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SOME THINGS OUGHT NEVER BE DONE: MORAL ABSOLUTES IN CLINICAL ETHICS

ABSTRACT. Moral absolutes have little or no moral standing in our morally diverse modern society. Moral relativism is far more palatable for most ethicists and to the public at large. Yet, when pressed, every moral relativist will finally admit that there are some things which ought never be done. It is the rarest of moral relativists that will take rape, murder, theft, child sacrifice as morally neutral choices.
In general ethics, the list of those things that must never be done will vary from person to person. In clinical ethics, however, the nature of the physician–patient relationship is such that certain moral absolutes are essential to the attainment of the good of the patient – the end of the relationship itself. These are all derivatives of the first moral absolute of all morality: Do good and avoid evil. In the clinical encounter, this absolute entails several subsidiary absolutes – act for the good of the patient, do not kill, keep promises, protect the dignity of the patient, do not lie, avoid complicity with evil. Each absolute is intrinsic to the healing and helping ends of the clinical encounter.

KEY WORDS: clinical encounter, dignity, moral absolute, moral relativism, physician–patient relationship, The good of the patient

INTRODUCTION

In the many productive years of our scholarly collaboration, David Thomasma and I energetically discussed, and debated virtually every major topic in Bioethics and moral Philosophy. Most of this never appeared in our published work. Some was projected to become part of our revision of *A Philosophical Basis of Medical Practice*,[1] a work sadly interrupted by David's untimely death.

One topic we confronted repeatedly was the ancient question of moral absolutes. All the tides of modern secular Bioethics have been moving to moral relativism, and to subjective and cultural justifications for moral decisions. In clinical ethics, the search for moral truth has yielded gradually to procedures for conflict resolution and assuring of autonomous moral preferences. Pragmatism, consequentialism, and personal values have lubricated the road to a quasi-absolute relativism.[2]

We wondered often if a normative ethics based in some natural law perception of moral norms common to human nature could be retrieved. The "richness" of moral diversity seemed so seductive to so many, that the idea of "absolute" norms seemed inimical to the moral creativity many thought would be released by liberating ethics from the moral restraint of universal norms.

Significant numbers of our contemporaries seemed to us to be going back to the primordial relativistic attitudes of Protagoras, Thrasymachus, and Gorgias, and away from the absolutism of Plato and the rationality of Aristotle. On this view, dialogue, social construction, and reflective equilibrium were transformed from methods of ethical discourse to criteria for right and wrong. At the bedside, the absolutization of autonomy made the search for moral truth "unrealistic." Consequentialism and proportionalism seemed better suited to a plurality of values than stable moral norms.

Our alarm could not erase the practical fact that given the powers of electronic communication, the transnational impact of biotechnology, and the worldwide spread of Bioethics, the moral differences between, and among, the peoples of the world could not be ignored. How should these differences be accommodated? Did tolerance require cooperation with moral practices inconsistent with our own moral norms? Was it unjust, or ethnocentric to argue for the superiority of certain moral norms over others? How are we to live together, within nations, and across nations, when our moral beliefs are radically different?

Is some form of moral relativism justifiable to avoid violence or unfair supremacy of one culture over another? Or, must we somehow retrieve those moral norms that under no circumstances can legitimately be set aside? Thomasma and I were in principle agreed that the latter course was the one to take. We were not agreed on how, under what circumstances, and by what form of justification.

Moral relativism is too formidable for brief discussion here. However, it seems to me that it might be possible to retrieve moral absolutes at least in a limited field like the clinical encounter. Here, it might be easier than elsewhere in ethics to agree on some things which should never be done. It is in this spirit that I offer this contribution to this volume devoted to David Thomasma's memory. I do not know whether he would have agreed with this approach. David was always decidedly an independent thinker. But I do think he would consider a proposal for a modest retrieval of moral absolutes

possible at least within clinical medicine, which he regarded as the fulcrum of professional ethics as I did.

