10. Beauchamp and Childress, *Principles of Biomedical Ethics*, pp. 90–92.

11. His rhetoric is worth noting:

The balance—the tolerance, the *sophrosyne*, required by secular pluralist societies—is empty, insipid, and effete in comparison to the consuming commitment that can be felt as a member of the Baader-Meinhof gang, of the Communist party, of the National Socialist party, of the Inquisition, or for that matter of any religious or ideological group ready for consecration of self and of all to what is felt to be the truth." (*The Foundations of Bioethics* [New York: Oxford University Press, 1986], p. 52)

See also pp. viii, 3, 4, 10, 11, 12, 13, 80, 239.

12. John H. Evans (*Playing God: Human Genetic Engineering and the Rationalization of Public Bioethical Debate* [Chicago: University of Chicago Press, 2002]) captures such characterizations of theologians and religious thinkers in the work of bioethicists Eric Juengst and LeRoy Walters (p. 157). Further, a case could be made for what one might call the "feminization of religion/theology" within the dominant discourse of bioethics. For the characteristics now ascribed to religion or theology are those traditionally ascribed by modern rationalism to women—emotional, irrational, particular, private, embodied, and so on. Alternatively, one might refer to it as the impoverishment, indigenization, or ethnicization of religion or theology insofar as characteristics now ascribed to them are those ascribed to poor, ethnic persons, as depicted so well by Roberto Goizueta in his *Caminemos con Jesus: Toward a Hispanic/Latino Theology of Accompaniment* (New York: Orbis, 1995).

13. James F. Childress, "Religion, Morality, and Public Policy: The Controversy about Human Cloning," in *Notes from a Narrow Ridge: Religion and Bioethics*, edited by Dena S. Davis and Laurie Zoloth (Hagerstown, Md.: University Publishing Group, 1999), 74–75. Emphasis added.

14. Judith Sklar, *Ordinary Vices* (Cambridge, Mass.: Harvard University Press, 1984), p. 5. Rawls, as Childress notes, tells the same story.

15. William T. Cavanaugh, *Theopolitical Imagination* (New York: T & T Clark, 2002), pp. 15–31.

16. *Ibid.*, pp. 31–42.

17. *Ibid.*, p. 22.

18. *Ibid.*, p. 25.

19. For further critique of this notion of religion, see also John Milbank, *Theology and Social Theory* (London: Blackwell, 1990); and Catherine Bell, *Ritual Theory, Ritual Practice* (New York: Oxford University Press, 1992).

20. For my own initial development of this account of bioethics, see my *Sharing Christ's Passion: A Critique of the Role of Suffering in the Discourse of Biomedical Ethics from the Perspective of the Theological Practice of Anointing of the Sick* (diss., Duke University, 1992). In employing a Foucauldian account of medicine, Gerald P. McKenny, in his *To Relieve the Human Condition: Bioethics, Technology, and the Body* (New York: SUNY Press, 1997) also suggests that "standard bioethics . . . participates in discursive formation" (p. 9). Joel James Shuman, in his *The Body of Compassion: Ethics, Medicine, and the Church* (Boulder, Colo.: Westview Press, 1999) displays even further how deeply captured the major approaches to bioethics are by "the politics of modernity" (pp. 52–57). Beyond us three, however, one is challenged to find another who explicitly discusses bioethics in Foucauldian terms (except Joanne Finkelstein, as noted below). It is not coincidental that McKenny, Shuman, and I focus particularly on the embodied dimension of medicine and technology, with attention to how bodies function as sites of formation and power. I also think it unlikely to be a chance event that all three of us are theologians.

21. Robert Zussman, "The Contributions of Sociology to Medical Ethics," *Hastings Center Report* 30, no. 1 (January–February 2000): 8. See also James Lindemann Nelson, "Moral Teachings from Unexpected Quarters: Lessons for Bioethics from the Social Sciences and Managed Care," *Hastings Center Report* 30, no. 1 (January–February 2000): 12–17. Renee Fox, of course, stands as a pioneer in bringing the social sciences into conversation with medical ethics.

