Clinical ethics radically reconsidered: bioethics, common morality, and the law#

Clínica ética reconsidera radicalmente: bioética, moralidade comum e a lei

H. Tristam Engelhardt Jr.*

CHAPTER SIX

I. Bioethics Without Foundations

As far as the foundations of secular bioethics, there are none.[1] There is no canonical secular morality; there is no canonical secular bioethics. There is an intractable plurality of moralities and bioethics. There are no foundations that can secure any one particular morality or bioethics as canonical. There is no way out of this difficulty through an appeal to social contracts, which are plural (Bishop 2011), and whose authority is in question, once foundations are lost, once one has gone beyond the minimal state. The history of bioethics discloses persistent disagreement (Koch 2012). There are multiple incompatible clusters of intuitions supported by disparate narratives, such that each account or narrative is freestanding within the horizon of the finite and the immanent. Some as those from Singapore and China, which affirm a one-party capitalist state (Fan 2010 and 2011; Fan et al. 2012; Lim 2012; Li & Wang 2012), as well as from the Philippines (Alora 2001), collide strongly with the supposed common morality and bioethics of Beauchamp and Childress (Beauchamp & Childress 2012). Some moralities and bioethics are social-democratic (Daniels 1985, Buchanan 2009). Others are embedded in libertarian understandings of various sorts (Engelhardt 1986, 1996, 1991; Kukathas 2007). Bioethics are diverse (Hoshino 1997).

What ought one to make of secular bioethics and secular clinical ethics, since their longed-for justification through sound rational argument fails? Because there is no canonical, secular, sound rational argument to establish the liberal, social-democratic moral vision or the political authority of a liberal, social-democratic constitution and the governments it authorizes, how should one understand the fields of secular bioethics and secular clinical ethics with their liberal, social-democratic content? Beyond constituting quasi-political movements, how should one understand these fields? Or is there, as Tom Koch argues, a self-deception that dominates contemporary bioethics and that involves *inter alia* an affirmation of a neoliberal economics of scarcity (Koch 2012, p. 250)? Do bioethicists self-deceive themselves due to the psychological challenge of reconsidering their self-identity (i.e., some may actually imagine themselves to be moral experts or "morally" successful ethicists who draw comfort and self-esteem from their supposed expertise)? Are large segments of the public mistaken about the significance and roles of bioethics, especially clinical ethics? What can or ought the future of bioethics and clinical ethics

DOI: 10.15343/0104-7809.20153903377391

A seção "*Bioética no Mundo da Saúde*", foi criada para comportar trabalhos de grande relevância na área da Bioética e da Saúde. Nesta edição, dando continuidade à publicação da obra "After God: Morality and Bioethics in a Secular Age", do importante bioeticista Prof. Tristram Engelhardt, Jr, que gentilmente nos cedeu os direitos, será apresentado o capítulo seis. Tal trabalho foi primeiramente apresentado na seção "artigos em séries", da revista Bioethikos em 2014;8(1):80-88. This chapter is drawn in part from a lecture, "Bioethics after Foundations: Feeling the Full Force of Secularization," delivered at the Centro Evangelico di Cultura "Arturo Pascal" and the Consulta di Bioetica ONLUS, Turin, Italy, January 31, 2012. An ancestral version of this chapter appears as Engelhardt 2013.

* Graduado em Medicina e Filosofia. Doutor em Filosofia pela faculdade do Texas-TX, USA. Doutor em Medicina pela Faculdade de Tulane, New Orleans-LA, USA. Professor da Rice University, Houstoun-TX, USA. Autor das obras Fundamentos da Bioética e Fundamentos da Bioética Cristã Ortodoxa, pelas Edições Loyola, e de Bioética Global, pelas Edições Paulinas. E-mail: htengelhardt@juno.com

1. I must admit to having since my youth been disappointed by the claims of moral philosophy regarding sound rational argument. When I was still a Roman Catholic, I had tried to my utmost to use philosophy to secure its natural law, natural theological, and other rationalist claims. I was shocked by my failure. I found that the moral-philosophical and –theological arguments of Roman Catholicism required the concession of crucial and controverted initial premises and rules of inference. Then I discovered that the same difficulty lies at the basis of any secular moral-philosophical viewpoint, morality, or bioethics. This chapter is a special gloss on this difficulty in bioethics.

to be, given that there is no canonical, secular, common or universal morality. Why despite all these puzzles do health care ethics consultants succeed so well (Engelhardt 2011; 2009; 2003)? It is, after all, the success of clinical bioethics that, by accident of association, has made academic bioethics appear so successful, which of course it is not, if success lies in establishing a conclusive rational warrant for the moral and ethics forwarded. The aspirations of academic secular bioethics have not succeeded in establishing a canonical bioethics, in that academic bioethics has failed to justify a canonical morality, because, as we saw in chapter 2, this is impossible. At best, one can conclude that academic bioethics has failed to appreciate sufficiently its situation as after God and after morality. Nevertheless, secular bioethics has succeeded politically and functions in triumph as a political movement whose political agenda is widely passed off as a moral conclusion. Bioethicists have emerged with a remarkable self-identity. Bioethicists appeared to be the intellectuals who have succeeded in being relevant to society through doing something that "really" mattered. One could be proud to be a bioethicist or clinical ethicist.

Beauchamp and Childress, with the aid of Eunice and Sargent Shriver, as well as the Kennedy Institute, helped establish bioethics, even though they eschewed the term "bioethics", giving preference to "biomedical ethics". The Center for Bioethics of the Kennedy Institute with its total-immersion courses ordained cadres of a new order of secular chaplains who transformed the ethos of health care practice, the oversight of research, and the functioning of advisory panels of various genre. They made bioethics the moral and intellectual master of medical ethics (Engelhardt 2002).[2] These courses at the Kennedy Institute, along with the *Principles of Biomedical Ethics* (1979, 1983, 1989, 1994, 2001, 2009, 2012), abetted the development and flourishing of bioethics. As it was, it was still too risqué for some former Christian theology students wholeheartedly to accept all of the secular bioethics that was becoming dominant (e.g., that it had no conclusive arguments against infanticide). Nevertheless, despite whatever their initial relative conservatism may have been on some matters, Beauchamp and Childress embraced without hesitation a strong social-democratic, political-constitutional agenda and took the first steps to a post-Christian morality, the full force of which is still just beginning to be appreciated. It is enough in this chapter to acknowledge some of the implications for bioethics, both academic and clinical, of being beyond foundations.