THE IRREDUCIBILITY OF MORAL ABSOLUTES

Moral absolutes are anathema in secular Bioethics and medical ethics today. They are judged invalid, morally bankrupt, and inimical to a culturally diverse society. On this view, they are elitist, undemocratic, authoritarian and inadaptable to rapid societal change. They stifle human freedom, imprison human beings in their history, and stunt moral creativity.

This litany of the "immorality" of moral absolutes confuses tolerance with uncritical acceptance of the validity of opposing views. It undermines the intellect's capacity to grasp moral truth and eliminates the need for "foundations" for moral theory and practices. The first principle of ethics, i.e. "do good and avoid evil" is replaced by something much more irenic, i.e. "avoid conflict, get agreement" at any cost except assertion of a negative moral norm.

In professional ethics, the antipathy to moral absolutes is reflected most concretely in the contemporary deconstruction of the Hippocratic Oath. 2400 years ago, the ancient creed was unapologetically defined in terms of negative and positive moral absolutes, i.e. acting always for the good of the patient, avoiding harm, avoiding abortion and euthanasia, seeking consultation, protecting confidentiality, not engaging in sexual relationships with patients and family, and leading a life of virtue.

These absolutes are now judged to be out of date. Over the last few decades, bowdlerized, sanitized, and morally anemic revisions have been composed and intoned solemnly at medical school graduations. Even this is not enough. Some now call for a totally "new" professional ethic, one which allows for individual choice of abortion, infanticide, euthanasia, mutually consensual sex with patients, etc. The ideal oath for some is an oath with no code, or one consistent primarily with what the law, culture, political climate and custom permit.

The trend is away from any set of universal moral precepts that bind and define the medical profession everywhere in the world and are fitted to the ends of medicine rather than social or personal choice. Patients no longer can expect a standard of professional moral conduct. Each clinical encounter will become a lottery whose

constants will be competence, personal preferences, and legal requirement, not norms intrinsic to being a doctor.

The ultimate effect of these ideological transformations is the loss of moral absolutes in the care of patients at the bedside. There are also implications of the loss of moral absolutes for public health and social medicine. But the care of the individual patient is the more sensitive area where profound changes in the ethics of the profession are most clearly manifest. It is here that adherence to certain moral absolutes is essential to assure morally responsible action by the health professionals entrusted with the care of human beings in distress.[3]

MORAL ABSOLUTES IN MORAL PHILOSOPHY, GENERALLY

Ultimately, the moral life and moral philosophy must begin in, and end in, some moral absolute, some exceptionless statement that guides acts and actions by responsible human agents. The most fundamental of all moral absolutes is the one that makes ethics what it is. That exceptionless absolute is "do good and avoid evil." This is the ancient principle that springs from synderesis, whose roots are in Aristotle, St. Jerome and Aquinas. Synderesis is literally the "good guardian," the faculty by which one grasps the first principles that guide conscience in its judgments about individual and concrete moral choices. From synderesis springs the first principle of all clinical ethics as well, i.e. "Do the good of the patient, avoid harm to the patient." It is the first moral precept of the Hippocratic ethos.

Without this first precept, there could be no ethics since even those who deny the possibility of any moral absolutes believe they are doing, or advising, something good and not something evil. The problem is that their definition of good and evil is the definition of the moment, or a particular situation and not a universal obligation in the pursuit of the good. The negation of moral absolutes becomes itself a surrogate absolute, a substitute for the self-evident axiom of synderesis.

Until the Enlightenment, moral absolutes had a central place in ethics. Though his moral philosophy is virtue-based, Aristotle nonetheless held unequivocally that certain acts were always wrong and should never be done, e.g. murder, adultery, lying, stealing.[4] These were absolute prescriptions categorically and intuitively true.

Much the same view was held by the Stoics, St. Thomas, and St. Jerome. Similarly, the Decalogue of the Hebrew Bible, the Sermon on the Mount in its own way, and the ethical systems of many cultures had their quota of things that ought never be done.

St. Paul was somewhat wary about the ethics of the Greek philosophers. He relied upon synderesis when he taught that "Evil cannot be done for the sake of good."[5] Paul thus anticipated the familiar utilitarian and proportionalist arguments that acts are measured by whether or not they produce a greater or less good state of affairs.

