Special Section: Consensus in Bioethics: Negotiating the Challenge of Moral Pluralism

Narrative as Bioethics: The "Fact" of Social Selves and the Function of Consensus

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Several months ago, I was walking down the hallway outside our medical school faculty offices and a colleague stopped me to ask a question. He phrased his query in the context of a "hypothetical" case that raised ethical issues for him, and he asked me to respond. I obligingly offered my opinion given the details he presented, ending my comments with the phrase, "at least, that is what I would say." To this he kindly shot back, "OK, but what is the consensus of medical ethicists?" To be honest, this question caught me off guard. Though his particular dilemma was relatively well-trod territory for many bioethicists, I had done little research on the issue and could not immediately render a response to his latter query.

On further reflection, however, I found my concerns for my colleague's issue waning while three more general concerns about my own profession began to take hold: (1) Why would my "learned opinion" not count as an acceptable answer? (2) Should bioethicists strive for consensus among themselves? And (3) if so, how would we get there, and what would it even look like? The first question addresses a seeming weakness in bioethics (and practical aspects of ethical theory), a weakness that may be misunderstood not only by laypersons but professional ethicists as well. Namely, it is believed that the "touchy-feely" nature of the discipline does not allow for reliable, acceptable knowledge expressed by any one person. Meeting the problems raised by the first question leads to an answer for the second question as well, for the question of whether or not bioethics should strive for consensus is answered by what bioethicists in fact do in their usual practices. Finally, the third question may be too big to take on herein, but the preliminaries of a possible answer will be sketched by relying on the insights of social psychology and philosophy in the classical American vein.

As professionals on the "frontlines," bioethicists are expected to offer physicians, nurses, patients, and society at large helpful insights into and deep understanding of the moral conflicts that arise in medical practice. And with greater frequency, not just our own colleagues but media and government are turning to "professional" bioethicists for the "last word" concerning right and wrong in medicine. Cloning sheep becomes a reality while a Presidential Commission determines whether cloning humans is ethically acceptable. Conjoined twins are to be separated by an order of the court, so newspapers call a

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medical ethicist for a way to frame the ethical concerns. The entire human genome is "mapped out" by a collaboration of scientists around the world, and television reporters interview the growing number of available bioethics personalities willing to speak up about the meaning of such findings for human interaction and living. Meanwhile, the public surfs the Web, chatting with professors and practitioners of bioethics to reach a better understanding of the confounding issues in medicine that surround them.

But what of the opinions expressed by these bioethical groups and individuals? With what voice do they speak, and what can they say that is not itself misleading, misunderstandable, or simply malpractice? Do they in fact speak for the community of bioethics itself? (Is there even such a community?) With what degree of suspicion should we approach the comments of the vocal few?

Of course, these questions are no different than those to be asked of each and every bioethicist whenever he or she speaks out in his or her role as a professional. Whether it be on ABC, to the AP, at bioethicstogo.com, or whether in the face of a surgical team, an ethics committee, or at medical conference, a challenge is always present to each bioethicist. With what voice, with what authority, with what justification does he or she speak? The status of a "consensus" in bioethics is the burden we *must* bear, and I am not alone in this belief.

Recent publication history would show that since the mid 1980s, "consensus" has been a topic of concern to philosophers in general, and to bioethicists in particular.[1] Stemming from his early 1970s work, *A Theory of Justice*,[2] John Rawls did much in the 1980s to bring the concept of consensus into the philosophical conversation. With Rawls's later work in *Political Liberalism*,[3] we find the culmination of his thought focused on the concept of "overlapping consensus"[4] politically necessary in the face of what Rawls calls the "fact of reasonable pluralism" as constitutive of a free society. That is, he believes that there are fundamental gaps between each of us at the level of our beliefs. As such, the best that we can hope for is that we can develop agreement about what to do even if we can never agree about the best reasons for doing it.

