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https://doi.org/10.1017/S0963180102101034 Published online by Cambridge University Press

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

Consensus Formation: The Creation of an Ideology

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Consensus: The Strategic Ambiguities

Bioethics is not merely a theoretical discipline but a practice as well. Indeed, bioethics is a sort of moral trade. Bioethicists serve on ethics committees, give expert testimony to courts, provide guidance for healthcare policy, and receive payment for these services.[1] The difficulty is that their role as experts able to guide clinical choice and public policy formation is brought into question by the diversity of moral understandings regarding central moral issues at the heart of the culture wars in healthcare. The disconfirmation of the expert role of bioethicists by their apparent actual role as partisans of particular moral schools and perspectives could be set aside, were there an avenue to moral consensus, a door to a common moral vision to guide this new profession of moral experts. This brief article addresses the hunger for consensus in bioethics, its impossibility with respect to the controversial issues that mark the field, and the inclination nevertheless to deny this manifest diversity by appeals to a consensus that could allow bioethicists to function as ethics experts able substantively to guide clinical choices and public policy.

Secular Bioethics and the Search for Consensus

Understanding the role of consensus in bioethics requires first understanding the origins and nature of secular bioethics, for which consensus is not only of theoretical but also of public-policy significance. This area of scholarship and practice developed under the rubric "bioethics" scarcely three decades ago. It emerged against the background of significant social and moral changes in American society, as well as elsewhere in the world. Just as healthcare and the biomedical sciences came to command a significant portion of the gross domestic product (7.6% in 1970[2]), to engender policy and moral challenges due to the increased safety and ease of established but ethically controversial medical interventions (e.g., abortion), and to pose seemingly novel moral questions due to new technologies (e.g., organ transplantation), the usual or customary sources of moral authority were brought into question. Just as healthcare had more power than ever, there was less of an understanding of how to use it.

The result was a moral vacuum produced by the marginalization of two traditional sources of medical moral guidance and authority. First, the profession of medicine, which had in great measure entered the twentieth century as

Cambridge Quarterly of Healthcare Ethics (2002), **11**, 7–16. Printed in the USA.
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https://doi.org/10.1017/S0963180102101034 Published online by Cambridge University Press

a self-confident guild, was recast by American constitutional legal holdings into a trade forbidden to impose its own canons of deportment, if these were in restraint of trade.[3] An epiphany of this transformation of medicine into a trade was the prohibition of organized medicine from controlling the character of advertisements by its members.[4] The society of physicians ceased to be able to regulate itself as a quasi-independent community of self-governing experts within a larger society. The result was that organized medicine (i.e., the American Medical Association) came to claim less than half of the registered physicians in the United States as its members (data supplied by the American Medical Association headquarters on March 28, 2001). Moreover, organized medicine came to be regarded by many as representing a particular economic interest group.

Between the physician and the patient there entered numerous powerful third parties. These included employers who now increasingly paid the funds for patient care to fiduciaries that came to engage managers to oversee patient care. The relationship of physician and patient was radically transformed from a dyad to a complex interrelationship among numerous parties. Governmental regulations began encompassingly to frame the character of the physician/patient relationship. The result is that medicine has ceased to be a self-regulating profession in the sense of being in authority to develop its own norms and then impose them on its members. As restraints were placed on the self-governance of physicians, the legitimacy of internal norms for guiding healthcare choices was itself brought into question. This change was further underscored as physicians became one member among others of the healthcare team. These shifts deconstructed the privileged moral status of physicians in directing healthcare. As the independence of medical ethics was deconstructed, there arose the need for a canonical medical morality and a new cadre of medical moral experts.

This need was made more acute by a second, profound cultural change in the morality of the West: the secularization of the Western culture. In the latter half of the twentieth century, in particular the latter third, America and most of the West, which had been de facto if not de jure Christian societies, were rendered post-Christian, secular polities.[5] This transformation constituted a cultural revolution in the United States, whose general moral sentiments had reflected the moral views of established Protestant Christianity. The metaphysical foundations that supported the traditional views that had guided healthcare in the West were politically delegitimated as a basis for healthcare policy. As a result, traditional moral commitments regarding reproduction, dying, and death were brought into question, as for instance with respect to abortion, artificial insemination by donors, and the use of physician-assisted suicide. The decision of the American Supreme Court in *Roe v. Wade* marked this change.[6] The traditional moral culture for medicine had lost its foundations, and a new one required articulation.