The decline in acceptance of moral absolutes began with the Enlightenment ideal of a religion-free, metaphysics-free, autonomous morality. Since then, the status of moral absolutes has diminished by the erosion of religious belief in a source of morality beyond man, by the emergence or moral skepticism, and a veritable cascade of moral philosophies, each with its own methodology for determining what is morally right and wrong. The resulting moral pluralism breeds an inevitable relativism that militates against selection of any one moral absolute in preference to any other.

Similar forces have been operating in moral theology.[6,7] Proportionalists deny the intrinsic rightness or wrongness of acts and argue for the production of a greater proportion of good states of affairs and a lesser proportion of states of bad affairs.[8, 9] Theologians have sought to be more inclusive in a morally pluralist society by de-emphasizing the traditional moral absolutes of their own belief systems. Many have abandoned a natural law ethic in the belief that one or another modern moral philosophy is more appropriate for moral decision-making in the age of science and technology.

These powerful, ubiquitous, and strongly held viewpoints have had their impact on all branches of bioethics – clinical ethics included. Indeed, in clinical ethics, the trend is strongly in the direction of social construction, dialogue ethics, narrative, hermeneutics, and most recently American pragmatism. Moral absolutes have no place in these systems, which emphasize process more than norms.[10]

Moral realism has also suffered with the loss of moral absolutes. Moral judgments are no longer true or false. Nor can they be discovered. Rather, they are willed and become the products of negotiation, societal preferences or individual choice. Moral truths are no longer rooted in human nature. Human nature is now simply the way natural selection has fashioned us, at least as we understand it now,

according to the intersubjective value judgments that pass for scientific truth at the moment. Even as we examine what it is to be human now, our humanity is in the process of changing and along with it the norms of the good for humans. With our new biotechnology, it is presumed by our more enthusiastic geneticists that we will create a new, more perfect human nature.[11]

These several centuries of upheaval in moral philosophy and theology have profoundly affected the method and content of clinical decisions. At the bedside, decisions must be made with some firmness, not simply argued about. Their immediate consequences are often painfully manifest. Without universal moral norms, there is no "moral compass" to guide the physicians, the patient, the institution, or society. Without them, the patient's and physician's power are unbounded. There is no restraining *telos*, no defined good, for the clinical encounter. It becomes what we want it to be.

Moral Absolutes at the Bedside

Any creditable moral absolute for medicine ultimately derives from the nature of the clinical encounter and the human experiences of illness and healing. Illness is a predicament no mortal can escape. The predicament of illness refers to the total *nexus* of experiences that engulf a human when she becomes ill, sick, disabled and, thus, becomes a *patient*, i.e. one who needs the help of a heath professional.

Then "patient," by definition, is a person who is suffering in some degree and in some way. He is in an altered existential state – anxious, dependent, vulnerable and impeded in the pursuit of his daily life. He becomes a patient formally when he decides he needs professional help.

In that state, the physician asks how he can help. The patient understands this as a promise of the possession of skill and knowledge and a promise that they will be used in the patient's interest primarily. The physician's offer of help is literally his act of profession, a declaration privately that he is committed to the good of the patient. This act of profession is the "moral cement" which binds physician and patient together in the project of healing – healing particularized in this patient here and now.

The covenantal promise, to be authentic, must eventuate in a proximate and distant good end. The proximate and immediate end is a technically correct and morally good decision designed to assist a particular patient out of the predicament of illness. The more distant

end is health, the well functioning of the human organism, body, mind, and soul, to the degree possible. This totality of wellness can only be approached asymptotically.

The end of clinical medicine is the good of a particular patient who consults a particular health professional in particular circumstances. Any principle, rule, guideline or practice that frustrates, compromises, or endangers that end is an unethical and immoral infringement of the ethics of clinical medicine, and thus of the human covenantal relationship that underlies that ethic. Clinical moral absolutes are norms and mandates that must never be abrogated because their abrogation vitiates the healing ends of medicine.