II. Living with Moral Pluralism

Against the background of the loss of foundations for secular morality and bioethics, one can better appreciate that there is no conclusive rational basis for taking any particular secular morality or bioethics to be canonical. Theory is understandably not just in disarray but brought into question. In this light, one can also better understand Tom Beauchamp's observation that secular bioethics can proceed without attention to theory. Beauchamp reminds us that it is best not to pay attention to and/or be embarrassed by the failure of theory. After all, theory cannot vindicate the dominant secular morality and culture, much less Beauchamp and Childress's common or "universal" morality.[3] As Beauchamp puts it, quite understandably, "this [moral] theory part of the landscape of bioethics … [will] vanish

2. Confiteor quia peccavi nimis. From the early 1970s, I was culpable in part for the development and success of the dominant secular bioethics. I helped teach the Kennedy Institute summer courses and myself directed courses in bioethics supported by the National Endowment for the Humanities Seminars for Medical and Health Care Teachers between 1974 and 1980. Also, from 1977 through 1982 as the Rosemary Kennedy Professor of the Philosophy of Medicine at Georgetown University, I made my modest contribution to the development of the field. I am as guilty as any for what naively took place in the 1970s and early 1980s.

3. Let me be quite clear that my reflections concerning Beauchamp and Childress's bioethics are not advanced in criticism of them. Personally, I am deeply indebted to them both and consider them to be my friends and colleagues. Moreover, I acknowledge them as likely the two most important figures for the emergence of bioethics in the latter part of the 20th century. Their *Principles of Biomedical Ethics* gave the new field the substance and direction it felt that it needed. My critical repositioning of their work recognizes their importance. I have approached their work in an Hegelian spirit (caveat lector: I have taught Hegel for decades, but I am not a Hegelian). My goal is to lay out the higher truth of their work.

soon, because it is serving no useful purpose" (Beauchamp 2004, p. 210). Since it is impossible, given deep disagreements regarding basic moral premises and rules of evidence, to establish any particular concrete morality or bioethics as canonical, theory fails to aid in securing a particular canonical secular morality or bioethics. Without the possibility of establishing a particular canonical morality by sound rational argument, one cannot identify, much less ground, a canonical, common, or "universal" morality or bioethics. Without such a warrant for morality or bioethics, why take bioethics and its practitioners seriously? Is this state of affairs disastrous both for those that seek counsel from clinical bioethicists and for such bioethicists themselves? Are such bioethicists like the priest who has lost his faith, like "Those who stay on the job [and] become like old prison lags, the long-time prisoners who mop the floor and proclaim the institution fine because the floor is clean" (Koch 2012, p. 253)?

Where, then, do we find ourselves? Theory can offer analyses, exegeses, and comparisons of alternative moralities. That is, theory can lay out the content and the character of the various claims of particular or regional moralities, including the dominant secular morality of our society, drawing out the implications in specific areas or regarding specific cases. Theory can lay out alternative geographies of morality and bioethics. But theory cannot establish which account of a particular morality, which morality it is that should serve as the canonical, common, or "universal" morality, so as to provide a secular canonical ethics for a particular bioethics to apply. As Beauchamp admits,

> The reasons for the demotion of ethical theory are the lack of distinctive authority behind any one framework or methodology, the unappealing and formidable character of many theories, the indeterminate nature of general norms of all sorts, the turn in bioethics to more practical issues, and most importantly, the stumbling and confusing manner in which philosophers have attempted to link theory to practice (Beauchamp 2004, p. 216).

Three points are crucial. First, there is "the indeterminate nature of general norms of all sorts" (Beauchamp 2004, p. 216); second, there is "the stumbling and confusing manner in which philosophers have attempted to link theory to practice" (Beauchamp 2004, p. 216). Finally, as already underscored, no particular morality or bioethics can by sound rational argument be established as canonical. What is one then to make of bioethics under these circumstances?

Beauchamp appears to accept something like a biopolitical view of this state of affairs. He is willing to live with core ambiguities regarding key moral terms and principles in morality and bioethics, including his cardinal principle of autonomy, as long as the agenda of his biopolitics is advanced. One should note that a strategic ambiguity is often rhetorically useful in building political coalitions, in that a certain amount of ambiguity serves the force of political persuasion by appealing in different ways to different audiences. Clear definitions exclude particular bases of support, while strategically ambiguous definitions help to build political coalitions. Politics is not an area that encourages analytic precision or clear sound rational argument. Instead, politics in its practice is marked by the art of persuasion, sophistry in the classical sense of the term. One need not be Foucaultian in order to recognize that statecraft is the exercise of persuasion and power.

Consider the ambiguities of autonomy, the focus of Beauchamp and Childress's first principle. The meaning of autonomy is multiple. The term autonomy, as well as the principle of autonomy, has different intensions and extensions. For instance, one can identify at least four different understandings of autonomy, each with a distinctly different meaning.

> 1. Autonomy as a source of authority – When persons meet who do not agree regarding God's commands, regarding what moral rationality requires, or regarding what common customs dictate (if there be any), they can always draw authority from the consent or permission of those who decide to collaborate peaceably (Engelhardt 1996). Autonomy in the sense of the conveyance of authority through permission for common collaboration is at the root of the authority of contracts,

the market, and the minimal state, but not the more-than-minimal state. In these circumstances, no value and/or no virtue is imputed to this practice of gaining common authority for peaceable collaboration. It is simply the case that if one enters into this practice of gaining authority from permission, one can together with others who also explicitly enter the practice share the authority of common permission, the authority of consent that is derived from the collaborators. The source of this authority is nothing other than the consent or permission given by all participants.

2. Autonomy as a value or goal – Autonomy can also be valued as an end in itself or as an overriding good. Various philosophies and ideologies have valued persons choosing on their own, setting their own goals as autonomous agents, rather than submitting to the authority of others. When persons freely submit to the authority of others, they do not violate the principle of autonomy as permission, but they reject giving an overriding value to autonomy. Thus, when one sells oneself into temporary slavery (i.e., allowing another to compel one's services rather than being allowed to pay damages for the failure to provide promised services), such as when joining the military, one values other goods more highly than the good of autonomy. During the Enlightenment and following the French Revolution, views regarding autonomy as an overriding value became salient, often construing freedom or liberty as a good in itself. The value of autonomy is cardinal to many contemporary accounts of bioethics.

