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Bioethics and the Failure of Success

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ABSTRACT

Since its inception in the 1970s Bioethics has become the dominant perspective on issues of medical care and organization. It has done so with the declaration that neither the traditional Hippocratic ethic nor ethicists grounded in religious perspectives should have a similar posture in debate over medical dilemmas in modern, post-industrial society. It has failed, however, to offer convincing answers to a range of issues arising in both the evolving medical science and the realities of medical practice. While acknowledging its strength an understanding of its failures may permit a better and more comprehensive and humanistic medical ethics to be presented.

Keywords: Bioethics, commercialization, Hippocratic ethics, moral philosophy marketization

Bioethicists are, in the main, an optimistic lot. Since the first edition of Beauchamp's and Childress's 1979 *Principle of Bioethics*—now in its eighth edition—they have become an institution with, according to a count by ChatGTP, more than sixty university departments in the United States and myriad courses elsewhere in departments of philosophy or applied ethics. There are also think tanks like The Hastings Center and associations like The American Society for Bioethics and Humanities (ASBH) promoting bioethics programs, research, and discussion. There are the now famous, four main principles (beneficence, nonmaleficence, autonomy, and justice) Beauchamp and Childress put forward as guides to the resolution of ethical dilemmas in medical practice and society. The assumption was, and at least implicitly remains, that "the simple application of existing philosophical principles or concepts" would be capable of answering any ethical problem arising in medicine (Blumenthal-Barby, Aas, Brudney et al. 2021).

While challenges exist (Rukovets 2025), few bioethicists doubt their ability to address emerging issues (Ravidsky 2024). And yet, after decades of debate, critical moral issues and ethical values surrounding treatment in the face of medical futility, the conscientious objection of practitioners, abortion and medical termination, to name a few, remain hotly contested and unresolved (Shea 2024, 393). At another level, bioethics presents no definitive position on pregnancy the moral distinctiveness of the fetus (Grose 2020), or the ethics of embryo editing on personhood (Wiley, Cheek LaFar et al. 2024). More generally, the ethics of embryo editing remains deeply problematic at least for some (Wiley, Cheek LaFar et al. 2024). Nor is there a definitive literature on the moral distinctiveness (or lack of it) of the fetus (Grose 2020). And in emerging areas of uncertain what are or may be the "ethical and policy implications of the brain-computer interface?" (Dubljević and Coin, eds. 2023). It is hard to see how Bioethics' *modus operandi*, principlism, can help with these or a host of other issues.

As Carol Elliott (2021) argued, the practical and systemic challenges of COVID-19 created a kind of existential reckoning "that ought to make physicians [and by extension bioethicists] rethink the fundamental ethos of medicine, which has produced an individualistic, consumerist, science-worshiping form of medical practice." That challenge requires first, a review not of Bioethics' institutional successes but its conceptual and practical failures in ordering both medical practice and defining medicine's place in society. For that, a kind of Foucaldian archeology, excavating the history and assumptions of bioethics as an ideology may be of service (Foucault 1976).

PRINCIPLED BIOETHICS

In 1974 Philosopher and ethicist Peter Singer declared moral philosophers were, *Back on the Job*. Training and methodology "makes him [them] more than ordinarily competent in assessing arguments and detecting fallacies" (Singer 1974). Having studied the logic of moral disputation, he insisted, those so trained are "more than ordinarily competent" to adjudicate issues of care and policy irrespective of "what most people in our society think we out to do". With a coterie of other, moral philosophers Singer made the arena of medical issues, practice, and policy job one.

They adapted, one might say hijacked, the term "Bioethics" coined by Van Rensselaer Potter, to describe "a global perspective with an ecological focus on how we as humans will guide our adaptations to our environment" (Richie 2020). Instead it would now serve as the name moral philosophers would apply to a perspective focusing on medicine. Declaring the traditional, Hippocratic ethic deficient in an era of advancing medical technology, all their new ethic would require was, first, a "philosophical reflection on morality and ethics … that affords some distance from assumptions still evident in the biomedical sciences and healthcare" (Beauchamp and Childress 1979,1). That lead to its short series of principles to first order and then hopefully resolve moral queries and ethical dilemmas arising in practice, research, and social organization.

Despite the training Singer promoted it has never been clear precisely how the resulting principles might be applied. Indeed, how those principles might be defined was not overly clear. Beauchamp (1993), for example, complained that a principle of 'respect for persons' conflated the ideal of autonomy with another arguing the avoidance of harm in the care of incompetent persons. Further, should non-malfeasance be understood broadly or be restricted to that class of persons? And while most moral philosophers originally believed a principal of "justice" should be focused on research ethics both Childress and Beauchamp thought it could and perhaps should be understood as a broader principle (Beauchamp 1993).