Do Not Kill

Physicians must never kill. Nothing is more fundamental or uncompromising as this moral absolute. Nothing is more contrary than killing to the ends of medicine as a healing art. Until it was quietly removed from the Hippocratic Oath, the prohibition against taking life was an unquestionable precept of professional ethics. With the legalization of abortion, and more recently of assisted suicide in the state of Oregon, killing patients for reasons of compassion, convenience, or the quality of their lives, has been legitimated. To avoid the inconsistency of taking an Oath that forbids abortion or euthanasia, these prohibitions have simply been left out of the Oath now given at graduation in all but a few medical schools.

This is not the place to provide arguments against the omissions of killing from the Oath, or the participation of physicians in acts of killing. This article accepts this moral absolute as the most fundamental of medical absolutes. Intentionally ending the life of a patient is to ''kill'' the patient despite the euphemisms generated to call it something else. Killing can never become healing. It is by definition a denial of the first end of medicine – acting for the good of the patient.[12]

Act For the Good of the Patient

As noted above, the foundation stone distinctive of all moral discourse and action is ''do good and avoid evil''. Translated into clinical ethical terms, the good in question is the good of the patient. Any medical, nursing, administrative act that impedes the effort to advance the good of the patient is intrinsically, always, and on every

occasion, morally wrong. Such an act obstructs fulfillment of the covenantal promise to the patient, harms rather than heals, and converts a healing into a hurting activity.

In its negative form, this principle – never act against the good of the patient and never harm – is the moral *leitmotiv* of the oldest codification of clinical ethics, the Hippocratic Oath.

The good to be thus protected is a complex notion.[13] The lowest level is the medical good and ascends through the good as perceived by the patient, through the good of the patient as a human being endowed with a nature of a particular kind and capped by the patient's spiritual good. The good of which we speak here is, therefore, far more than the good that comes from the use of medical knowledge.

Examples of violation of this absolute are many and diverse, ranging from negligent use of knowledge and technique, human experimentation without appropriate consent, under-treating disabled infants to keep them from "suffering," ordering unnecessary procedures for purposes of profit, etc. These harmful acts are sadly too many and too frequent. On this view, inflicting harm or killing is justified because the good of pain relief is the greater good. The absolute restraint on this kind of maleficent thinking is the moral dictum that the patient may never, for any reason, be intentionally harmed. Any good which can be done only as a result of inflicting harm, i.e. euthanasia, is an evil, not a good.

Some proponents of assisted suicide and euthanasia argue that these acts do not harm, but help. But even on purely naturalistic grounds there are very good reasons to show that the beneficence of killing to relieve suffering is highly illusory.[14] Intentional killing of course is intrinsically wrong and in medicine it is a clear negation of the end of medicine; that is why it has been a repeated negative precept of clinical ethics since Hippocrates. Negative precepts are binding without exception.

Some proponents of assisted suicide, euthanasia, or terminal sedation, insist that their *intention* is to relieve suffering, not to kill the patient. They invoke the principle (or doctrine for some) of double effect. But they do so erroneously since one moral absolute for licit use of the principle is that the good effect must not depend on the evil effect. But this is what happens in assisted suicide and euthanasia. The patient's suffering can only be relieved by the demise of the sufferer.

There are other absolutes in the double effect principle. For example, the act in question may itself be morally good or indifferent

but must never be intrinsically wrong. Only the good effect must be intended, and the evil effect merely permitted. Here we have examples of moral absolutes as conditions for the application of a very practical and necessary way to recognize the moral complexity of clinical decisions.

To be sure, as part of the general aversion to moral absolutes *per se* or within other moral principles, the principle of double effect has been challenged – in the minds of some of us, unsuccessfully.[15]

Solemn Promises Must Never be Broken

The healing relationship rests existentially on the implied, explicit, and often repeated act of "*pro-fession*" – the promise by the physician to act in the patient's behalf. This is not a contract since the patient has no alternative but to trust that the promise is genuine. The vulnerability of the person needing and seeking help makes fidelity to promise absolutely obligatory.