22. Joanne L. Finkelstein, "Biomedicine and Technocratic Power," *Hastings Center Report* 20, no. 4 (July–August 1990): 16.

23. See Michel Foucault, *Madness and Civilization: A History of Insanity in the*

Age of Reason (London: Tavistock, 1971); *The Birth of the Clinic: An Archeology of Medical Perception* (New York: Vintage Books, 1973); *Discipline and Punish: The Birth of the Prison* (New York: Pantheon Books, 1977).

24. That Foucault might be relevant to bioethics is signaled first by the ideological erasure of bodies within the discourse of bioethics and the fact that bioethics is about nothing if it is not about the organization of bodies in contemporary culture.

25. Bryan S. Turner, *The Body and Society: Explorations in Social Theory* (New York: Basil Blackwell, 1984), p. 34.

26. Anthony Giddens, "From Marx to Nietzsche? Neoconservatism, Foucault, and Problems in Contemporary Political Theory," in *Profiles and Critiques in Social Theory* (Berkeley: University of California Press, 1982), p. 219. See also Finkelstein, "Biomedicine and Technocratic Power," p. 14.

27. Finkelstein, "Biomedicine and Technocratic Power," p. 14.

28. *Ibid.* She writes, "It is also an instance of 'structural violence' in that disadvantages are perpetuated by a legitimated social structure."

29. Turner suggests that in order to preserve its boundaries and thus reproduce itself, a society must negotiate four tasks: "the reproduction of populations in time, the regulation of bodies in space, the restraint of the 'interior' body through disciplines, and the representation of the 'exterior' body in social space" (p. 2; see also p. 91). It would be fruitful to display the many ways in which bioethics is involved with all four of these tasks.

30. While Foucault uses the word "governmentality," Dorothy Smith (*Reading the Social: Critique, Theory, and Investigations* [Toronto: University of Toronto Press, 1999]) refers to the mechanisms that connect the local and extralocal with the intriguing phrase "ruling relations." Governmentality or "ruling relations" does not ascribe agency to a class or any specific individuals, although some individuals and groups clearly benefit from a given system of ruling relations. They are not, per se, intentional, nor directly under control of particular individuals or groups. Rather, their power lies in that they are "pervasive and pervasively interconnected" (p. 49). Ruling relations organize local settings through the medium of discourses and are themselves the effects of that textual organization. Ruling relations make extralocal imperatives appear under such rubrics as *rationality*, *efficiency*, and perhaps most relevant to social sciences, *objectivity*. Cited in Arthur W. Frank, "Can We Research Suffering?" *Qualitative Health Research* 11, no. 3 (May 2001): 353-362, p. 357.

31. Most fundamentally, bodies are corporeal, physical, empirical: "Bodies, of course, do not emerge out of discourses and institutions; they emerge out of other bodies, specifically women's bodies" (Arthur W. Frank, "For a Sociology of the Body: An Analytical Review," in *The Body: Social Process and Cultural Theory*, edited by Mike Featherstone, Mike Hepworth, and Bryan S. Turner [Newbury Park, Calif.: Sage Publications, 1991], p. 48).

32. Stuart Hall, "The Work of Representation," in *Representation: Cultural Representations and Signifying Practices*, edited by Stuart Hall (London: Sage Publications, 1997), pp. 44ff.

33. Frank, "For a Sociology of the Body," p. 42. Turner adds: "Discourses are not linguistic machines which routinely and invariably produce the same effects but possible modes of social construction the consequences of which contain a large element of contingency" (p. 175).

34. As he further notes: "Bodies too exist within space and time, as physiologies. But 'physiology' is at any given time produced in a discourse which seeks some

'truth' of bodies, and the history of physiology proves only that this truth may be re-defined without apparent limit" (Frank, "For a Sociology of the Body," p. 48). Of course, not only social theorists see medicine in these terms.

35. Frank, "Can We Research Suffering?" p. 356.

36. *Ibid.*, p. 357.

37. Finkelstein, "Biomedicine and Technocratic Power," p. 14. She continues: "In the normal transaction between consumer and provider the consumer does not feel exploited by the provider's monopolization of knowledge nor abused as his or her experimental subject, because the desire for the product or service has been publicly cultivated while its cost, in monetary and moral terms, has not been so broadly debated or examined."