3. Autonomy as the rational choice – The existence of a canonical, content-full moral choice is at the core of a rational "Kantian" way of life and as such is held by Kant to be obligatory for all rational beings. This sense of autonomy does not affirm one's choosing as one wants (*Willkür*), but only as one rationally should will (*Wille*). For example, according to Kant, to act autonomously one must rationally choose in conformity with what the moral law requires as the choices of rational agents *qua* rational agents. Here Hegel notes in his critique of Kant in the "Moralität" section of *Elements of the Philosophy of Right* that Kant either imports content without sufficient argument or leaves crucial terms underdefined so that a thick set of moral commitments is imported without due notice into Kant's notion of moral rationality.

4. Autonomy as union with God – Through freedom from sin, distorting passions, and death, one can be granted union with God. This is the traditional Christian account of freedom, which is expressed in "You shall know the truth and the truth shall set you free" (John 8:32). This account of freedom realizes that the good, the right, and the virtuous are such only when they are aimed at the Holy, the Persons of the Trinity. One can aim properly through purification of the soul and submission to God's commandments, so that free from improper attachments one can come into union with God. In this case, truth is not propositional but refers to the Persons of the Trinity. Christ, after saying "you shall know the truth and the truth shall set you free," explains Who the Truth is: "I am the way, the truth, and the life: no man cometh unto the Father but by Me" (John 14:6). One only becomes truly free by becoming a god by grace (i.e., through the uncreated energies of God – St. Athanasius, *De incarnatione verbi dei* §54.3).

These four senses of autonomy are in many ways incompatible. They at most show or possess some family resemblances. There is no obvious way to parse the meaning of autonomy in the principle of autonomy.

The first sense, autonomy as permission, can be affirmed in the face of skepticism regarding Kant's claims about what rational agents should choose. Moreover, autonomy as permission, in contrast with the second account, simply identifies a source of authority (i.e., permission) that can serve as the basis for collaboration among moral strangers. It is not a rationally required, independent, right-making condition (i.e., apart from its standing within the practice

of permission-giving itself), nor is a claim made about the value of freedom, nor is it claimed that autonomy has a particular content. Indeed, in terms of the first meaning of autonomy, no claim is even made about the moral importance of this practice of gaining authority, but only that this practice exists as a possibility that can bind moral strangers, should they wish to enter into it. The meaning of autonomy is, in short, plural.

Given this state of affairs, what can one then say about the principle of autonomy? What precise meaning for Beauchamp's account of bioethics does autonomy have, if any? In particular, it should be clear that there is no one canonical view about the importance or meaning of autonomy or of the significance of the principle of autonomy. Beauchamp appears without any concern in recognizing and conceding these deep ambiguities.

> What it is about autonomy that we are to respect remains unclear, and it remains obscure what "respect" means. Most obscure of all is how practice is affected by a theory of autonomy. The contemporary literature in bioethics contains no theory of autonomy that spells out its nature, its moral implications, its limits, how respect for autonomy differs from respect for persons (if it does), and the like (Beauchamp 2004, p. 214).

Autonomy is not taken by Beauchamp to identify a particular interpretation or meaning of autonomy. At best, for Beauchamp and Childress the principle of autonomy (1979) functions as a guiding heuristic to identify a diverse cluster of moral concerns associated with the character of choice, self-determination, and collaboration with others. That is, autonomy as a principle draws attention to a complex and heterogeneous cluster of moral intuitions and concerns bearing on choice and self-determination that within the dominant secular moral narrative that have some family resemblances. The result is that an appeal to autonomy can in different contexts identify different moral and bioethical concerns, to which it may be important to attend. However, secular morality cannot establish any particular content-full sense of autonomy as canonical. There is, after all, a plurality of moral concerns associated with choice, self-determination, freedom, and liberation, which are nested within disparate moral frameworks.

Again, Beauchamp appears to be at peace with the central ambiguities of autonomy. Once more, a plausible interpretation of this state of affairs is that Beauchamp's agenda is at bottom political, so that his contentions should be understood as a form of political rhetoric. Like Richard Rorty, and like the later Rawls, Beauchamp can be understood as having taken a political turn so that the higher truth of the dominant secular morality is its support for the social-democratic positions in law and in public policy that he embraces. Given such an interpretation, Beauchamp would, and indeed should, tolerate a broad range of theoretical positions and different construals of autonomy. Their unity would not be conceptual but political: the support they afford in advancing a particular social-democratic policy agenda. From this perspective, Beauchamp would want to reassure bioethicists that "there is no need to embrace only one of the [moral] frameworks that have seemed in intractable conflict. One can, without inconsistency, embrace principles, rules, virtues, rights, narratives, case analysis, and reflective equilibrium" (Beauchamp 2004, p. 210). One can use whatever works, whatever has rhetorical success.

Given this political interpretation of Beauchamp's position, the morality and bioethics of the dominant secular culture, by being established at law and in public policy, become the common secular morality and bioethics. Moral philosophy and bioethics provide clusters of rhetorical strategies that can through their very ambiguity prove politically useful in advancing particular political or public-policy agendas, such as a liberal, social-democratic movement to refashion society in general, and health care policy in particular. Once one recognizes the dominant secular morality and its bioethics as constituting dimensions of the strategies integral to a socio-political movement, if one is part of that movement, one can choose among moral and bioethical arguments on the basis of which

best helps rhetorically to advance one's political or public policy agendas. There appears to be no obvious political gain from openly and honestly admitting to this state of affairs, in fact to the contrary. The higher truth of secular bioethics becomes secular biopolitics.

Given this state of affairs, bioethics consultants or clinical ethics consultants earn a living by advancing a particular healthcare policy or by expositing a particular bioethical perspective that has become established at law. In the case of clinical ethics or clinical ethics consultation, one can offer the service of expositing a particular established law and public policy bearing on decisions regarding health care and the biomedical sciences. Following Karl Marx (1818–1883) and Friedrich Engels (1820–1895), one can recognize that there is no independent basis for one's morality and bioethics. One need only recognize morality and bioethics as part of "the ruling ideas of the epoch", as concretely realized in a particular jurisdiction (Marx & Engels 1967, p. 39). One can then sell one's services as a "conceptive ideologist", as a defender and/or expositor of "the ruling ideas" established at law and in public policy in that particular jurisdiction or jurisdictions. As a step toward securing status and approved market constraints, clinical ethicists can seek to become recognized and/or approved "conceptive ideologists" through some form of certification or official recognition.[4] In this circumstance, moral and bioethical theories play various roles as political rhetoric and/or marketing devices.