For bioethics itself, the seminal moment may have been the publication of Tristram Engelhardt's *The Foundations of Bioethics*.[5] Engelhardt's analysis of the contemporary reality of "secular pluralism" and the corresponding lack of moral authority that comes with it, like Rawls's before him, expresses a fundamental gap between what Engelhardt calls "moral friends" and "moral strangers."[6] In response to this analysis, accounts of consensus in bioethical decisionmaking arose. In particular, the late 1980s saw the first scattered discussions in print. By 1991, the *Journal of Medicine and Philosophy*[7] published a volume dedicated to a discussion of consensus in group processes. Jonathan Moreno later published his own monograph on consensus and hospital ethics committees.[8] There is also the 1998 collection, *Consensus Formation in Health Care Ethics*,[9] dedicated to the topic—to name but a few examples.

All this is well and good, but whereas in much of these writings a great deal of emphasis has been placed on consensus among members of a committee or commission, there has been little discussion about what consensus might look like within the community of bioethicists itself. Even analyses of the concept of bioethical "expertise" as discussed by authors like Tong[10] and Veatch[11] has focused more on the role consensus plays in creating expertise and not the experts' roles in consensus-building (or destroying). That is, it has not looked at the so-called experts themselves—namely, those who profess to be bioethicists by both vocation and avocation. But given that it would seem, at least prima facie, that to be an expert is to have one's "finger on the pulse" of that which he or she professes, my fear is that we may, in fact, often be guilty of the worst of the sophistry against which Socrates railed. The question, then, raised by this fear is: How can we profess to teach or dispense bioethical wisdom if there is no consensus about what that wisdom is? As my own anecdote at the beginning of the paper shows, this lack of consensus in our own profession may pose a concern to others.

Note, however, an interesting disjunction in our academic and social practices. Practically speaking, students and laypersons alike rarely question the authority of a Ph.D. scientist. The anatomist, geneticist, or nutritionist, for all intents and purposes, is taken as speaking for his or her scientific brethren as he or she speaks of the subject in question. Of course, there are controversies and disagreements in the sciences, but as a society we rarely operate with that in mind. Why can the same not be said for how we understand the "expert" bioethicist?

The reasons for this disjunction are many and complex, but a few simple insights can be given. First, as ten Have and Sass point out:

> Bioethics as a discipline is flourishing because a moral consensus has evanesced and is itself in question. Physicians, philosophers, lawyers, and theologians are engaged in bioethics, since they no longer concur with the moral consensus which prevailed in the past.[12]

There is a well-known phrase in bioethics that ours is a young discipline.[13] This statement often acts as an apologetic for the as-of-yet-uncoalesced definition of what we do and who we are. Bioethics, it can be argued, is at the point of its own development where biology was in the mid-nineteenth century, physics in the early twentieth century, or medicine itself in the eighteenth century. And whereas those more "scientific" endeavors do still have their revolutionary moments, much of the turmoil that once marked those disciplines as they moved from an Aristotelian classificatory system to evolutionary theory, from Newtonian concepts to relativity and quantum mechanics, or from humors theory to the biochemical, disease model, respectively, has subsided, whereas bioethics still has yet to settle many of its more *fundamental* differences.

In particular, much of this unsettlement occurs with regards to the tools and instruments—that is, the "technologies"—we have developed, or have yet to develop, in bioethics. Whereas the scientific, industrial, and high-tech revolutions have furthered and strengthened the sciences, no such analogous revolutions have had similar impacts on the humanities and social sciences. We continue to strain for progress. Such concepts as "principles," "rules," and "virtues" compete with each other and with ideas of "narrative" and "care." While we champion our own tools, we degrade others. No theory is without its critics, and no critic is without his or her competing theory. In many ways, bioethics is still in the dark ages.

In other ways, however, it is certainly not as bad as it might seem. Much of bioethics' problems are politically charged growing pains, and the politics of ethics and ethical theory may obscure some important practical insights. The differences among theories and accounts, real as they may be in certain aspects, are not as great as they may appear in others. By focusing on practice over theory, we find that consensus may, in fact, be forming on some important matters in bioethics. In particular, Mark Kuczewski suggests that consensus can be found concerning the very methods employed in bioethics. Specifically, Kuczewski argues that "all methods in bioethics presuppose a kind of narrative construction" concerned with a "process" that is "largely character-dependent." This consensus "is a moderate and balanced approach distilled from several decades of the 'doing' of medical ethics."[14]