Just as healthcare and the biomedical sciences became effective, costly, and productive of moral public policy and legal controversies, it was unclear which morality should direct healthcare and the biomedical sciences. One could no longer uncontroversially draw on either physicians or religious moralists for direction. A cleft was opening, separating traditional professional and religious moralities from the emerging posttraditional liberal cosmopolitan moral vision. One needed a source of moral guidance accessible to all those outside of

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particular professional and religious commitments. Secular bioethics gained prominence through the promise of supplying this guidance. In great measure, bioethics developed by reaffirming the Enlightenment promise to establish a non–religiously based common morality. Secular bioethics drew on the aspiration to ground this morality in a discursive rational account of appropriate behavior, to give rational authority to public policy, and to disclose that all persons are members of one moral community united in those moral commitments to which rational individuals should accede. A moral consensus could then be promised as that set of moral commitments to which rational analysis and sound rational argument should lead.

The challenge was then to articulate that moral vision so as to guide clinical choice and healthcare policy formation. Because of the need for such guidance, there was a cultural demand for moral practitioners, persons in authority to provide moral guidance for healthcare decisions. The result was the *novum* of ethicists functioning not simply as individuals who (1) analyze concepts, (2) assess the coherence of arguments, and (3) lay out the geography of possible moral approaches, as well as (4) at times frankly give moral instruction. Additionally, (5) the new ethicists or bioethicists came to be regarded as being in sociopolitical authority to guide clinical public-policy choices. Bioethicists or ethicists assumed a sociopolitical authority that placed them as experts before courts and guides for clinical and public-policy decisionmaking. The social authority of these moral experts was embedded in the imputation of an ability to disclose the morality that rational persons should embrace. That is, their sociopolitical authority presupposed the possibility of disclosing a consensus in the strong sense of that set of moral commitments that rational and unbiased persons should embrace.[7]

Given a commitment to the possibility of providing a canonical moral vision on the basis of sound rational argument, and out of the assumption that secular bioethics should be united through sound rational analysis and argument in one moral vision over against the diversity of religious moral understandings, it was natural to assume that there should and would be a consensus or agreement regarding the existence and nature of one common morality—a morality that ought to be articulable by careful analysis and conceptual exploration. After all, the possibility of such consensus lay at the roots of the plausibility of bioethicists being experts regarding a common moral reality. These aspirations to consensus to the contrary notwithstanding, the diversity of secular moral, not to mention religious moral, visions regarding the moral propriety of abortion, third-party-assisted reproduction, cloning, germline genetic engineering, physician-assisted suicide, and euthanasia has remained substantial. Additionally, foundational disagreements regarding the nature of justice in healthcare have not disappeared. Indeed, bioethics has been confronted by the unpleasant reality that the diversity of moral viewpoints reflects itself in the diversity of political approaches to these important moral concerns. As a result, different moral positions have political force.

In this sense, morality has become politics. For example, one might consider the diversity of moral perspectives in the year 2000 American presidential election in order to appreciate the depth of the disagreements regarding the proper structure of healthcare and the difficulty of resolving these important moral controversies. This moral diversity is expressed in the bioethical battles of the culture wars, as was underscored in the clash of moral perspectives

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between Senator Edward Kennedy of Massachusetts and Attorney General John Ashcroft. One need only envisage how different the moral advice of a National Bioethics Advisory Committee would be, depending on whether the members were chosen by Senator Kennedy or Attorney General Ashcroft. Instead of disclosing a single canonical secular notion of morality, moral reflection and bioethics have been beset by numerous competing moral rationalities. The Enlightenment hope of secular bioethics has gone aground on the postmodern recognition of competing moral narratives and accounts, among which choice in a principled fashion has not proved possible without begging the question of which moral vision should give guidance.[8] The question has then become whose moral consensus should be recognized as the moral consensus to guide public policy.

Despite the diversity of views regarding abortion, euthanasia, and justice in healthcare, the now-established profession of bioethicist has nevertheless hoped to disclose a single canonical background moral consensus. To justify the role of bioethicists as non–politically partisan moral experts, it became necessary to find some device to transcend the manifest moral diversity of secular bioethics. In the absence of an underlying consensus establishing a particular moral vision, the significance of engaging bioethical experts could be brought into question. The engagement of bioethics would have to be recognized as a dimension of political activity. Which is to say, to receive the bioethical advice needed to endorse a particular political activity, policy, or agenda, one need only pick bioethicists with the appropriate moral commitments to come to the wished-for consensus. In these circumstances, the constitution of a guiding bioethical perspective or consensus was destined to take on the character of morally authorizing a particular political agenda.