III. A Common Morality? A Common Bioethics?

A critical reinterpretation of secular bioethics is thus in order. Among other things, this involves deciding how to understand Beauchamp and Childress's claims regarding a common morality, in the face of the circumstance that there is no common morality or secular canonical morality. Beauchamp and Childress in *Principles of Biomedical Ethics* (Beauchamp & Childress 1979) assume there is a common morality. Crucially, they proceed as if, given this common morality, appeals to the principles of autonomy, beneficence, non-maleficence, and justice can give concrete guidance for moral and bioethical decision-making,[5] despite the prevail-

4. For an overview of the drive in the United States on the part of clinical ethics consultants to establish themselves as a profession, see Kodish & Fins 2013.

5. *Mea culpa*. I must confess my involvement in the emergence of the so-called four principles. Beauchamp and Childress's four principles grew out of the success of the National Commission's three principles of respect for persons, beneficence, and justice in guiding the commissioners in the articulation of regulations for research involving human subjects (National Commission 1978, pp. 4-10). The three principles of the *Belmont Report* themselves were in part developed out of principles suggested in a background paper I had authored.

A. One should respect human subjects as free agents out of a duty to such subjects to acknowledge their right to respect as free agents.

B. One should foster the best interests of individual human subjects.

C. One should have concern to maximize the benefits accruable to society from research involving human subjects, taking into particular regard interest in values such as (1) the amelioration of the human condition through advances in the biomedical and behavioral sciences and technologies; (2) preservation of human autonomy as a general value; (3) increase in knowledge apart from any consideration of its application to the amelioration of human condition; (4) the personal satisfaction of human subjects derived from their feeling of having contributed to the common good or to the advancement of human knowledge by participation in research (Engelhardt 1978, pp. 8-5, 8-6).

The first two principles were recast under the rubrics of a principle supporting respect for persons and a principle of beneficence (Jonsen 1998, p. 103). The third principle was substantially recast as a principle of justice.

Albert Jonsen in his history of the emergence of bioethics gives an account of the emergence of the focus on principles of bioethics. He states that, in the development of the Belmont principles, his fellow commissioner, Joseph V. Brady, professed that he was attracted to three principles only: beneficence, freedom, and justice. I seconded Brady's point because these three principles seemed to do what ethical principles should do—namely, serve as rational justification for decisions and policies. We also had in our dossier of philosophical essays H. Tristram Engelhardt's paper which had suggested three basic principles: "respect for persons as free moral agents, concern to support the best interests of human subjects in research, intent in assuring that the use of human subjects of experimentation will on the sum redound to the benefit of society." Tom Beauchamp had also contributed a paper entitled "Distributive justice and morally relevant differences." After much discussion, the commissioners took Engelhardt's first two principles and Beauchamp's principle of distributive justice and crafted "crisp" principles: respect for persons, beneficence, and justice. Stephen Toulmin was directed to redraft the report for presentation at the March meeting. ...[These] principles found their way into the general literature of the field, and, in the process, grew from the principles underlying the conduct of research into the basic principles of bioethics (Jonsen 1998, pp. 103, 104).

The final outcome was a broad public appeal to principles.

ing moral pluralism, and despite Beauchamp's recent acknowledgement of core ambiguities in the principles. In the first edition of their *Principles of Biomedical Ethics*, Beauchamp and Childress simply remark regarding the existence of a common morality: "Most of the principles and rules that we will consider are accepted by most deontological theories and can also be discovered in the 'common morality'" (Beauchamp & Childress 1979, p. 34). They repeat this claim verbatim in the second edition (1983, p. 33). In the third edition, Beauchamp & Childress state, "Most of the principles and rules adopted in this book are accepted by most deontological theories and can also be discovered in the 'common moral consciousness'" (Beauchamp & Childress 1989, p. 37).

By the 4th edition, which appeared in 1994, they finally provide an account of what they hold common morality to be.

> In its broadest and most familiar sense, the *common morality* comprises socially approved norms of human conduct. For example, it recognizes many legitimate and illegitimate forms of conduct that we capture by using the language of "human rights." The common morality is a social institution with a code of learnable norms. Like languages and political constitutions, the common morality exists before we are instructed in its relevant rules and regulations. As we develop beyond infancy, we learn moral rules along with other social rules, such as laws. Later in life, we learn to distinguish general social rules held in common by members of society from particular social rules fashioned for and binding on the members of special groups, such as the members of a profession (Beauchamp & Childress 1994, p. 6).

This account of common morality with its reference to "social approval," "social rules," and a "social institution" seems open to a political interpretation so that the common morality would be the morality established at law and in public policy, so as to become the morality of a particular regnant ethos. However, their account at this point does not make it clear whether each society has its own common morality (e.g., like Hegel's *Sittlichkeiten*) or whether Beauchamp and Childress are asserting that all humans share one common, universal morality. One is not helped by Beauchamp and Childress to see which society, or part thereof, gets to approve "the norms of social conduct". Is this determined by a democratic procedure, and if so, guided by what constitutional constraints?

It is only in the fifth edition (2001) that Beauchamp and Childress more clearly, but nonetheless somewhat rhetorically, advance the claim that there is one common human morality in the sense of one universal morality shared by all "morally serious" persons. Beauchamp and Childress by employing the rhetorically weighted term "morally serious" invite agreement with their position. Who, after all, would want to deny being "morally serious"?

> All persons who are serious about living a moral life already grasp the core dimensions of morality. They know not to lie, not to steal property, to keep promises, to respect the rights of others, not to kill or cause harm to innocent persons, and the like. All persons serious about morality are comfortable with these rules and do not doubt their relevance and importance. They know that to violate these norms without having a morally good and sufficient reason is immoral and should lead to feelings of remorse. Because we are already convinced about such matters, the literature of ethics does not debate them. Such debate would be a waste of time.
>
> We will refer to the set of norms that all morally serious persons share as *the common morality*. The common morality contains moral norms that bind all persons in all places; no norms are more basic in the moral life. In recent years, the favored category to represent this universal core of morality in public discourse has been human rights, but moral obligation and moral virtue are no less vital parts of the common morality (2001, p. 3).