38. Frank, "For a Sociology of the Body," p. 48. He continues: "People construct and use their bodies, though they do not use them in conditions of their own choosing, and their constructions are overlaid with ideologies."

39. *Ibid.*

40. Finkelstein: "It is principally through discourse, that is, through the ways in which systems of knowledge are established, expectations of human abilities discussed, and subjects and practices described in the working literature of a professional group, that the 'normal' is defined" ("Biomedicine and Technocratic Power," p. 15).

41. The major definitions of "public" in the *Oxford English Dictionary* include references to national identity, nation, and state.

42. Evans, *Playing God*, p. 43.

43. Kevin Wm. Wildes, "Religion in Bioethics: A Rebirth," *Christian Bioethics* 8, no. 2 (August 2002): 169. In addition to the increase in technology, Wildes credits the eclipse of theological discourse to "the development of knowledge in the basic sciences along with the development of medical bureaucracy to deliver care" (p. 165), which, he says, "changed the fundamental ethos of medicine." The clear implication is that "traditional" loci of moral reflection (the Hippocratic ethos and religion) were superseded.

44. *Ibid.*, pp. 163-164; similarly, see p. 168.

45. Clearly, my account of the discipline of bioethics relies significantly on John H. Evans's extraordinary sociological analysis of the development of the discourse surrounding genetics in *Playing God*. Though I find his Weberian reading of the development of bioethics to be extraordinarily insightful, it needs to be further developed in three ways—economically, vis-à-vis the body, and sociologically. Ironically, although many of his findings highlight the reconfiguration of bioethics, he does not seem to detect the relationship between that reconfiguration and the growth of the biotech industry—for example, he does not attend to the connections between science and the economic dynamics underlying its growth, especially in the United States, between 1970 and 1995. He is concerned, rather, with the reduction of the four principles/ends to one, that of autonomy. He finds this to be a threat to the internal logic of the profession of bioethics and therefore a threat to the profession itself. However, linking bioethics to its economic substrate would clarify for Evans how the move to the single principle of autonomy actually furthers the internal logic of bioethics, insofar as it is rooted in furthering the economic ends of a state—and a biotech profession—committed to late capitalism: all becomes consumer choice directed toward the end of producing profit. Thus, the profession of bioethics is not threatened by the reduction of all ends to autonomy; it will simply become the profession that ensures

that no other ends come into competition with that of autonomy, so as to protect the unbridled operation of the marketplace within the realm of biotech research, application, and health care.

With regard to embodiment, he notes in a couple of places how, for example, in the arguments about human genetic engineering (HGE), the move to make it more acceptable was to "limit the claim to the application of HGE to the bodies of patients [and in doing so] they linked the new means with the means used in their safe home jurisdiction" (p. 75). But beyond this, he does not attend to the obvious relationship between the human genome project and the management/production of bodies. Which leads me to point three: he makes no reference to the work of Foucault, whose analysis of bodies and power is indispensable to developing a fully adequate account of the disciplinary role of bioethics. I, then, am employing his Weberian analysis of bioethics to undergird an allied but, I would argue, ultimately more compelling Weberian account.

46. Evans, *Playing God*, p. 73.

47. *Ibid.*, p. 36; see pp. 72ff.

48. *Ibid.*, p. 76.

49. Casarett et al., "The Authority of the Clinical Ethicist," p. 6. They concur that "technical expert" and specialized knowledge are part of the identity of the ethics consultant (p. 9). They prefer the language of "consensus building": "Our claim is that consensus building is precisely what ethics consultants do. . . . When she acts as an engineer of the consensus process, and guides the process according to the rules of discourse ethics, the ethics consultant is both a mediator *and* a moral expert" (p. 7). One might, of course, raise questions about the reality of such a consensus insofar as for the most part, after such a "consensus" is established, those involved will part company. It also fails to account for the power imbalance between parties within the clinic. For more on the topic of the specialized knowledge of the clinical ethicist, see also Scot D. Yoder, "Experts in Ethics? The Nature of Ethical Expertise," *Hastings Center Report* 28, no. 6 (1998): 11-19.