The partisan character of bioethical expertise tended to be obscured, given the general secular aspirations of bioethics. In the past, demands by physicians on behalf of their own medical ethics would have been regarded, at least on the part of some, as special pleadings. So, too, the requirements of religious, especially nonmainline Protestant, groups on behalf of their medical moral insights would have been easily recognized as sectarian. In contrast, the hope on the part of many is that bioethics could speak in the voice of secular morality and that it could thus offer an ethical lingua franca for a posttraditional world. If that voice could have found unity, it could then have directed public action with an unchallenged secular authority. It is for this reason that the search for consensus could take on such urgency. Medical morality has become medical politics.

The Concept of Consensus

The English term "consensus" identifies an "agreement in opinion: the collective unanimous opinion of a number of persons."[9] It derives from the Latin *consensus*, which forms the fourth part of the verb *consentio*, to feel together, to agree, or to unite in a common purpose. In the Latin as in the English, consensus carries with it the notion of unanimous consent. The difficulty is that in bioethics there is no unanimous consent regarding most if any bioethical issues. Indeed, the partisans of different views of the moral appropriateness of different policies regarding abortion, third-party-assisted suicide, the allocation of resources in healthcare, and physician-assisted suicide are separated not

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simply by the different behaviors they would affirm. They are separated by different rankings of human goods, understandings of right-making principles, as well as their ordering, not to mention different understandings of moral evidence and of the deep metaphysical significance and meaning of existence (e.g., whether there is a God and immortality). Bioethicists are divided by different understandings of what our common morality ought to be and of the bioethics it should affirm. The hope for a unified, common, content-full lingua franca proved vain.

The controversial character of secular bioethics goes to its roots. As Kant recognizes in his "as-if" invocations of God and immortality, it has not proven easy to disarticulate Western morality from its roots in Western Christianity.[10] Once morality is no longer grounded in God—that is, in the very ground of being itself—one can rationally ask questions that admit of no uncontroversial resolution. Even the general rationality of assuming and acting from the moral point of view can be brought into question when the costs to oneself and to one's loved ones is considerable. Moreover, given the disputes regarding initial moral premises that separate competing moral accounts, the content of the moral point of view itself is controversial, as is disclosed for example in the debates among utilitarians, Kantians, and so on. When morality is not rooted in the very ground of being itself, an irresolvable tension develops between the right and the good, as well as between the justification for a moral perspective and the motivation to act on it.[11] To hope for a foundational accord among competing possible moral rationalities represents an illegitimate projection of the metaphysical aspirations of the Christian morality that once framed Europe's moral hopes onto the actual possibilities for a secular morality. That is, aspirations that were legitimate within a theocentric understanding of morality involve a category mistake if transferred to considerations of secular morality.

The expectation that a supporting consensus establishes the truth of a particular moral account may also be a relic of a Christian understanding transposed to a secular context. Traditional Christianity identifies those beliefs as authentically Christian which have been affirmed everywhere, always, and by all. This criterion of the consensus of universality and antiquity was expressed in St. Vincent of Lerins' († ca. 450) famous dictum that the Christian Church follows the rule that:

> We confess that one faith to be true which the whole Church through out the world confesses; antiquity, if we in no wise depart from those interpretations which it is manifest were notoriously held by our holy ancestors and fathers; consent, in like manner, if in antiquity itself we adhere to the consentient definitions and determinations of all, or at the least of almost all priests and doctors.[12]

Given St. Vincent's religious and metaphysical understandings, he could know that such a consensus was not simply an accident of history, but the result of the direct action of the Holy Spirit. This presumption cannot be made on behalf of a secular consensus. If a foundational, sound rational argument cannot be given to establish the canonical status of a particular moral vision, then the question must be whether any seeming agreement or consensus reflects anything more than a passing historical fad, an established political correctness, or regnant ideology. In short, the search for a consensus and the view that it should carry moral weight may at least in part be one of the many relics from

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the Western Christian past that have been carried over inadvertently into contemporary Western secular moral reflection. To appreciate the full significance of this search, it is important to attend to the multiple meanings of consensus.