The difficulty is that people do in fact disagree as to when it is morally licit, forbidden,

or obligatory to take property, break promises, honor the rights claims by others, and kill other humans. "Morally serious" persons disagree about when it is appropriate to lie or to tell the truth. For example, the norms of civilized society involve dissimulating one's true feelings, with the norms for truth-telling varying remarkably across cultures. As has already been mentioned in Chapter Four, the Christianity of the first centuries and Orthodox Christianity differ from Western Christianity in recognizing an obligation at times to lie.[6] Beauchamp and Childress do recognize that there are a number of moral accounts of a common morality, and in their reflections they give special attention to William Frankena (1908–1994) and W. D. Ross (1877–1971). What is at stake beyond a rhetorical and strategically vague but powerful appeal to being "morally serious" is unclear.

In the fifth edition, Beauchamp and Childress hold that their common morality will allow some customary moralities to be criticized as deficient in not meeting the moral standards set by their "common morality". To do this, they invoke a "coherence model of justification" that at best begs the question as to which morality (i.e., their common morality or the customary morality) is canonical and why. If by a coherence model of justification they mean to engage a wide reflective equilibrium, the problem is that Beauchamp has expressed skepticism as to what this could mean. "I am asserting that it has never been made clear how the method [a wide reflective equilibrium] connects to practical problems, how one would know whether it has been followed, and how it might be used by others in bioethics. … It continues to be unclear whether anyone in bioethics has followed the reflective-equilibrium model (I include myself), despite its standing as the most widely mentioned model" (Beauchamp 2004, p. 213). In any event, in the fifth edition they state: "This strategy [distinguishing and comparing common morality and customary morality] allows us to rely on the authority of the principles in the common morality, while incorporating tools to refine and correct unclarities and to allow for additional specification of the principles" (Beauchamp & Childress 2001, p. 403). At this point, it would seem that they wish to identify their common morality with a supposed universally binding morality.

This concern with common morality is also associated with an increased invocation of human dignity and human rights. But the appeal to human rights only compounds the uncertainty regarding Beauchamp and Childress's position, further depriving it of an unambiguous moral force, in that claims of human rights are notoriously rhetorical through being politically powerful but conceptually unclear. To quote from Kozinski:

> The post-World-War II overlapping consensus on moral goods that was to serve as the political foundation of the democratic charter, then, was an illusion. Though citizens may have shared a common lexicon of "human rights" and "democratic values," in reality, it was a house built on sand with a sinking foundation of disparate understandings of that lexicon and radically disparate traditions of practical rationality: Thomist, Lockean, Humean, Kantian, Rousseauian, Nietzchean, Deweyean—or an eclectic and incoherent mix of these or other less systematic ways of thought and practice (Kozinski 2010, p. 175).

What the supporters of human rights, Beauchamp and Childress included, seem to have in mind is a political agenda. Nevertheless, as Beauchamp and Childress put it in the sixth edition (2009), they consider their common morality to be a universal morality. They provide no supporting studies that convincingly show that the common morality is a product of human experience and history and is a universally shared product. The origin of the norms of the common morality is no different in principle from the origin of the norms of a particular morality in that

6. St. John Chrysostom (344-407) emphasizes the obligation at times to deceive others. "The straightforward man does great harm to those he will not deceive" (Chrysostom 1984, p. 51).

both are learned and transmitted in communities. The primary difference is that the common morality is found in all cultures (Beauchamp & Childress 2009, pp. 3–4). Indeed, they claim that "Our hypothesis is simply that all persons *committed to morality* adhere to the standards that we are calling the common morality" (Beauchamp & Childress 2009, p. 4).

Of course, everything turns on the notion that "all persons committed to morality" accept *their* common morality. Their view appears to assume a background canonical morality that allows one to identify who these persons are, as well as the canonical morality that persons do and should hold. That they assume a particular morality to be the common morality is also clear in the 2012 edition of *The Principles of Biomedical Ethics* (Beauchamp & Childress 2012). Here they state that "We have defined the *common morality* in terms of 'the set of norms shared by all persons committed to morality'" (Beauchamp & Childress 2012, p. 417). The issue is which is the morality to which all should be or are implicitly committed. As with Beauchamp and Childress's reference to those who are "morally serious" and to "those who are committed to morality," there is rhetorical power but insufficient conceptual specificity or detailed argument. How does one determine what that morality is or who morally serious persons are?

Beauchamp and Childress appear to have finally come to the view that whether a common morality exists is an empirical question that can be addressed through anthropological study, such that[s] hould it turn out that the persons studied do not share the norms that we hypothesize to have their roots in the common morality (we claim to present only norms pertinent for biomedical ethics), then the research would have shown that there is no common morality of the sort we have envisioned, and our hypothesis would be falsified (Beauchamp & Childress 2012, p. 418).

Their thesis of a common morality appears not to turn on a conceptual criterion for being "morally serious", but rather empirically on whether a particular morality is common. If this interpretation is the case, how many of which people (e.g., professors of moral philosophy, educated persons, persons generally, persons never convicted of a felony, etc.) need to hold what norms to make them the common morality? How does one go about the sociological project of determining this state of affairs? Can it really be that Beauchamp and Childress do not in fact see that the moral project has already been falsified and that morality has collapsed into a plurality of competing moralities, while they all along continue to assert that there is a common, indeed universal, morality?

The cardinal difficulty is that Beauchamp and Childress do not give an adequate justification of their claim that there is a common morality despite the circumstance that there is wide and pronounced disagreement as to when it is obligatory, licit, or forbidden to have sex, reproduce, transfer property, tell the truth, or kill humans. It may be that all humans in being incarnate beings have concerns about sex, reproduction, pleasure, possessions, suffering, and death, but their moral views regarding these matters are manifestly diverse. There is no one morality or bioethics regarding these matters. One encounters radically different moral life-worlds (e.g., that of the secular social-democrat from Cambridge, Massachusetts, that of the Confucian familist from Singapore, or that of the pious Muslim from Tehran). If there is no sound rational argument that can identify one among the many different conflicting moralities and bioethics as canonical, then in what sense can there be a common morality? Nevertheless, Beauchamp and Childress assert that there is a common morality, and that it is the universally binding morality. They imply that those who do not agree with them are not morally serious. Yet, they give no basis for establishing what counts as moral seriousness.