I will return to Kuczewski's more controversial claim about the centrality of narrative later, but what is most striking at this juncture is his emphasis on the role of "doing" in developing this moral consensus. By situating the political solution—that is, consensus—in practical activities of bioethicists, Kuczewski has offered up a valuable and useful insight. Namely, regardless of the differences in what we *say* about bioethics, in fact what we *do* turns out to be pretty homogeneous.[15]

So what is it that bioethicists *do*, and might it help to both illuminate existing consensus and form further consensus? If we divide the activities of bioethicists into three, not mutually exclusive, categories—scholarship, teaching, and consulting—we may begin to see a (albeit simple) picture emerging. Scholarship consists of research and writing, interpreting others, and presenting our own thoughts. Teaching, at least in its more formal sense, includes the interaction of faculty and students in schools and classrooms, explaining and discussing ideas. Finally, consulting focuses on specifically raised problems that are addressed and discussed by bioethicists, medical personnel, patients, and so forth.

Note that in each of these activities, communication is the key. Understanding and being understood are central to the success of all three modes of behavior for the bioethicist. As John Dewey has rightly and simply pointed out, "Consensus demands communication."[16] But good communication both arises from and forms communal bonds and shared experiences. In community, members share in what Justus Buchler calls a "potency for many individuals" of a given situation, event, or object.[17] They are "moved" by the same things, taking similar attitudes toward objects of beauty, enjoyment of sport, appreciation of foods, and the like. But further still, there is a normative element in communities that establishes an organized way of behaving such as language use and social roles. Along these lines, social psychologist George Herbert Mead says that "sociality" is a fact of human living and that the self is formed only by way of transaction with community (what he calls, the "generalized other").[18] It is upon these features of community that consensus, of any sort, forms.

It must be clearly noted, though, that regulating individual activity according to community demands need not wholly subsume individual interests under community ones. The power of philosophical liberals like Rawls, Nozick, and so forth is that they remind us that each of us contributes uniquely to the community in a way that would be altogether lost to the community if that particular individual were not present. Individuals embody novel nexuses of experiences.[19]

It would seem, then, that we are in the presence of two "facts" of human living that, at least prima facie, may be in contrast with each other. Each of us is unique, an individual of specific and novel value and worth. And yet, we are social beings, products of the communities in which we reside. These two facts have become polarized in the debate on politics and ethics with thinkers like Rawls, as mentioned briefly above, opting for an irreconcilable pluralism based on atomic individuality. On the other hand, philosophers like MacIntyre[20] and Sandel[21] have opted for a so-called communitarian approach that threatens to eradicate all individuality. But it would seem that *if* Mead is right about this "fact" of sociality *and* Rawls is right about the "fact" of "reasonable (irreconcilable) pluralism," then they cannot *necessarily* be in conflict.[22]

Rather than choosing one side over another, then, we might be better served by embracing the idea that shared experiences, realities, and purposes as well as pluralistic individuality are both "facts" about community. That is, these concepts are not in fundamental conflict, as they might seem. It is quite possible, I would argue (and have[23]), to have unique expressions of purpose that can, as a matter of accident or design, work together as shared purposes. Cannot the communitarian and the liberal both win, at least a part of, the day? Although MacIntyre might argue that the idea of extreme insular individualism is simply wrongheaded, at the same time it must be conceded that the concept of shared experience may itself be a bit misleading. It seems a truism that no two persons ever have the exact same experience. So, if by "shared" we mean that you and I possess one and the same entity called "X experience," then the concept of "shared" in this sense is ridiculous (at best) to expect. However, people who have leukemia, passengers who survive an airline disaster, and individuals in AA are said to have shared experiences—in other words, there are elements of their personal experiences that intimately connect with others'—and it is this "sharedness" that brings them together. The illness process, the event, the way of life are lived through together, and this association, then, form deeper ties. In this way we can and do affirm each other's unique experience while noting the connections inherent within our lived experiences. Community, then, does not mean mere "sameness." As Beth Singer explains, "The condition of community is one of sameness-in-difference, of partial commonality of perspective among persons whose perspectives as individuals also include other perspectives, some unique to themselves and some shared with members of multiple communities to which they belong."[24]