Consensus in the Face of Postmodernity

Appeals to consensus in politics and in the framing of theoretical as well as applied scientific understandings of empirical reality have a quite different character from appeals to consensus in bioethics. In the first three instances, there is a search for authorization through permission, a procedure to check majority power, or a political power likely to prove decisive, the views of political minorities to the contrary notwithstanding. In the case of scientific and medical consensus conferences, there is a search for a workable understanding among scientists, physicians, public health educators, or others, when they are involved in a practical, albeit nonmoral project. A conclusion is reached that presupposes the reliability of antecedent data as well as the concession of crucial *ceteris paribus* conditions and notions of success. Also, in none of the foregoing is there an appeal to consensus as the disclosure of a morally normative account. However, in the case of a search for consensus in bioethics, such a morally normative account is sought as the basis for clinical and public policy without acknowledging that the consensus depends on first granting the canonical character of an initial moral vision or point of departure.

Consensus as Unanimous Consent

In the face of intractable disputes concerning the nature of moral rationality, common moral authority can nevertheless be drawn from the agreement of those who freely join together in an endeavor. Despite foundational moral disagreements, persons can agree in limited areas to collaborate. In the absence of a common theoretical and substantive understanding of morality, the authority for what is done by collaboration can be regarded as drawn from the permission of those who use others only given their concurrence. This permission-based source for moral authority does not appeal to any particular ranking of goods or of right-making principles. Instead, by default, the moral standing of choices lies solely in the concurrence of the collaborators. Given the moral diversity of contemporary societies, such procedural means for resolving moral controversies tend to be very salient and successful expedients that in great measure provide the moral authority of many physician/patient interactions, advance directives, and market transactions.

Consensus as an Authorizing Majority

To protect political minorities against the majority's easy tyranny, political procedures can be established, requiring a widespread but not unanimous agreement or consensus in matters political. For example, all federal laws in the United States require for their authorization the concurrence of the House, the Senate, and the President. Because the Senate does not represent the population of the United States, but is based on an equal representation of each of the 50 states, it serves as a brake on a majority's ability to pass legislation. Even

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further barriers are erected through the requirement of an even more widespread consensus to make amendments to the Constitution: an amendment can be secured by a two-thirds majority of both the House and the Senate, followed by an agreement of three-fourths of the states. The requirement of a widespread consensus can provide protection against rapid alterations in original legal and constitutional structures.

Consensus as Rhetorical Power

Disagreement in the face of vociferous opposition takes courage. To be a member of a political minority is to be at risk of being labeled as an extremist whose views are marginal and representative of a fringe group. As a consequence, a strategy of Realpolitik is to assemble a coalition sufficient to quell minority opposition through the rhetorical intimidation that comes from finding oneself at the periphery of a society's established spectrum of opinion. In particular, in the face of widespread approval for the "consensus" political view, dissenters can be characterized as holding views deviant from those the majority will describe as rational and well informed. However disagreeable such rhetoric of the mainstream against the politically deviant may be, it is integral to the discourse of politics.

Consensus as a Mark of the Truth: The Epistemology of Practical Knowledge

Unlike consensus as the source of moral authority, as a safeguard against majority tyranny, or as a rhetorical resource in Realpolitik, consensus can be invoked by scientists as a mark in favor of the truth of empirical claims. Given that empirical reality is explored through repeated experiments and observations, an increase in the number of observations in accord with a particular empirical account can convey a strengthened confirmation to its truth, Karl Popper to the contrary notwithstanding.[13] The more widely that predictions of a scientific claim are confirmed, the more it is compatible with all that one could know that this particular empirical claim is true. This approach to the ascertainment of scientific consensus either with regard to theoretical issues or practical interventions (e.g., standards of medical treatment) does not exclude the possibility that further research will disconfirm the propositions currently sustained by the scientific or medical consensus. Moreover, the product of most consensus conferences and consensus statements is a useful guide to prudent action rather than a declaration of enduring truth.[14] The usual focus of consensus conferences is on useful interventions set within taken-for-granted *ceteris paribus* conditions regarding the character of empirical knowledge and widely accepted standards concerning what should count as successful interventions. They require conceding in advance a common empirical experience of the matters at hand.