50. Nancy Dubler, *Ethics on Call* (New York, Random House, 1995). One might suggest against this position that in fact it is precisely the patients and their families, and only them, that have any idea of the true complexity and ramifications of the decisions that they face, since they—in their own bodies and in their own lives—are the ones who will bear the burden of the decision.

51. Evans, *Playing God*, p. 13.

52. Bioethics also privileges a particular conception of what counts as legitimate in moral discourse (the impersonal/public/universal/intellectual/rational/objective/secular as opposed to the personal/private/particular/bodily/affective/subjective/religious); of moral anthropology (autonomous individualism); of moral agency and authority (freedom to define, choose, and pursue one's own goods); of society (a composite or collection of discrete individuals who exist in competition and do not a priori hold goods in common); of rationality and knowledge (disembodied, mentalist, positivistic); and so on. These and related commitments are part of the extralocal apparatus that work via the practices of bioethics to produce particular sorts of persons, thereby reproducing the truth of these commitments in the world.

53. Evans, *Playing God*, p. 11. More specifically: "What became known as either the Belmont principles, principlism, or more pejoratively, the 'Georgetown mantra,' became the accepted form of argumentation in public bioethical debates about human experimentation. . . . In a hallmark of formal rationality, the ends came to be

taken as outside the realm of debate, leaving only thin debates about whether technologies (means) maximized these given ends" (pp. 88–89).

54. Although public bioethics is often referred to as "procedural," Evans characterizes the principles of autonomy and justice as "substantive ends" (*Playing God*, p. 90), a position shared by Bette-Jane Crigger ("Negotiating the Moral Order," p. 106). Most important, in a formally rational debate, the ends are either explicitly or implicitly assumed and considered no longer open to debate (see Evans, *Playing God*, p. 16).

55. The debate over the "expertise" of bioethicists dates back at least to the early 1980s. See the exchange in the *Hastings Center Report* 12, no. 3 (May–June 1982) between Cheryl N. Noble, "Ethics and Experts" (7–9), Peter Singer, "How Do We Decide?" (9–11); Jerry Avorn, "A Physician's Perspective" (11–12); Daniel Wikler, "Ethicists, Critics, and Expertise" (12–13); and Tom L. Beauchamp, "What Philosophers Can Offer" (13–14).

56. Evans: "This system is taught by the elite to the average members of the profession. . . . Elite bioethicists likewise perform a maintenance role (which Callahan calls 'foundational' bioethics). . . . The fact that principlism is also the legally required decisionmaking system for recipients of federal research funds also encourages this process" ("A Sociological Account of the Growth of Principlism," *Hastings Center Report* 30, no. 5 [September–October 2000]: 36). More to the point, esoteric, abstract knowledge is the essence of bioethics: "In the particular case of the work of ethics, the system of abstract knowledge is the form of argumentation typically used by the profession. An ethicist's work is precisely to make those arguments" (Evans, *Playing God*, p. 30). Evans in fact delimits those identified as "bioethicists" to those "professionals . . . who use the profession's form of argumentation" (p. 34).

57. As Edmund Pellegrino laments: "At its beginnings, bioethics was not a separate discipline; nor were its practitioners regarded as 'professional' bioethicists. Rather, bioethics was considered a branch of general or professional ethics as applied to medicine and biology. In the last two decades, however, 'bioethics' has become a specialized field of its own, with its own literature, professional societies, and practitioners" ("Secular Bioethics and the Catholic Conscience: The Growing Divide," *Newsletter of the Institute of Catholic Studies, John Carroll University*, April 10, 2003, p. 4).

58. Evans, *Playing God*, p. 193.

59. Henk A.M. ten Have, "Medical Technology Assessment and Ethics: Ambivalent Relations," *Hastings Center Report* 25, no. 5 (September–October 1995): 13–19.