Bioethicists As Practitioners

However, they might be defined, those governing principles can "function neither as adequate surrogates for moral theories nor as directives or guides for determining the morally correct action" (Clouser and Kleinhardt 1990). From the start a problem has been simply, that, "Philosophy cannot do its job well unless it is informed by fact and experience" (Nussbaum 1998) and most moral philosophers cum bioethicists had little experience and less knowledge of issues arising in the arenas of medical organization or practice. As H. Tristram Engelhardt, Jr. observed in 2011, for example, "there [still] remains the central challenge of giving an adequate account of the nature of the ethics of clinical ethics consultation" (Engelhardt 2011, 134). Even today, after almost 50 years, ""It is often unclear how the notion of ethics operative in clinical ethics is related to other ones, such as those found in moral philosophy" (Shea 2025).

Of course, ignorance concerning the realities of practice did not prevent bioethicists from assuming an expertise they lacked. As Daniel Callahan would later admit in his autobiography: "We felt most like the wizard [of Oz], pulling levers behind a screen and talking in a way that projected a wisdom about large moral puzzles we did not yet have" (Callahan 2012,77).

Bioethics and the Market

Prior to the 1980s and the ascent of Bioethics, health care services were governed primarily by nonmarket values, rules and practices (Blumenthal and Galvin 2025). Medicine had been understood as "an activity peculiarly grounded on a commitment to proximity and care towards the suffering (Rechlin 1994). Bioethicists, however, from the start "embraced a commercial view in which, "everything on offer in a market is, by definition, a *good*" (Mol 2002, 167). It was assumed the market could organize and then efficiently deliver most transactions (Radin 1996, 36). Radically, this transformed medicine from a good *itself*, dedicated to care, into simply one more product, a good subject to commercial dictates.

That fit nicely with the neoliberal, Regan-Thatcher economics of the day. "Bioethics became successful, because its programme and procedures were a clean fit within the medical power structures of a neoliberal society with its social and economical priorities (Zuckerman, Kimsma, and Devisch 2023). Commercialization as a governing principle was enthusiastically embraced by bioethicists. The traditional focus on care as the principal concern in traditional ethics became an at best secondary goal. As Callahan (1993, 132-3) put it: "The market was treated as a moral, not just an efficiency value … little interested in the common good." It was "the sell," perhaps heart-felt but also practical and self-serving. In the commercialized sphere bioethicists needed to assure their "product" had a favoured place. As former ASBH director Mark Kuczewski admitted, "Ethicists have been a guest in the house of medicine,' and in order to survive in that environment have had to align themselves with money and power" (Kuczewski 2010, 4).

To assure not simply Bioethics' survival but its primacy required the removal of potential competitors. "The first thing that those in bioethics had to do," as Daniel Callahan wrote in 1993, "was to push religion aside." Imams, pastors, priests and rabbis were accepted by many—patients and practitioners—as ethical guides with a moral perspective many bioethicists did not share. Major religions—Christian, Jewish, and Muslim, were governed by an ethic that set life as a principle good and care of all and any as a moral duty irrespective of governing market realities. And, too, many hospitals were affiliated with one or another religion (St. Paul's, Mt. Sinai, etc.) with a value set, including life as a primary good, distinct from that of bioethicists (Cherry 2025). Their authority needed to be diminished for bioethics to be accepted.

Prior to Bioethics, practitioners had enjoyed a sense of moral authority and a position of respect in society at large (Starr, 2017). This included the trust of patients and a broader respect in society for their experience (Pilkington, Caplan, and Pars 2025). Bioethicists like Callahan and

Veatch dismissed practitioners as little more than technicians with no more moral insight or standing than the average shoe salesperson (Veatch 1993, S7-8, 2012). The practitioner's perspective was redefined as at best equal to but certainly no better than that of the patients they served (McCullough 1983).

At the same time, bioethicists dismissed the traditional Hippocratic ethic of relational care and the experiential knowledge gained from interpersonal experience. As a result, when dilemmas arose in the future only those with a moral philosopher's training, and thus with a bioethical perspective would be deemed capable of handling what were now called bioethical dilemmas (Veatch 2012).