One way to look at an idea or ideal of community can be expressed well when this idea(l) is set in contrast to a mere gathering of individuals. The individual members in a social gathering may work toward their own ends that, by either chance or external construction of the situation, may or may not fit well with the ends of others in the group. The co-workers (nurses, specialists, and subspecialists) in a hospital, for instance, can easily find themselves members of a "mere" social gathering in their daily activities to the extent that their activities are routinized and their pursuit of ends is limited to their individual tasks. These bonds are strengthened to form a community, however, when individuals become aware of the ends of others, take others' ends as common and shared, and recognize that satisfying the interests of others in the community is of value to themselves.[25] Members of a community, while attempting to fulfill their own interests, communicate with each other, taking note of others' desires and regulating their activities to the mutual fulfillment of common ends. This awareness of mutually fulfilling interests manifests itself as shared experiences—that is, through a sharing of activities that forges a common perspective. I would venture to say that this is precisely what happens in a well-run emergency room, staffed by professionals who know and trust each other. As a flurry of activity arises, all participants in the care of an emergent patient, though given particular roles (attending, lead, nursing support, etc.) are encouraged to view their activities not simply from a narrow personal perspective but from the shared perspective of affecting a good final goal—the best care for this particular patient.

Individuals are not over-and-against society but are only fully integrated beings when part of a community that helps to shape and mold who they are and further provides outlets for action. This is what Dewey calls a "new individualism," which is "marked by *consensus with others* . . . [and] sociability . . . [as] cooperation in all regular human associations."[26] As Kuczewski importantly reminds us, however, "Consensus is not unanimity. It does not mean that every person in the field agrees on every point."[27] For some 30 years, professional bioethicists have been communicating with each other, with medical personnel, and with patients, and through these activities, common ground has been formed. Even if only in the most minimal and general ways, enough consensus exists (illness and suffering are generally bad, health is generally good, medical interventions should not worsen matters, doctors should not mislead patients, etc.) to form a certain kind of community that, by being formed, is itself the basis for attempts at further consensus—namely, consensus about bioethical issues that we have been avoiding the harder work of developing.

However, if both Dewey and Kuczewski are correct, I would argue, what "consensus" does mean cannot best be understood in ontological terms. That is, consensus is not a thing to be achieved. It is, instead, a continuum of process and outcome known as intelligent inquiry. As Jonathan Moreno explains, a development and an awareness of consensus is sought whenever we confront problematic situations that call for resolution. In particular, consensus is the *process* of communal inquiry into problematic situations to determine a particular solution, as well as the *outcome* of just such a communal inquiry.[28] Moreno's is a functional definition of consensus marked by participation in inquiry that works toward solving problematic situations. What we need to recognize, then, is that what we commonly call "consensus" is merely the end of a process of inquiry marked by participation in a community of inquirers. Not just any communal activity will do, for surely some inquiries are unsuccessful (on these terms) of reaching consensus (as we commonly understand such a term). However, consensus understood in this functional definition marries the means of inquiry with the ends achieved in and through inquiry.

This functional and naturalistic account is well stated by the "physiological" definition of "consensus" found in the Oxford Universal Dictionary—that is, "General accord of different organs of the body [read: 'individuals in a community'] in effecting a given purpose."[29] In this way we see that though there should be "accord" among several individuals, this accord must have an effect; through the process of inquiry, accord arises *purposefully*, producing an outcome. This infusion of purpose, and coordinately process, into our discussion of consensus enables us to dispense with questions like "How many individuals within a given community must agree in order to say consensus has occurred?" Instead, we can ask, "What function is served by any particular inquiry, and does it arise as a process of general accord developed to effect a given purpose?" Clearly, this take on consensus places inquiry itself centrally into the discussion.

Historically, it is important to note, though, that inquiry and problem solving have often been seen in a formal light—that is, they are taken as mechanical and routine, following specific, repeatable steps—and in particular, *ethical* investigation has also been described as the application of imperatives or principles, the following of rules and order. But in fact, much imaginative activity is involved that is simply not captured by mechanical accounts of intelligence. Moral deliberation in practice is not and cannot be rote application of principles and rules; it must be creatively flexible and adaptive.