60. Tod Chambers, "Centering Bioethics," *Hastings Center Report* 30, no. 1 (January–February 2000): 22–29.

61. Interestingly, Chambers marks Art Frank's work as the latest attempt to re-center bioethics, recentering it this time on patients, on bodies. Chambers question is telling: "Yet where does the ethicist fit into Frank's scheme, that is, besides being another person waiting his or her turn sooner or later to be another wounded storyteller? In his detailed analysis of Frank's argument, Howard Brody notes how in Frank's perspective it does not seem that 'bioethics does any better than modern medicine in helping rather than hindering' the liberation of the sick person" ("Centering Bioethics," p. 28). It is not clear that Chambers hears the power of Frank's critique.

62. "Metaphorically, bioethicists have been able to center their discipline and in doing so marginalize the academic philosopher and perhaps defend themselves as well against the charge leveled by academic philosophers that they are no longer doing 'real' philosophy" ("Centering Bioethics," p. 23).

63. Chambers, "Centering Bioethics," p. 23.

64. Wildes, "Religion in Bioethics: A Rebirth," p. 170.

65. Evans, *Playing God*, p. 89.

66. *Ibid.*, p. 90. "Departing slightly from the commission, they derived four ends by splitting the principle of beneficence into nonmaleficence and beneficence." For my own analysis of the shift in the form of the principles from Belmont to Beauchamp and Childress—particularly the not insignificant transformation of the principle of "respect for persons" into the principle of "respect for autonomy," and the relocation of vulnerable subjects and patients from the principle of respect for persons to the principle of beneficence—see my "RESPECT, or How Respect for Persons Became Respect for Autonomy," *Journal of Medicine and Philosophy* 29 (December 2004): 665–680.

67. Evans, *Playing God*, p. 90.

68. *Ibid.*, p. 91.

69. James Lindemann Nelson, "Moral Teachings from Unexpected Quarters: Lessons for Bioethics from the Social Sciences and Managed Care," *Hastings Center Report* 30, no. 1 (January–February 2000): 13.

70. Bette-Jane Crigger, "Negotiating the Moral Order: Paradoxes of Ethics Consultation," *Kennedy Institute of Ethics Journal* 5, no. 2 (1995): 89.

71. *Ibid.*, pp. 91, 92.

72. *Ibid.*, p. 92.

73. *Ibid.*

74. *Ibid.*, p. 93.

75. Evans, "A Sociological Account of the Growth of Principlism," p. 36.

76. *Ibid.*, pp. 36–37.

77. Evans, *Playing God*, p. 73. Although he is talking about the area of human subjects research, the same process could be displayed with regard to issues at the end of life.

78. Evans rightly notes that "hospitals lacking legitimate ethics mechanisms will be denied accreditation and thus Medicaid funds, while research institutions may be denied government research funding or may have such funding removed" (*Playing God*, p. 194). Carl E. Schneider writes in this regard: "'Bioethics' is contesting medicine's power to influence the way doctors treat patients. If it follows the classic pattern, bioethics will solicit work and authority by recruiting government's power" ("Experts," *Hastings Center Report* [July–August 2001]: 11).

79. Nelson, "Moral Teachings," p. 34.

80. Evans, *Playing God*, p. 89.

81. *Ibid.*, p. 26. Elsewhere Evans observes: "The reason for this further spread of principlism [into the realm of 'cultural bioethics'] is that principlism itself has become an institution. . . . [Institutions take] on a life of their own, independent of the social conditions of their founding, and are self-replicating. . . . Principlism has similarly taken on a life of its own, independent of the conditions that encouraged its early growth, although the continued appetite of the state and bureaucracies for bioethical decisions continues to encourage principlism directly. This independent life of principlism has been encouraged by the rise of bioethics as a profession" ("A Sociological Account of the Growth of Principlism," p. 36).

82. Ruth E. Malone, "Policy as Product: Morality and Metaphor in Health Policy Discourse," *Hastings Center Report* 29, no. 3 (May–June 1999): 18.

83. Nelson, "Moral Teachings," p. 34. Similarly, Evans, *Playing God*, p. 26.

84. Nelson describes the usefulness of social science to bioethics in terms of

surveillance: "How many people are willing to make out advance directives? How do chronically ill people experience their illness? What impact does shifting a state's Medicaid population to managed care have on health outcomes overall?" ("Moral Teachings," p. 13).