The promise to help – the act of profession – is one of the fundamental absolutes of medical ethics. Its indispensability to the attainment of the good of the patient, the end of medicine, is clear. The promise cannot include a willingness to do harm, even if the patient wishes to run risks, try dangerous treatments, or have her life ended. Within the ethical purview of clinical medicine, a promise to do harm, or cooperate with its doing is an intrinsically invalid promise. It violates what it is to be a physician.

The promise to act for the good of the patient means to act to foster the whole good of the patient as a human being. Medical good is at the lowest level of these goods. It is essential, of course, that the physician be competent. If not, the whole relationship is a lie and morally invalid. But the good of the patient includes three other levels that are included under the absolute prohibition against doing harm.

Thus, above the medical good is the good of the patient as he sees his own good. This may well be at odds with the medical good, or the physician's assessment of what is good for the patient. To override the patient's clearly and responsibly expressed notion of his own good even for medical reasons is an assault on his humanity. The physician need not agree with the patient's assessment nor is he under any compulsion to do something simply because the patient wants it. But under these conditions the physician–patient bond must be courteously but clearly dissolved.

It goes without saying that other human goods of the patient – her good as a human being, her human rights, and her spiritual good are things that must never be violated. This is not the place to examine all the ways in which the patient's good, the good of the physician, and the good of society interact. The main point here is that when bonded by the solemn promise to help, and to act for the patient's welfare, the physician incurs a morally absolute obligation not to violate that promise.

Never Compromise the Inherent Dignity of the Patient

Until only very recently, the inherent dignity and worth of every human being, simply because she or he was possessed of human nature was an intuitively grasped moral absolute. It has been honored by ancient, medieval, modern, and contemporary moralists. On this view, every human being is entitled to equal respect for his or her person. Many of the other absolutes of the moral life are rooted in respect for human dignity.

The concept of dignity and equality underpins the rights we enjoy under the American Constitution. More recently, human dignity has been recognized as the first principle of the U.N. Declaration of Human Rights.[16] Human dignity as an ineradicable property of humans as humans is a precept both of Divine and natural law.

In most recent years, this moral absolute, along with virtually all others, has been questioned and, indeed, denied its place of primacy. Only a few examples need be cited. For one, dignity has been called a "useless concept" because it is supposedly so ill-defined and bears too visibly the signs of its religious origins. Autonomy, in this author's view, more than adequately replaces dignity.[17] Another very recent commentator picks up the same theme, seeing dignity so complex and varied that it demands "re-examination."[18] What is more likely the case is that dignity is too clear, too absolute and too respectful of human nature to permit the kind of freedom from absolute norms some bioethicists today deem essential for human fulfillment.

But where can autonomy attain moral force if not from the ancient notion of inherent dignity, that which grants each human equal worth and an equal claim for respect? Autonomy, as it is understood by many bioethicists, is a quality we confer on humans and which we use to designate them as persons. Those whose autonomy is impaired or absent are thus devalued, and depersonalized, e.g. the person in a permanent vegetative state, the mentally retarded, the senile elderly,

the Alzheimer's disease patient, and eventually those underprivileged persons whose education, or social status make them *de facto*, if not *de jure*, lacking in autonomy. Infants are at special risk.[19, 20, 21] When autonomy displaces inherent dignity, large numbers of humans are deprived of their humanity and their personhood. Autonomy is a *prima facie* principle, but not a moral absolute. As a *prima facie* principle, autonomy can be trumped, e.g. when it leads to definable, probable, significant harm to identifiable other persons, when it is invoked to require a physician to do something she may take to be intrinsically immoral, something which violates good medical or professional practice, or clearly is not in the patient's best interests.

Inherent dignity, being indissolubly tied to our human nature, cannot be overruled by autonomy. Autonomy has no moral substance without inherent human dignity. Inherent human dignity is fixed in Divine Law[22] or natural law, and thus open to discernment by human reason. Inherent dignity is absolutely distinct from imputed dignity, which is the worth others attach to us, or we attach to ourselves. We can lose, be robbed of, or deprive ourselves of imputed dignity. It is subject to both correct and mistaken human judgment. It is a perception, not a fundamental, inherent and unassailable characteristic of human life.