The consensus of scientists as a mark in favor of the truth of an empirical proposition does not have an analogue in moral reflection, because foundational moral disagreements turn on different rankings of the good and of right-making principles. Depending on the foundational moral account, the character of moral reality will appear irreformably different. It is not just that, as in empirical science, the paradigm of the scientist shapes the experience of the phenomenal world. Additionally, moral experience does not have a ready

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analogue to the costs imposed by external empirical reality more heavily on some rather than on other accounts, thus directing empirical knowledge claims. Moral accounts, unlike scientific accounts, are not constrained by the discipline of an external empirical reality that makes particular accounts cumbersome or more burdensome to support. As a result, diverse moral accounts easily persist for centuries as competing paradigms or moral visions. There is no neutral moral reality to which discursive reason can turn to help resolve the controversies at hand, as occurs in empirical science by appeals to tensions between particular empirical accounts and the reality confronted. Given the foundational moral disagreements at stake and the absence of a surd reality against which conjectures must be tested, *ceteris paribus* conditions cannot be established that could lead to a moral consensus statement regarding the morally controversial issues of bioethics without conceding at the outset that which is in controversy.

Consensus as the Creation of an Ideology

Intractable controversy defines contemporary morality. Even if one were to grant common understandings of human values but rank them in different orders, one would have different understandings of the moral consequences of policies, as well as a different moral sense to guide hypothetical contractors, or rational decisionmakers. An appeal to a disinterested moral observer will not bring instruction regarding appropriate action. One must first fit out that observer with a particular moral sense, vision of the good, or understanding of justice. Appeals to intuitions can be met with appeals contrary to intuitions. Any understanding of the proper balancing of moral claims can be met by a contrary understanding of how appropriately to set the balance. Parties to a foundational controversy in bioethics can only come to a resolution by sound rational argument if all first grant the foundational moral assumptions needed for the conclusions they wish to embrace. Given the foundational roots of intractable moral diversity, it should not be unanticipated that disputes persist regarding the moral probity of genetic engineering, the allocation of healthcare resources, and euthanasia.[15]

Given the contentious diversity of bioethical views and the foundational grounds for doubt regarding the possibility of resolving the cardinal controversies of bioethics by sound rational argument, one might wonder not only about the credibility of any claim to consensus but even about the motivation for the persistent search for consensus. One would think that the energies directed to the pursuit of consensus would be better deployed in the search for better ways of taking moral diversity seriously, were it not for the important political and personal gains to be derived from acting as if consensus were achievable. Consensus is alluring because a consensus would offer a basis in terms of which bioethicists can act as conceptive ideologues so as to aid rulers in guiding healthcare policy. Only if diversity can be denied through a consensus can the role of moral experts be taken seriously in a secular pluralist culture. Only then can bioethicists command the authority to require as a matter of uncontroversial morality the realization of their favored political agendas. Given the authority of a moral consensus, bioethicists could then through their moral endorsement of particular political programs aid those politicians sympathetic to their agendas.

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The phenomenon of the persistent search for consensus in bioethics can thus be explained in terms of its usefulness as an instrument to convey authority to bioethicists as moral experts, whose moral recommendations can then in turn guide not only moral discourse but public policy. Despite obvious and persistent moral diversity, the plausibility of the search for consensus will be reinforced by the experience of consensus by persons of like moral and political viewpoints when they approach bioethical controversies. They will recognize a concord in their common commitments, even if it is not shared with persons of different moral understandings. The social phenomenon by which people of common political and ideological commitments tend to associate with others of like commitments may for many obscure the depth of real moral differences as they contemplate how to bring their moral sentiments to structure the political and social world around them. If they serve on bioethics committees, they are likely to find themselves with persons of like mind, for no one with a practical disposition would appoint individuals with radically different commitments to serve on an advisory board. The logic of prudent administration argues against true moral diversity of such bodies. Moreover, as the field of bioethics was taking shape, it was greatly influenced by a volume authored by a rule utilitarian and a deontologist who, despite their theoretical differences, were able to craft middle-level principles through which they could come to common resolution of controversial cases.[16] No one seemed to notice that they had begun from a common moral vision in which the authors shared moral intuitions and political agendas. Their seeming consensus, which transcended their theoretical differences, was a testimony to their ability to reconstruct the same commitments within two different conceptual frameworks, not an indication that a common consensus or common morality was shared by all in the field of bioethics, but only by these authors and their co-ideologists.