As Steve Fesmire argues, moral rationality is best understood through Dewey's concept of dramatic rehearsal. Fesmire emphasizes Dewey's focus on

> our capacity for *imagination*. Imagination, like *drama*, is story-structured and is spurred by conflicts and contrasts among characters and contingent events. . . . Rather than being a lyric outburst, imagination (and thus the aesthetic) is constrained and guided by the exigencies and pressures of a situation along with our vast array of internalized *social habits*. (pp. 569–70)[30]

That is, the imagination has a *moral* function. This "story-structured" capacity "guided by" environmental pressures, cultural institutions, and social habits is part and parcel of deliberation when choosing a particular path to follow. "For deliberation to be brought to a dramatic resolution, it must develop so as to have a form that expresses coherently the conflicts that originally set the problem of inquiry."[31] Moral deliberation, thus, starts from particular problems in order to develop a coherent story. Specifically, particular problems are characterized by conflict with existent conditions. Moral deliberation through imagination works, in part, to develop a coherent story (or "narrative") that adequately "expresses" the conflicts that characterize the particular problem to be solved. And here, it might be best to understand, for moral purposes, the term "coherence" in a particular way.

In William James's essay "The Moral Philosopher and the Moral Life," the moral philosopher is anyone who attempts to bring about a coherent moral universe—that is, a world in which we recognize the connection of our desires with those of others to fashion a common moral viewpoint. Deliberation by the moral philosopher must attempt to *create* a narrative that includes as many concrete interests as possible. James states succinctly, "*Invent some manner* of realizing your own ideals which will also satisfy the alien demands—that and only that is the path to peace" (p. 623).[32] In other words, the narrative of the "moral philosopher" should include disparate narratives of his or her own *and* others in its own account. Fesmire, in turn, tells us that this is best done by setting ourselves in the place of the other:

> [A] . . . "complete" dramatic rehearsal strives to weave the interests and purposes of ourselves and others into an integrated and enduring tapestry. Hence, not only must we forecast consequences for ourselves, but also, as Mead observes, we must (and do) dramatically play the role of others whose lives interlace with our own. We must imaginatively project ourselves into the emerging dramas of *their* lives to discover how their life-stories or "narrative" may be meaningfully continued alongside our own. Immoral conduct is thus not merely a deficiency in one's capacity to follow moral laws or rules. Much more than this, immorality stems from a scarcity of moral imagination and a failure in moral artistry.[33]

Dewey's dramatic rehearsal in imagination, which leads to Fesmire's account of moral artistry through the weaving of Jamesian-style coherent narratives that take the other in his/her desires seriously, demands a great deal of work. *Moral activity is not easy*. The moral artist never merely attempts to apply abstract rules or principles; he or she learns to view problems through communally consensus-driven intelligence that creatively and dramatically rehearses possible solutions to problematic situations at hand, adjusting desires and the situation in order to develop a story that takes the other seriously. "Deliberation is not a mathematical utilitarian calculation, nor is it a Kantian determinate judgment; it has a dramatic *story to tell*."[34]

And so we return to Kuczewski's insight about a consensus on methods in bioethics, for through a sociology of bioethical practice, we see that bioethicists, at least, use methods of narrative construction and reconstruction of situations and experiences of actual persons (patients, physicians, etc.) to understand a given situation and to project into the future where we see these stories "going from here." This, it would seem, is the process of imagination itself. Thus, by looking at what bioethicists do in their daily pursuits as bioethicists, we see that those practices are the deliberations of morally imaginative individuals who are told and tell stories about what is happening in bioethics and public policy as well as in medicine and at the bedside. No matter the theory carried around or professed—be it principlism, casuistry, or other—the actions of bioethics do show consensus in *method*, and this method is captured, if not always agreeably, in the arena of what has been called "narrative ethics."

Since its introduction by thinkers like MacIntyre, Hauerwas, Charon, and others, narrative ethics has attempted to supplant traditional, Western moral theories and a principle-based ethic, which has both arisen from them and governed much of bioethics since the late 1970s. Using many different, and sometimes differing, approaches, narrative ethicists have attempted to analyze moral activity using the vocabulary and tools of literary analysis and narrative construction. At the same time, because of concerns about "authorship" and interpretation of storytelling and story-hearing (or reading), narrative ethics has had to fend off accusations of philosophy without substance, gross subjectivity, and rampant relativism. That is, narrative ethics has been accused of practices antithetical to consensus itself.