Despite their claims about the existence of a common morality as a universally binding morality, a political interpretation of Beauchamp and Childress's position still appears most plausible, especially if one holds that within the sphere of the immanent, the political is the

higher truth of morality. The political account is particularly plausible, given Beauchamp's pessimism regarding theory, indeed even regarding the impossibility of an appeal to a reflective equilibrium that could establish what counts as the content of a common morality. Appeals to balancing moral claims and/or moral concerns will not help either unless one can identify a canonical balance by which definitively to balance moral claims and concerns. As a moral project, the search for a common morality appears to be a self-deception. However, matters change if "common morality" points to the morality that Beauchamp and Childress's political agenda is aimed at establishing. That is, the common morality can be read as that morality that, given Beauchamp and Childress's political agenda, they seek globally to enact through law and public policy. Again, it may be the case that both Beauchamp and Childress recognize that one morality is indeed common, but only in the sense of being the morality that they hold should be globally regnant, that they hold should be universally established at law and public policy. If so, Beauchamp and Childress would be taking a position similar to that of Hegel and Rorty, namely, that a particular morality exists concretely only in being the morality established at law and public policy, or as that morality that some particular group aspires to impose by law. Politics then provides the standpoint from which to identify a common morality and its bioethics, in that the state establishes a morality as common in the sense that it is realized through law and public policy. The political turn also allows one to identify the morality that one wishes to establish through one's political movement as common in anticipation of future political success. The result is that with Rorty politics is "[t]he right way of reading these [moral] slogans [about common humanity, natural human rights, and the philosophical foundations for democratic politics, in that it] lets one think of philosophy as *in the service* of democratic politics – as a contribution to the attempt to achieve what Rawls calls 'reflective equilibrium' between our instinctive reactions to contemporary problems and the general principles on which we have been reared" (Rorty 1989, p. 196). Crucially at stake is a "shift from epistemology to politics" (Rorty 1989, p. 68). After the failure of the universalistic aspirations of secular morality and bioethics, one is left with morality as politics.

In the case of *The Principles of Biomedical Ethics*, secular bioethics and its common morality are realized in the realm of the social-democratic political agenda that Beauchamp and Childress endorse and seek to advance. If one's goal is political, one will be at peace with philosophy and bioethics' failure to provide foundations and with the ambiguity of key concepts such as autonomy and reflective equilibrium, while nevertheless speaking in anticipation of a common morality as the morality that is to be established at law and in public policy. The common morality can in this sense be common in anticipation of the coming realization of a political agenda. Beauchamp and Childress can thus identify those moralities that do not accord with their political agenda as "deficient" customary moralities. Or to put the matter a bit differently, the common secular morality is the customary morality that accords with the favored political agenda. Beauchamp and Childress can thus anchor the communality and universality of their morality in the future, the realization of their political agenda. For them, all turns on their political commitments.

For Hegel, this would be beyond the scope of his reflections, because it would require philosophical prophecy, and Hegel warns that philosophy cannot prophesy, "the owl of Minerva begins its flight only with the onset of dusk" (Hegel 1991, p. 23). But for Beauchamp and Childress, given their political agendas, there can be prophecy about a moral view that will be established in law and in public policy. From this future perspective, they can then speak of a common morality. Such a perspective would allow Beauchamp and Childress to speak of their "universal" common morality, while the truth of their claims is in the end a promissory note based on the hoped-for success of their political agenda. The future political agenda

warrants their morality, so they may assume that their "common" or "universal" morality is common and "universal", albeit it is currently neither universal nor common.

IV. Why, Despite Moral Pluralism, Secular Healthcare Ethics Consultants Succeed so Well

An appeal to law and public policy allows one better to appreciate the success of clinical ethics, despite intractable moral pluralism, despite intractable moral disagreements. Clinical bioethics succeeds by making reference not to a canonical morality or to a political agenda, but to that ethics currently established at law and in public policy. The success of clinical bioethics lies in the circumstance that the ethics about which secular clinical ethicists are experts is that ethics that is actually established in a polity through law and public policy. Despite intractable moral pluralism, clinical ethicists can nevertheless be experts about those mores and/or norms established at law and in public policy. Clinical ethicists are not sociological experts able to establish which norms are widely held, nor are they able to show, were they to know those norms, what would morally follow from such a sociological fact of the matter of their being widely held. Clinical ethicists would need canonical, secular, sound rational arguments that do not exist. It is about these norms that there are disputes in most large-scale societies, which lie at the roots of political controversies.

Clinical ethicists are not experts as to which professional norms or ethics should be followed apart from that which is established at law and in public policy. For example, there are states in the United States that establish norms for the practice of medicine, which do not include those norms established by the Code of Ethics of the American Medical Association, to which association the overwhelming majority of physicians in the United States do not belong. In any jurisdiction, apart from such an establishment at law and/or policy of particular professional norms, as for example through state licensing authorities, clinical ethicists are not authorities able to give guidance as to which professional norms or norms of medical ethics should govern. In the United States, unlike in countries where the norms of the local medical profession are imposed with the color of law on all physicians, American medical ethicists (who are conceptually different from clinical ethicists) can at best lay out disparate codes for the practice of medicine and particular specialties, as well as how they constrain members of particular associations of physicians.

The roles of healthcare ethics consultants as a result have strong family resemblances with the roles of lawyers. Lawyers do not directly give advice regarding "widely-held social norms", nor do attorneys give guidance about professional norms beyond those norms established at law and in public policy. Similarly, healthcare ethics consultants give what is tantamount to legal advice in functioning as experts about the norms and/or morality established at law and in public policy. They can give answers to questions, for example, as to who in a particular jurisdiction is in authority to make medical decisions for incompetent patients and with respect to the circumstances under which an advance directive is valid. To repeat once more, healthcare ethics consultants function by giving quasi-legal advice regarding that morality established at law and public policy (Engelhardt 2012, 2011, 2009, 2003). One thus sees why, despite the moral pluralism that would appear to be a cardinal impediment, healthcare ethics consultants, clinical ethicists, or clinical bioethicists, however one styles the profession, have succeeded so well in advancing their trade. Healthcare ethics consultants can function successfully despite intractable moral and bioethical disputes, because they do not in fact function as moral or ethics experts. Instead, they usually help families, physicians, nurses, and others to understand the implications for clinical decisions of established law and public policy bearing on health care and the biomedical sciences.