THE FAILURE

Despite fifty years of argument and hundreds of articles and books, principlism has never provided a clear mandate for practitioners or for society's responsibility for the health of its citizens. At best, bioethics has created a venue in which different issues might be raised and where different perspective could contend. How might one apply the idea of 'beneficence," a noun that can reflect either a utilitarian ideal promoting some good, the moral ideal of preventing (or removing) a harm, or attention to some other, morally required duty (Clouser and Gert 1990, 221)?

Does personhood extend to those with "disorders of conscience" (Fins 2015,) or may they be depersonalized and perhaps, as Miller and Truog argued in 2018, seen as little more than a convenient source of graft organs? Will society at large embrace a utilitarian economics and its allocation of care based on "the good of the many" or an individualistic ideal in which the care of any in need is the first priority? The Hippocratic tradition focused upon the physician's relation with and advocacy for the patient irrespective of other issues. And, too, it took life as a principal good that set the integrity of the person—poor or fragile, health or rich—as of generally equal value. Certainly, these values may be challenged and debated but across fifty years of discourse Bioethics has rarely sought to engage or challenge them in a comprehensive way.

Commercialization and Marketization

A central failure of the ethics that bioethics imposed has been on the adoption of the market as an "efficiency value," a means of best allocating care, or a moral good. But as Nobel Prize winner economist Kenneth Arrow argued in 1962, market models applicable to the average, competitive business cannot be applied to medical organization, service or delivery. The characteristics that make market economics work are absent when applied to the arena of medicine and medical care. Unlike the market for automobiles, for example, medicine is a closed area in which practitioners must be first licensed and then supervised in their practice by formal organizations. Those who wish to practice must complete studies in certified programs and then demonstrate proficiency through examinations before joining professional organizations that set parameters for their practice. "Ford cannot deny Kia a showroom in Detroit but practical and medical associations can deny the Koch clinic" should I seek to practice there (Koch 2012, 235).

And while most potential car buyers can intelligently choose between different vehicles—a Kia versus a Chevrolet or Ford—the same cannot be said about their ability to choose between different medications, or surgical procedures. The now constant media advertisements promoting varying prescription drugs are no substitute for the careful, knowledgeable balance of prescriptive choices required of the practitioner. Finally, while customers may test drive an automobile, try on varying jackets or visit an open house for sale, patients cannot test drive the practitioner or hospital shop when in distress.

The hope was that market mechanisms would result in an efficient system of healthcare delivery and organization. That has not occurred in the United States where, a market approach without a program of universal care has resulted in the most expensive, least equitable, arguably the least efficient system of healthcare in the industrialized world. Nor has it served well in Great Britain where the national health system has been plagued, as its medical journals almost weekly remind us, by bureaucracies and cost restrictions.

By the 1990 bioethics was enfolded, for practical purposes, in a vision of professionalism presenting medicine as partner in an unsigned, never negotiated social contract with business and government (Cruess and Cruess (2017). Its ethics would thus be muted, secondary to the standards of its partners; practitioners would no longer stand apart, as guardians, from their demands but serve instead as functionaries in a commercial perspective overseen by governmental priorities.

That can be contrasted with the Hippocratic directive to “keep the ill from injustice,” implicit in the historical definition of the physician as a moral agent. Because the Greeks did not distinguish between individual interests and those of the community they shared (Singer 1983, 20) the Hippocratic ethos created a set of community members whose duty to the wellbeing of patients and the community at large were inextricably entwined (Koch 2012, 34-35).

The professional identity of practitioners thus was irredeemably conflicted. On the one hand there were the traditional values of practical, personal care of the person and as at least potential critic of the bureaucracies and commercial entities (insurance companies, pharmaceutical companies, etc.) with which they were “partnered”. “It is something of a miracle that most physicians remain faithful to their professional values in a system that does all it can to turn them into better businessmen which in fact they must be to fit into the health care system” (Callahan 2012, 184).

Activism

At another level, the result has been that “policy functions *as* medical care, and operates without the self-regulating guardrails that shape medical practice” (McNamara 2025). In the older, Hippocratic tradition, practitioners served a “guardianship function” (Jacobs 1002) critiquing the excesses of business and government impeding public health and healthcare service (Koch 2012, 34-36). Their primary obligation as practitioners was the care of the individual patient as citizens. But with their specialized knowledge of causal factors with special knowledge (*Air, Water, Places*) they were equally obliged to see their communities *as* patients. Thus the Hippocratic physician might simultaneously argue a patient consider this or that treatment but also as citizens, demand officials enact improvements to the shared environment (Pikington and Caplan 2025, Star 2017). Agitating for not simply a single patient’s needs but better health and living conditions in general was thus a constant theme from the Hippocratic canon (*Air Water, Places*) through at least the early Twentieth Century.