However, when narrative ethicists take even more seriously and develop even more thoroughly the implications of their own insights—namely, an overthrow of Enlightenment individualism based on a mythical dichotomy between subjects and objects, atomic selves and communities—they will be more at ease with charges of relativism, subjectivism, and voluntarism, because these charges themselves arise from a modernist worldview that narrative ethics itself rejects. If it does nothing else, narrative ethics shows selves to be socially situated, not fundamentally atomic, and as such, narratives are never wholly subjective nor mythically objective; instead they are novel constructs of social beings—*neither* without perspective *nor* without grounding in a culture or community. Though they are told by some particular person(s), stories and their "authors" demonstrate their own de facto grounding within cultures and institutions. We can see that narratives themselves *must* be relative to the situations, institutions, communities, and cultures in which they are developed because narratives start not with theory, principles, or rules but in particular experiences and contexts.

Furthermore, and most importantly for the purpose of our discussion here, it is *this very process of narrative construction and interpretation that is the process of moral deliberation itself and, therefore, of our functional understanding of consensus*. Thus, bioethicists need not "aim" at consensus at all so long as their practices are the practices of moral deliberators; consensus is there, not as "general agreement" but as participatory, inclusionary inquiry into problematic situations. Whether among themselves through scholarly journals and professional conferences, or with medical personnel and patients "at the bedside," the most important consensus is that which is functional to the moral inquiry of the community at the time. What the activity of bioethicists shows is that bioethics is primarily aimed at developing a responsible and responsive community of deliberation.[35]

So when we ask ourselves not, What *is* bioethics?, but instead, What do bioethicists *do*?, we can answer the three questions that started this paper: Why would my "learned opinion" not count as an acceptable answer? Should bioethicists strive for consensus among themselves? And if so, how would we get there, and what would it even look like? The youth of our discipline and the misunderstanding of our roles and functions lead to the misguided impression that any one individual is (in)capable of professing an acceptable bioethical position. Bioethics is not immediately in the business of giving "answers" to bioethical questions—bioethicists are not self-help gurus for the medical profession. Bioethics *is*, however, the attempt to think clearly and deliberate well about important questions in medicine and beyond, and when we look at what moral deliberation consists of, we discover that any bioethicist who sincerely and rigorously inquires into bioethically problematic situations is in the process of consensus itself, developing anew (though situated in a history and current context) the best solution possible. This process does not and cannot guarantee universal agreement, but when imaginatively pursued with "moral artistry," bioethics is narrative consensus.

Notes

1. Peter Caws lists a representative sampling of articles on the concept of consensus in: Committees and consensus: how many heads are better than one? *Journal of Medicine and Philosophy* 1991;16(4):375–91.
2. Rawls J. *A Theory of Justice*. Cambridge, Mass.: Harvard University Press, 1971. A revised edition came out in 1999.
3. Rawls J. *Political Liberalism*. New York: Columbia University Press, 1996.
4. This notion is in line with our colloquial (if rather weak) sense of the term "consensus" as "agreement in opinion" (*Oxford Universal Dictionary*, 1955:374).
5. Engelhardt HT Jr. *The Foundations of Bioethics*. New York: Oxford University Press, 1986. A second edition came out in 1996.
6. This distinction has been criticized by many over the years—see, among others, Loewy E. *Moral Strangers, Moral Acquaintance, and Moral Friends: Connectedness and Its Conditions*. Albany: State University of New York Press, 1997. Strong C. Is there no common morality? *Medical Humanities Review* 1997;11(1):39–45. Wildes KW SJ. *Moral Acquaintances: Methodology in Bioethics*. South Bend, Ind.: University of Notre Dame Press, 2000.
7. *Journal of Medicine and Philosophy* 1991;16(4).
8. Moreno J. Ethics by committee: the moral authority of consensus. *Journal of Medicine and Philosophy* 1988;13(4):411–32.
9. ten Have HAMJ, Sass H-M, Introduction. In: ten Have HAMJ, Sass H-M, eds. *Consensus Formation in Health Care Ethics*. Dordrecht: Kluwer, 1998. This collection contains essays based

on papers originally given 8 years earlier at the Fourth Annual Meeting of the European Society for Philosophy of Medicine and Healthcare (1990).