85. This story he labels "the Genesis narrative of the bioethics profession, a narrative that "retells the profession's founding as following the central themes of American democracy, thus legitimating its jurisdiction" (Evans, *Playing God*, p. 40).

86. Evans, *Playing God*, p. 83, also p. 85. Interestingly, lacking in most sociological accounts of the development of bioethics is the role played in the development of the field by the courts, a key agent in policing normalization.

87. Crigger, "Negotiating the Moral Order," p. 90. Nelson writes:

It might be interesting to ask, for example, why the chief values of mainstream bioethics—most conspicuously pride of place given to respect for autonomy—have remained relatively fixed despite countervailing theoretical ferment in other areas of ethics and even in the light of what seems to be rather disturbing empirical findings. . . . The social sciences might make a contribution to bioethics by helping the field's practitioners understand better what's behind its deeply installed respect for individual autonomy and whether it has assumed more the character of an ideology than a moral philosophy." ("Moral Teachings," p. 15)

More ominously: "If bioethicists can better understand how various moral understandings become practically effective, either in the world of medical practice or within the field itself, they clearly are in a better position to have the kinds of influence that they want" (pp. 15–16).

88. Crigger, "Negotiating the Moral Order," pp. 89, 90.

89. *Ibid.* Emphasis added. Or as she states equally clearly: "The public scrutiny of ethical analysis is softened and made more intimate, palatable, and accessible in the person of the consultant at the bedside. . . . That the intention is to serve the patient's interest in receiving the best possible care and that consultations may extend beyond the particular question brought for resolution and seek to educate the requesting physician do little to ameliorate the bald fact of medical control" (pp. 95, 98).

90. Casarett et al., "Experts in Ethics?" p. 7. Emphasis added.

91. *Ibid.*, p. 9. All values—even the commitment that human life does not have a dollar value—are open to challenge.

92. The emphasis within biomedical ethics on public policy correlates with exponentially increasing financial investment in and control over biomedical sciences and medical care services by the private sector and government since the Second World War. Diana B. Dutton gives a fascinating historical account of how the biotechnology and medical industries have come to be seen as "critical to national security and a strong economy," in her book *Worse than the Disease: Pitfalls of Medical Progress* (New York: Cambridge University Press, 1988), p. 23. Paul Starr documents the beginning of this process in the public health movement of the 1800s, in his *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Makings of a Vast Industry* (New York: Basic Books, 1982).

93. Troyen A. Brennan, *Just Doctoring: Medical Ethics in a Liberal State* (Los Angeles: University of California Press, 1991), p. 23.

94. As Joel Shuman notes: "Modernity—and this includes modern medicine—cannot be understood politically or philosophically apart from the development of capitalist markets. Not surprisingly, the market forces of capitalist political economy are a

significant influence in the emergence of bioethical expertise" (*Body of Compassion*, p. 54).

95. Malone, "Policy as Product," pp. 16–22. She does not explore, however, how deeply intertwined the military and markets are in late capitalist political economies. While she treats these notions as metaphors, she might well explore their concrete referents—the concrete embeddedness of medicine and bioethics in the military and economic infrastructure of the United States.

96. *Ibid.*, pp. 17–18.

97. As Malone notes, metaphors "maintain and modify the kinds of common understandings that set up our possibilities for action in any situation. Words not only reflect, but shape what is real to us; they also shape us, as any wise parent knows. . . . [They] structure understanding and experience by bringing forth certain aspects of that experience and hiding or silencing others, and they do this so seamlessly and constitutively that we are often hard put to identify them as metaphors, much less to identify alternative metaphorical connections" ("Policy as Product," pp. 16, 17).

98. Malone, "Policy as Product," pp. 18, 19.

99. *Ibid.*, p. 19.

100. *Ibid.*, pp. 18, 19.

101. *Ibid.*, p. 19.