There is a long history of physician engagement with the limits of officialdom and the resulting effects on healthcare. During the 18th century physicians like Benjamin Rush, a signatory of the United States Declaration of Independence, railed against the conditions causing poverty in the emerging mercantile economies (Koch 2012. 33-36). In the 19th century physicians in England, Europe and the United States critiqued the increasing gulf between rich and poor, and the resulting effect on health (Hamlin 1998). Famously, Rudolph Virchow (2006) blamed a vicious outbreak of “hunger-typhus” in Upper Silesia on Prussian governmental policies and inaction. Medicine, he would declare, is a social science; a physician the attorney for the poor (Taylor and Rieger 1985). That role of guardian and protector of health as a primary social good was lost or at least diminished with bioethics and its market and governmental orientation. As Daniel Callahan put it in 1993, “it became clear that the field was not going to be dedicated to whistle-blowing--bioethics has not turned out many Ralph Naders, certainly not the way the environmental field has.”

AUTONOMY

It perhaps was inevitable with marketization and the disavowal of both practitioner experience and religious perspectives that autonomy would become the governing principle of bioethical practice (Veatch 1987, ix). “The prevailing [commercial] ideology held that each individual could and should decide how to manage their own health” (Pickington, Caplan and Parsi 2025). Perhaps without realizing it, bioethicists embraced an American, 19th century Jacksonian vision insisting that every person can and should manage his or her own health. Similarly, in Europe there was in mid-nineteenth century the Whiggish sentiment that in the marketplace, “free people took care of their own health” (Hamlin1998, 4-5).

There were and remain at last three fundamental problems with this principled ideal. First, at the heart of the bioethical proposition was an “economic Philistinism,” (Smith 1973, 60) with the individual as consumer in a market economy. Lost was the traditional Hippocratic ethic in which individuals had an intrinsic value solely as members of the wider community rather than as isolated entities (Smith 2000, 182).

Medicine has never been a simple matter of individual preference but a relational experience engaging a practitioner in the diagnosis and care of a patient. And both patient and practitioner are either assisted or limited by the greater, social structure governing the distribution of care and its resources (clinical compensation, hospital availability, pharmaceuticals costs, etc.). Medicine is grounded in social realities that may not only limit options for care but contribute to the illnesses a patient suffers. In the United States (Koch 2012, 35-36), Europe and Great Britain (Hamlin 1998) physicians eighteenth and nineteenth century physicians actively lobbied for social policies and programs for officials to create an environment in which causal elements resulting illness might be reduced. Principal actors in market economics seeking increased income and diminished costs, on the other hand, assumed health was an individual rather than communal concern and a free market might limit environmental deficiencies and social shortfalls.

Altruism

Where autonomy dominates in a marketplace of commercialized medicine the ideal of altruism is not so much dismissed as ignored. Before bioethics, physicians acting as researchers typically sought not dimply personal gain but to advance medical science for the good of all. Famously, for example, Fredrick Banting and Charles Best, co-discoverers of insulin, sold its patent for$1 to assure availability to all in need. "Insulin," Banting declared, "does not belong to me, it belongs to the world" (Lewis and Brubaker 2021). In the same spirit, in the early 1960s physician Robert Warner and microbiologist Robert Guthrie identified phenylketonuria (PKU syndrome) as an inherited metabolic disorder and then developed a simple blood test for its presence in newborns. That basic assay identifying PKU, based on a small blood sample, permits early treatment of what otherwise would be otherwise serious developmental disorders. By late in the 1960s it was almost universally accepted as the first of what later would be a number of newborn screenings for a range of endocrinopathies and congenital metabolic disorders (Guthrie 1992). Like Banting and Best, Warner and Guthrie patented their work in a manner that assured general accessibility without returning personal profit for their work.

Finally, cancer cells taken during treatment from an African-American patient, Henrietta Lacks, were discovered to be "immortal," uniquely stable in their reproduction. Harvested by Dr. George Gey, "HeLa" immortal cells, named after her, became an indispensable tool in cancer and cellular research (Sklott 2010). Dr. Gey did not profit from that discovery but instead grew them and made resulting cells available to other researchers at his own expense. In this he followed, as did the others, the Hippocratic tradition of treating medicine not as a product to be maximized for profit but as for, in Roy Porter's words, *The Greatest Benefit to Mankind*.