Like lawyers, clinical ethicists can identify and characterize grey zones so as to make suggestions about how to act with the least moral (read legal and public policy) risk. In addition,

by means of consultations and through entering notes into the patients' charts regarding controverted cases, clinical ethicists can help show that due diligence has been taken in reaching a decision. Establishing that due diligence has been taken tends to serve as a protection against malpractice suits and other legal adversities. Healthcare ethics consultants thereby support effective risk management. Last but not least, clinical ethicists while noting the constraints of law and public policy can function, as do lawyers, as expert mediators among disputing parties. When they function well, they function as talented, legally cognizant mediators. In none of this is there any need for an agreement regarding a canonical morality or canonical bioethics. There is no need for ethics expertise as traditional morality had once conceived of it. Clinical ethicists do not know better than others what people should do, apart from law and public policy. Instead, secular clinical ethicists by appealing to that ethics enshrined in law and established healthcare policy can bypass the problems of moral and bioethical pluralism. They need only know the norms of the morality and bioethics established at law and in healthcare policy in their particular jurisdiction. Healthcare ethics consultants can therefore function well and even flourish in the face of moral pluralism, in a secular society whose established morality and bioethics are without foundations and where in addition robust moral pluralism prevails.

The result of this state of affairs is that there is not just an American clinical bioethics and a European clinical bioethics, but also a German clinical bioethics, an Italian clinical bioethics, a Chinese clinical bioethics, a Japanese clinical bioethics, a Texan clinical bioethics, and a Californian clinical bioethics, not to mention a Norwegian clinical bioethics. In each jurisdiction, given its own law and public policy bearing on health care and the biomedical sciences, the ethics of clinical ethics consultation (however one wishes to style the field) will be different. This is the case in that a clinical ethicist must know local law and established policy in order to practice clinical bioethics. Again, in this matter clinical ethicists have a great similarity to lawyers. Clinical ethics is jurisdiction-specific, although, as with some lawyers, a clinical ethicist may be able to practice competently in different jurisdictions. In general, some talents (e.g., for mediating disputes) may be presumed for competent practice in nearly every jurisdiction.

The matter is different for bioethicists who have expertise regarding a particular morality and its bioethics, which morality and bioethics are not only held to have a force apart from law and public policy, but which are also applied within particular institutions. This involves circumstances such as when a morality or bioethics is established in an institution nested within a non-geographically-based moral community. For example, a Roman Catholic clinical ethicist in a Roman Catholic hospital does function as a moral expert about a morality that is recognized by a particular community as having force apart from secular law and public policy, as being in fact grounded in the will of God. In addition, for such Roman Catholic healthcare ethics consultants, ecclesiastical law also plays a role, and it is understandable that Roman Catholic healthcare ethics consultants be subject to Roman Catholic canon law and meet the approval of the local bishop. Relevant knowledge concerning Roman Catholic canon law (e.g., regarding excommunication for performing an abortion) will therefore be important. In short, here there can be a morality about which a bioethicist can and should be a moral expert, where a morality and a bioethics qua particular morality and/or bioethics are held to have force. Such moralities and bioethics have been neither demoralized nor deflated. In this circumstance, Christian bioethics has a concrete and sectarian meaning. It is different in content and character, depending on whether it is an Episcopalian or Orthodox Christian bioethics. These Christian bioethics differ in terms of their content, as well as with respect to who are recognized as authorities and/or as in authority (e.g., bishops) to settle disputes. There are also different relevant literatures. The whole sense of appropriate religious bioethics, including clinical bioethics, differs from religion to religion.

One might consider, for example, the special role of rabbinic authorities in providing clinical ethical guidance in Orthodox Jewish hospitals.

In summary, despite moral pluralism and in the absence of foundations, secular clinical ethicists possess a very useful expertise, even though there is no canonical secular morality or bioethics about which such healthcare ethics consultants can be experts. Secular clinical experts are experts regarding the morality and ethics established at law and public policy within their polity, especially about how to apply that established morality and bioethics in particular situations. The practice of clinical ethics is like the practice of law (in fact, the public recognition of clinical ethics has allowed its practitioners to practice law without being admitted to the bar), which also does not require moral or ethical expertise. One does not need to have studied philosophical theories and other accounts of the law in order to practice law successfully. The successful practice of the law does not require that there be a canonical account of the foundations or moral significance of the law. There is, after all, no canonical secular account of the authority of secular law and public policy beyond its being imposed by a particular *modus vivendi*. Instead, there is an intractable plurality of accounts of secular morality and of the law, not to mention a large number of conflicting codes of law.[7]

V. Beyond Self-Deception: Bioethics and Clinical Ethics Reconsidered

In order to appreciate the success of secular clinical ethicists, one must radically revise one's assumptions about what is required to count as an expert clinical ethicist. If the appeal by healthcare ethics consultants explicitly or implicitly is to that ethics established at law and public policy, there is no need for, and there are good reasons against, secular clinical ethicists ever holding themselves to be normative ethicists or to be experts about what *ceteris paribus* one should do morally. After all, given moral and bioethical pluralism, the secular normative issue of what would be right, good, virtuous, or just to do is a matter of persistent disagreement. However, which morality is established at law and in public policy is a fact of the matter. Again, the success of healthcare ethics consultants is best explained by the circumstance that secular clinical ethicists give quasi-legal advice while rarely if ever providing straightforward moral or bioethical advice. Healthcare ethics consultants can function well in the contemporary dominant secular culture, despite intractable moral pluralism, as well as in the face of the demoralization and deflation of the secular morality and bioethics of the West. Clinical ethics is after morality.

If this account of bioethics and clinical ethics is justified, why do not all bioethicists and clinical ethicists recognize its truth? Of course, if one is a conceptive ideologist earning one's living as a bioethics expert, it may not help one's career to be too frank about the foundationless character of secular morality and bioethics. Also, if one has a political agenda, there may be no reasons for, and there may be good reasons against, acknowledging publicly and clearly this state of affairs. One may simply wish to establish the clinical ethics one favors. One's candor will be determined by political considerations. There will be significant conflicts of interest between one's serving as a conceptive ideologist (e.g., a bioethics or ethics expert) and committing oneself to forthrightness. There have always been tensions between personal political agendas and commitments to forthrightness about one's personal views regarding those policies one is advancing. The ethos of consultancy and of the political life is not one necessarily marked by frankness about one's deepest personal views

7. There is a significant demand for clinical ethicists, given the post-traditional character of Western society. In the face of the loss of the authority of traditional authority figures (e.g., physicians), the weakening of intermediate structures, and the fracturing as well as increasing infrequency of intact traditional families, clinical ethicists can, do, and will play an important default role. Moreover, they are relatively easy to train as well as generally relatively inexpensive. Using clinical ethicists instead of lawyers who have specialized in health law has advantages analogous to using nurse practitioners instead of physicians. Nevertheless, lawyers and physicians have more social prestige, which invites clinical ethicists to attempt to secure for themselves a prominent status in their own right.

concerning the service one is selling or concerning one's political agenda, if such forthrightness is likely to undermine one's marketability or political agenda.