102. Evans, "Sociological Account of the Growth of Principlism," p. 32. "This process is taken so much for granted," he notes, "it is hard to imagine an alternative" (p. 31). He recounts how before this, accounts were kept in narrative form:

Double-entry bookkeeping was a major innovation in economic history. Two changes in the accounts system also transformed it into a procedure that allowed for calculability, efficiency, and predictability in human action, paving the way for modern capitalism. The first change was that the new system was a means of discarding information deemed to be extraneous to decisionmaking. . . . The second change was that these numbers took on a new degree of calculability . . . translated into a common metric called "profit." . . . A similar evolution, I suggest, has happened in bioethics. . . . The Babel of information formerly thought to be relevant to an ethical decision has been whittled down to a much more manageable level through the use of principles, and the principles give us a commensurable unit—akin to "profit" in bookkeeping—that also allows for much simpler decisions. Weber called the calculable logic of the new accounting system "formally rational." . . . The principles are a system of commensuration. . . . They are a method that takes the complexity of actually lived moral life and translates this information into four scales by discarding information that resists translation. . . . This calculability or simplicity is largely gained by discarding information about deeper epistemological or theoretical commitments." (pp. 32–33)

103. Pellegrino, "Secular Bioethics," p. 2.

104. Albert R. Jonsen, *The Birth of Bioethics* (New York: Oxford University Press, 1998), p. 333.

105. An even more complete account of the normalizing function of bioethics would necessarily include the ways in which the popular media have become part of the institutionalized practice of bioethics, an important vehicle for reproducing its truth claims and normalizing the public. A recommended starting point would be Pe-

ter Simonson's "Bioethics and the Rituals of the Media," *Hastings Center Report* 32, no. 1 (January–February 2002): 32–39.

106. See, for example, Dena S. Davis, who opens her essay " 'It Ain't Necessarily So,' " seeking to posit "some ways that religious ethics scholars can meet the needs of clinicians . . . [arguing] that clinicians' needs should translate into goals for at least some religious ethics scholars, or at least some of those who contribute regularly to the field of bioethics (" 'It Ain't Necessarily So': Clinicians, Bioethics, and Religious Studies," in *Notes from a Narrow Ridge: Religion and Bioethics* [Hagerstown, Md.: University Publishing Group, 1999], pp. 9–10). Or see Courtney Campbell's essay, which suggests that religion ought to "enable constructive civic discourse" ("Bearing Witness," p. 38); or James Childress, who finds it important to understand religious views so as to "gauge the[ir] intensity . . . as part of a cost-benefit analysis of different public policies (for instance, predictable serious and sustained opposition might count as a major cost)" ("Religion, Morality, and Public Policy," p. 73).

107. As Cavanaugh notes, the modern state is built on a false or heretical soteriology (account of salvation) insofar as it positions itself as that agent which can save humanity from violence (*Theopolitical Imagination*, p. 2). This is but one of a number of problematic claims of the state identified by Cavanaugh and Milbank.

108. In other words, if power (as productive) is tied through embodied disciplinary practices to truth, one can see how the dis-empowerment of the church as a public institution correlates with the evisceration of its ability to claim truth status for religious convictions. As the church loses disciplinary authority over bodies, religious truths simultaneously become located in subjectivity, not amenable to emerging epistemological canons, thereby rendered objectively meaningless.

109. A refrain that echoes throughout *Notes from a Narrow Ridge: Religion and Bioethics* is precisely that the proper space of religion is circumscribed by informed consent. See Davis (" 'It Ain't Necessarily So,' " p. 9), Campbell ("Bearing Witness," p. 26), Childress ("Religion, Morality, and Public Policy," p. 65), and so on. Stephen E. Lammers, in his essay "Bioethics and Religion: Some Unscientific Footnotes" in the same volume, masterfully deconstructs this position, problematizing voluntarist notions of religion as "choice" as well as the ogre of "choice" within bioethics (pp. 154–162).

110. Along these same lines, Edmund Pellegrino raises concerns about the policing of the medical profession. Questions are raised, he notes, about whether or not applicants who refuse to participate in certain practices—abortion, certain reproductive technologies, capital punishment—ought to be refused admission to medical school. What we see here is the placement of a binding set of norms and practices necessary to preserve our contemporary social order put forward as "value-free."

III. William T. Cavanaugh, *Torture and Eucharist: Theology, Politics, and the Body of Christ* (Malden, Mass.: Blackwell, 1998), p. 197.