Certainly, not all medical researchers were similarly altruistic. In a range of very public, scandalous cases—Tuskeegee, Willowbrook, Sloan-Kettering, for example—research was undertaken with little regard for subject welfare. Those and other researchers' redefinition of patients as simply research subjects rather than subjects of care violated the Kantian categorical asserting persons should be treated as ends in themselves, not means. And in the same vein, with the commercialization of medicine, a "political economy of pharmaceutical clinical trials developed in which patients of modest means were seen by physicians only if they agreed to participation in research protocols (Fisher 2009, 45).

It is important to separate those events in which the patient was treated primarily as a research subject, not a patient in care, from the earlier, Hippocratic tradition followed by most clinical practitioners. It is not the least of ironies that early bioethicists were largely silent where they might have invoked a Kantian, moral perspective that stood in tandem with the Hippocratic ethic. The marketization of medicine and medical research presented an essential conflict for physicians for whom was medicine first and foremost a caring vocation rather than an economic enterprise. When traditional Hippocratic values of care and advocacy abutted against the demands of a commercialized medical marketplace physicians "increasingly found themselves in the role of gatekeepers, rather than providers, of medical care" (Fisher 2009, 36). It thus is no surprise that a survey conducted prior to the Covid-19 pandemic pegged the prevalence of at least some degree of "burnout" at 67 percent of physicians surveyed (Rotenstein, Torre, Ramos et al. 2018, 1131). That has been accompanied by a sense of low personal accomplishment among an increasing number of experienced physicians and nurses.

DISCUSSION

Certainly, Bioethics has been successful. Its international organizations and academic programs have provided a vibrant context in which issues of medical care and treatment can be discussed. Its limits are evident when contrasted with the Hippocratic ethic that dominated medicine for more than two millennia. In the latter, individuals had an intrinsic value as members of the wider whole (Smith 2000, 182). Practitioners served first through their care of the individual in need, and second, as educated citizens concerned with the greater social good. Bioethics recast practitioners as salespersons and technicians in a commercialized medicine where the person in need was an isolate responsible for his or her own choices. But economic and social realities contributing to inequalities that might affect individual choices has been, with marketization, rarely considered.

The earlier ethic set life as a fundamental good to be preserved without reservation. Bioethics, on the other hand, has no similar principle good but instead set the individual's needs within a setting that, from the earliest debates over resources, were likely to be in scarce supply. It thus was, with calls for triaging in a context of scarcity a matter not of how all might live but who should die that others might survive (Koch 2012). In the Hippocratic tradition scarcities would be the focus of physician critiques of bureaucratic and commercial shortcomings.

While these elements refer to the social contexts of care and health the older ethic was profoundly environmental. Hippocrates's *Air, Water, Places* focused on a community's physical setting and the character of the homes (dense and crowded or more open) and their location (near swamps or in clear airs). Embracing the marketization of post-modern society bioethicists have typically left resolution of those problems to bureaucracies responsible for regulation and supply within a commercialized context. The bioethicist as whistleblower has been in short supply.

Nobody un-rings a bell once rung. "The past once destroyed never returns (Weil, 1952, 49). It is unrealistic to expect medicine to revert to a classical, Hippocratic perspective rejected by from the start by Bioethicists. One can, however, expect a reformation in which an ethics of medicine, call it what you might, will again embrace elements of the Hippocratic tradition. Let life again be declared a primary good and where that might be reduced or limited exceptions of an accepted value could be debated. If we believe the individual citizen has intrinsic value, then bioethicists must focus first on the contexts of care or its lack. Choices reflect the context of the person, not only clinical but familial and social influences as well. Without that focus the assertion of individual sovereignty has little meaning.

In the early decades of industrialization health was defined as a precondition of liberty and a ready yardstick of injustice (Hamlin 1998, 69). At that time, it was not simply a matter of individual choice but the context in which choices might be made recognizing he pathological deficits arising from economic and social inequality. A modern bioethics would again assert health as first a social good rather than a commercial enterprise and the outcome of bureaucracies grounded in a utilitarian, post-modern economics a (Marmot 2016).

These changes would create a new ethics of medicine in which both the technical advances of medicine and the methods of its practice might be considered in a social context. Its perspective would set the moral philosopher not only as adjudicator but as an activist promoting the necessities of health in their communities. Such an approach would not exclude but welcome in its dialogue experienced practitioners, researchers, religious ethicists and of course the citizenry who all today grapple with the realities of medicine in a post-modern society.

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