Let me underscore that this state of affairs does not impeach my view of those who act guided by career or political expediency. What else would one expect? Moreover, all surely do not act out of expediency. Some clinical ethicists also are undoubtedly honestly misled by their success in working through to resolutions of bioethical and clinical ethical quandaries so as to come to think of themselves as moral or bioethical experts. But of course, such "working through" is what good lawyers do in their practice of the law without being moral experts. Nevertheless, some clinical ethicists may derive an important dimension of their self-identity and self-esteem from their ungrounded view of themselves as moral experts. They may see themselves as clinical ethical experts apart from and beyond what they know about the morality and norms established at law and in public policy, and beyond their talents as mediators and in selling themselves as consultants. This is all personally understandable, but it does not count against the foundational reconsideration of bioethics and clinical ethics advanced by this chapter. Secular bioethics and clinical ethics are not what many thought the field to be.

REFERENCES

Alora, Angeles Tan & Josephine M. Lumitao (eds.). 2001. *Beyond a Western Bioethics: Voices from the Developing World*. Washington, DC: Georgetown University Press.

Beauchamp, T. L. 2004. Does ethical theory have a future in bioethics? *Journal of Law, Medicine, and Ethics* 32: 209–217.

Beauchamp, T. L. & J. Childress. 1979. *The Principles of Biomedical Ethics*. New York: Oxford.

Beauchamp, T. L. & J. Childress. 1983. *The Principles of Biomedical Ethics*, 2nd ed. New York: Oxford.

Beauchamp, T. L. & J. Childress. 1989. *The Principles of Biomedical Ethics*, 3rd ed. New York: Oxford.

Beauchamp, T. L. & J. Childress. 1994. *The Principles of Biomedical Ethics*, 4th ed. New York: Oxford.

Beauchamp, T. L. & J. Childress. 2001. *The Principles of Biomedical Ethics*, 5th ed. New York: Oxford.

Beauchamp, T. L. & J. Childress. 2009. *The Principles of Biomedical Ethics*, 6th ed. New York: Oxford.

Beauchamp, T. L. & J. Childress. 2012. *The Principles of Biomedical Ethics*, 7th ed. New York: Oxford.

Bishop, Jeffrey. 2011. *The Anticipatory Corpse*. Notre Dame, IN: University of Notre Dame Press.

Buchanan, Allen. 2009. *Justice & Health Care*. New York: Oxford University Press.

Chrysostom, St. John. 1984. *Six Books on the Priesthood*, trans. Graham Neville. Crestwood, NY: St. Vladimir's Seminary Press.

Daniels, Norman. 1985. *Just Health Care*. New York: Cambridge University Press.

Engelhardt, H. T., Jr. 2013. Bioethics and moral pluralism, *Notizie di Politeia* 105 (June): 7–21.

Engelhardt, H. T., Jr. 2012. Bioethics critically reconsidered: Living after foundations, *Theoretical Medicine and Bioethics* 33.1: 97–105.

Engelhardt, H. T., Jr. 2011. Core competencies for health care ethics consultants: In search of professional status in a postmodern world, *HealthCare Ethics Committee [HEC] Forum* 23.3 (September): 129–145.

Engelhardt, H. T., Jr. 2009. Credentialing strategically ambiguous and heterogeneous social skills: The emperor without clothes, *Hospital Ethics Committees [HEC] Forum* 21.3 (September): 293–306.

Engelhardt, H. T., Jr. 2003. The bioethics consultant: Giving moral advice in the midst of moral controversy, *HealthCare Ethics Committee [HEC] Forum* 15.4 (December): 362–382.

Engelhardt, H. T., Jr. 2002. The ordination of bioethicists as secular moral experts, *Social Philosophy & Policy* 19.2: 59–82.

Engelhardt, H. T., Jr. 1996. *The Foundations of Bioethics*, 2nd ed. New York: Oxford University Press; 1st edition, 1986.

Engelhardt, H. T., Jr. 1991. *Bioethics and Secular Humanism*. Philadelphia: Trinity Press International.

Engelhardt, H. T., Jr. 1978. Basic ethical principles in the conduct of biomedical and behavioral research involving human subjects. In: *The Belmont Report*, Appendix vol. 1, sec. 8, pp. 1–45. Washington, DC: Department of Health, Education, and Welfare, publication # (12) 78–0013.

Fan, Ruiping (ed.). 2011. *The Renaissance of Confucianism in Contemporary China*. Dordrecht: Springer.

Fan, Ruiping. 2010. *Reconstructionist Confucianism*. Dordrecht: Springer.

Fan, Ruiping, Xiaoyang Chen, & Yongfu Cao. 2012. Family-oriented health savings accounts: Facing the challenges of health care allocation, *Journal of Medicine and Philosophy* 37.6: 507–512.

Hegel, G. W. F. 1991. *Elements of the Philosophy of Right*, ed. Allen W. Wood, trans. H. B. Nisbet. New York: Cambridge University Press.

Hoshino, Kazumasa (ed.). 1997. *Japanese and Western Bioethics*. Dordrecht: Kluwer/Springer.

Jonsen, Albert. 1998. *The Birth of Bioethics*. New York: Oxford University Press.

Kukathas, Chandran. 2007. *The Liberal Archipelago*. New York: Oxford University Press.
Koch, Tom. 2012. *Thieves of Virtue: When Bioethics Stole Medicine*. Cambridge, MA: MIT Press.
Kodish, Eric & Joseph J. Fins. 2013. Quality attestation for clinical ethics consultants, *Hastings Center Report* 43.5 (Sept.-Oct.): 26–36.
Kozinski, Thaddeus J. 2010. *The Political Problem of Religious Pluralism*. Lanham, MD: Rowman & Littlefield.
Li, Jun & Jue Wang. 2012. Individuals are inadequate: Recognizing the family-centeredness of Chinese bioethics and Chinese health system, *Journal of Medicine and Philosophy* 37.6: 568–582.
Lim, Meng-Kin. 2012. Values and health care: The Confucian dimension in health care reform, *Journal of Medicine and Philosophy* 37.6: 545–555.
Marx, Karl & Friedrich Engels. 1967. *The German Ideology*. New York: International Publishers.
Rorty, Richard. 1989. *Contingency, Irony, and Solidarity*. New York: Cambridge University Press.