Those to whom we impute little or no dignity, because their autonomy is in some way impaired, are in mortal danger in any society. They are in danger of being given lesser priority when resources are scarce, deprived of their lives when they are a burden, used for experimental purposes, or discriminated against when they compete for justice with their more socially worthy fellows. Though it may be vigorously denied, once inherent dignity is undermined for any reason, personhood is lost, persons become objects, indistinguishable from any other form of life and given lower status than many of these other forms.[23] Inherent dignity is also the ultimate foundation for the now widely accepted four principles of beneficence, non-malfeasance, autonomy, and justice.

Beauchamp grounds these principles in common morality. Common morality can then change with time, place, political, or cultural ideology. As a result, the moral claims and the expression of the four principles cannot be absolutes. This is possible only if they are rooted in human nature, in human dignity as an ineradicable characteristic of human nature. This in its turn requires a metaphysical substratus, which Beauchamp explicitly rejects.[24] Despite this lack of a firm philosophical grounding, many ethicists persist in

making the four principles into moral absolutes. Clinicians who make this mistake, justify their bedside ethical decisions on some interplay of the four principles. This confuses a *prima facie* principle, which by definition can, for ''good'' reasons, be superseded with a moral absolute, which can never be superseded.

Never Lie

The clinical encounter, i.e., the physician–patient relationship, is based in trust as I have shown above. This trust is violated when physicians lie to patients. Patients are owed the truth about their diagnoses, prognoses, and treatments. There is no way they can participate in their own healing and treatment if they are kept in ignorance, nor can they arrange their affairs if the disease is fatal. Only with the truth can the patient truly be a partner in the healing process.

A number of objections are raised to making truth telling a moral absolute. One, for example, is the argument that telling a lie, shading the truth, or keeping a serious diagnosis from the patient may be a beneficent act. The proponents of this view invoke the ''therapeutic privilege'' which is used to justify lying if the physician believes there is a good chance that the patient will harm himself if he learns the truth. There may be such cases, but the obligation is not to lie but to provide whatever psychological assistance may be necessary when the truth is told. If the patient is truly suicidal, treatment for the depression or other reason for wanting to destroy oneself comes first. The truth usually can be held until the patient is ready to handle it with help.

Patients are not harmed by knowing the truth. The way in which the truth is made known is much more important. This is an art adapted to the patient as a person of a certain psychological temperament, age, culture, education, life experience, etc. The mix of all the factors that make this person who she is, will determine when, under what conditions, how, and who will communicate the truth. Physicians, nurses, other health professionals too lack the necessary personal skills. Telling bad things to good people is unfortunately as much a part of good clinical medicine as competence and ethical behavior. To tell the truth without harm is a moral obligation of the good physician.

A second reason, advanced for not telling the truth is the fact that, in certain cultures, patients are not given bad news about fatal

illnesses. If the custom is for a friend or family member to break the news, this may preserve the dictum about truth. The physician must be assured of what information is to be transmitted and how. The patient must however be told when significant life and death decisions regarding his person are involved.

Where the custom is for the patient never to be told then there is no breach of trust if the patient does not expect (or want) to be told. The physician then must decide whether he can adequately treat without the patient's participation. Depending on the answer to this question, the physician must decide whether he can take the case or not.

The same applies to a third objection to truth telling, namely that the truth can be given partially, or deception practiced to avoid worrying the patient, or preserving a cultural tradition. Deception leads to mistrust and anger when the truth becomes known as inevitably it will be. Much more harm is done by deception than truth telling, if the truth is told in a responsive way.

The preceding arguments regarding truth telling and deception show the wisdom of St. Paul's moral absolutes that evil must never be done that good may result. All too often the good intended turns out to be an evil – so that evil spawns evil, not good. This is especially relevant to clinical decisions where the utilitarian temptation to deviance from moral norms is especially attractive. This deviance is now being defended as a judicious application of John Dewey's pragmatism to clinical decisions.[25] The moral dangers of this approach cannot be detailed here. Its current fashionableness is evidenced by the dedication of a whole issue of the *Journal of Medicine and Philosophy* to "clinical pragmatism."