10. Tong R. The epistemology and ethics of consensus: uses and misuses of “ethical” expertise. *Journal of Medicine and Philosophy* 1991;16(4):407–26.
11. Veatch R. Consensus of expertise: The role of consensus of experts in formulating public policy and estimating facts. *Journal of Medicine and Philosophy* 1991;16(4):427–45.
12. ten Have HAMJ, Sass H-M, eds. *Consensus Formation in Health Care Ethics*. Dordrecht: Kluwer, 1998.
13. Even a book as recently published as Wildes's *Moral Acquaintances* states quite early on, “Bioethics is a relatively ‘new’ field . . .” (See note 6, Wildes 2000:1).
14. Kuczewski M. Bioethics' consensus on method: who could ask for anything more? In: Nelson HL, ed. *Stories and Their Limits*. New York: Routledge, 1997:137–9.
15. This is, of course, a “high level” observation about practice that may unnecessarily obscure the fact that the details of any particular bioethicist's work will vary greatly from another's. To say that what bioethicists do is “pretty homogeneous” is not to say that there is not a plurality of differences in the specific features of any particular case, just as to say that what authors do is, basically, to write literature, is not to say that Austen is not importantly different from Joyce or Vonnegut from Morrison.
16. Dewey J. *Democracy and Education*. New York: The Free Press, 1916:5.
17. Buchler J. *Towards a General Theory of Human Judgment*. New York: Dover, 1979:29–57.
18. Mead GH. Mind, self, and society. In: Morris CW, ed. Chicago: University of Chicago Press, 1962.
19. As Dewey puts it:

> [E]very individual is in his own way unique. Each one experiences life from a different angle than anybody else, and consequently has something distinctive to give others. . . . Each individual . . . is a new beginning; the universe itself is, as it were, taking a fresh start in him and trying to do something, even if on a small scale, that it has never done before.

Dewey J. *Construction and Criticism*. New York: Columbia University Press, 1930:1.

20. MacIntyre A. *After Virtue*, 2nd ed. South Bend, Ind.: University of Notre Dame Press, 1984.
21. Sandel M. *Democracy's Discontent*. Cambridge, Mass.: Harvard University Press, 1996.
22. That is, they cannot unless we hypothesize one more rather pessimistic existential “fact,” the “fact” of deep conflict within the human condition, a conflict never to be resolved.
23. Hester DM. *Community As Healing: Pragmatist Ethics in Medical Encounters*. Lanham, Md.: Rowman & Littlefield, 2001.
24. Singer B. *Pragmatism, Rights, and Democracy*. New York: Fordham University Press, 1999:83.
25. Dewey uses the following analogy to express his ideal of community:

> The parts of a machine work with a maximum of cooperativeness for a common result, but they do not form a community. If, however, they were all cognizant of the common end and all interested in it so that they regulate their specific activity in view of it, then they would form a community.

See note 16, Dewey 1916:5.

26. Dewey J. *Individualism, Old and New*. New York: Capricorn Books, 1930:89–90 [emphasis added].
27. Kuczewski M. Bioethics' consensus on method: who could ask for anything more? In: Nelson HL, ed. *Stories and Their Limits*. London: Routledge, 1997:135.
28. Moreno J. *Deciding Together: Bioethics and Moral Consensus*. New York: Oxford University Press, 1995:113–7.
29. *Oxford Universal Dictionary*. New York: Oxford University Press, 1955:374.
30. Fesmire SA. Dramatic rehearsal and the moral artist: A Deweyan theory of moral understanding. *Transactions of the Charles S. Peirce Society* 1995;21:568–97.
31. See note 30, Fesmire 1995:570.
32. James W. The moral philosopher and the moral life. In: McDermott JJ, ed. *The Writings of William James*. Chicago: University of Chicago Press, 1977:610–29.
33. See note 30, Fesmire 1995:571.
34. See note 30, Fesmire 1995:574 [emphasis added].
35. This quite apropos phrase, “responsible and responsive community of deliberation,” comes from Robert Talisse in conversations with him concerning this paper.