Formal Complicity With Evil is Never Justified

It is a commonplace fact that the preservation of moral norms is especially difficult in a morally pluralist society where personal norms can be used in ways that may touch others. This is not the place to review the principles of cooperation, which have a long history.[26] The principle of Material Cooperation recognizes that some degree of complicity with wrong doing is unavoidable and it defines the conditions under which it can be licit.

Formal cooperation is however absolutely, and always, forbidden. This is the case when the clinician shares the evil intent, partakes directly and freely, or in any way facilitates an intrinsically evil act

like abortion or assisted suicide. Clinicians may find themselves complicit in evil in their attempts to help a patient or by a lack of understanding of their own moral accountability for cooperation with others. Thus, some physicians believe themselves justified in deception and dishonesty in filling out insurance forms so that an inadequately insured patient will be treated. Physicians who work for a managed care organization may be guilty of cooperation for harm done by a bureaucratic decision designed to save money. Physicians may cooperate with a hospital policy they think wrong to save themselves censure or loss of income. Some do not realize that cooperation with evil, e.g. referring a patient to someone else to perform the procedure when one does not do abortions or engage in assisted suicide makes them complicit. Explanations like – "I don't agree, but its part of my job," or "I wanted to help a poor person get justice in the system" – simply do not provide moral exculpation.

As more ethically dubious practices are legalized, or incorporated into insurance mechanisms, demands on physicians to become "morally neutral" are bound to increase. The pressure will be even greater if the current moves in some state legislatures to require institutions and physicians to provide a full range of "reproductive services" get statutory blessing. This may be coupled with restrictions on the rights of conscientious objection for physicians who refuse to cooperate.

As our society becomes more morally pluralistic, culturally and ethnically, the occasions in which both formal and material cooperate will multiply. The importance of moral absolutes is obvious. It is important to affirm them, to understand their relevance to professional ethics and the fulfillment of the ends of medicine. This discussion has been limited to professional ethics. Obviously the same absolutes discussed here and others are applicable in all branches of bioethics and ethics more generally.

Moral absolutes are the only safeguards against a public and private ethic that has no limitations as proposed by current moral preference theorists. Without an uncompromisable moral boundary, there is no ethics beyond personal or social preference. This would be unthinkable in positive law. It is unthinkable in natural and Divine Law. It is to the dishonor of medical ethics, bioethics, and much of modern ethics that there are so few things that ought never be done.

Where is the Future?

The obstacles to even a modest place for moral absolutes or universal norms are formidable indeed. Where can one turn for signs of a retrieval of their importance for ethics?

Interestingly, on the international scene, there is growing awareness of the need to search honestly for some set of universal values which might be common to humans as humans.[27] It is perhaps significant that a convocation of world scholars seeking universal values should have occurred under auspices of the 2004 Olympics, and in Greece where so much of ancient moral Philosophy began.[28]

Of equal significance is the current work of the International Bioethics Committee of UNESCO. This committee at the request of the Director General, is engaged in the composition of a Declaration on Universal Norms of Bioethics.[29] This Declaration has been drafted by a writing committee, is available on the UNESCO website, and is being reviewed in the UNESCO process for publication in the foreseeable future.

These may be small beginnings, but they recognize the need for a clearer agreement among all peoples and cultures on some moral guidelines common to humans as humans. Both the UNESCO document forthcoming and the 50 year old U.N. Declaration on Human Rights begin with unequivocal assertion of the inherent dignity of the human person as the foundation for what is owed to each human simply as a human being. While not acknowledged as such, this is an approach consistent with Natural Law Ethics, and a propitious sign that there are indeed some things which must be done and some things which must never be done.

One may hope then, that the revelation of the moral consequences of extrapolation of the premises of moral relativism will reveal the impoverished ethics of those premises. What academic Bioethics may not accept seems recoverable by the common sense ethics of most thinking humans.

NOTES

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