The obscuring of moral difference in the search for a consensus despite the fundamental moral diversities that separate us is not merely a conceptual error but a fundamental expression of political power. As Marx and Engels understood a century and a half ago, claims on behalf of a consensus are claims on behalf of the political power for a particular group and its political agendas. This is the truth of Marx and Engels' observation when freed of its particular materialist commitments:

> The ruling ideas are nothing more than the ideal expression of the dominant material relationships, the dominant material relationships grasped as ideas; hence of the relationships which make the one class the ruling one, therefore the ideas of its dominance.[17]

Those who in the face of moral diversity claim the hegemony of one view as that which should constitute the moral consensus can then aspire to employment as moral experts, as "conceptive ideologists, who make the perfecting of the illusion of the class about itself their chief source of livelihood."[18]

Notes

1. For a critical assessment of the role of bioethicists as moral experts, see Wildes KW SJ. Healthy skepticism: the emperor has very few clothes. *Journal of Medicine and Philosophy* 1997;22:365–71,

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and Kipnis K. Confessions of an expert ethics witness. *Journal of Medicine and Philosophy* 1997;22:325–43.
2. Levit KR. National health expenditures, 1984. *Health Care Financing* 1985;7:3.
3. In a number of Supreme Court holdings, medicine came to be recognized as a trade, not a guild. See, for example, *The United States of America, Appellants v. The American Medical Association, A Corporation; The Medical Society of the District of Columbia, A Corporation; et al.*, 317 U.S. 519 (1943).
4. *American Medical Association v. Federal Trade Commission*, 638 F. 2d 443 (2d Cir. 1980).
5. The secularization of American society was achieved by applying the Bill of Rights of the compact styled the Constitution of the United States to the states, thus forbidding their establishment of a religion. See, for example, *Everson v. Board of Education*, 330 U.S. 1 (1947). The result was the disestablishment of Christianity through a number of important Supreme Court holdings. See, for example, *Tessim Zorach v. Andrew G. Clauson et al.*, 343 U.S. 306, 96 L. ed. 954, 72 Sup. Ct. 679 (1951); *Roy R. Torcaso v. Clayton K. Watkins*, 367 U.S. 488, 6 L. ed. 2d 982, 81 Sup. Ct. 1680 (1961); and *School District of Abington Township v. Edward L. Schempp et al., William J. Murray et al. v. John N. Curlett et al.*, 374 U.S. 203, 10 L. ed. 2d 844, 83 Sup. Ct. 1560 (1963). These holdings were finally expressed in Supreme Court decisions that had a radical impact on health law and policy. One might think in particular of the holdings in *Griswold v. Connecticut*, 381 U.S. 479, 85 Sup. Ct. 16787, 14 L. ed. 2d 510 (1965), *Eisenstadt v. Baird*, 405 U.S. 438, 92 Sup. Ct. 1029, 31 L. ed. 2d 349 (1972), and *Roe v. Wade*, 410 U.S. 113 (1973).
6. See note 5, *Roe v. Wade*.
7. Wildes, KW SJ. *Moral Acquaintances*. South Bend, Ind.: University of Notre Dame Press, 2000.
8. Engelhardt, HT Jr. *The Foundations of Bioethics*, 2nd ed. New York: Oxford, 1996.
9. *Oxford English Dictionary*, 1st ed., Vol. 2, 1933:851.
10. The role of Immanuel Kant's as-if God is explored in some detail in: Engelhardt, HT Jr. *The Foundations of Christian Bioethics*. Lisse, Netherlands: Swets & Zeitlinger, 2000:80–90.
11. See note 10, Engelhardt 2000, especially chapter 2.
12. St. Vincent of Lerins. *A Commonitory*, II,4,6. In: Schaff P, Wace H, eds. *Nicene and Post-Nicene Fathers*, 2d series, Vol. 11. Peabody, Mass.: Hendrickson, 1994:132.
13. See, for example, Popper KW. *Conjectures and Refutations*. New York: Harper & Row, 1965, and *The Logic of Scientific Discovery*. New York: Basic Books, 1961.
14. Bakris GL, Williams M, Dworkin L, Elliot WJ, Epstein M, Toto R, et al. Preserving renal function in adults with hypertension and diabetes: a consensus approach. *American Journal of Kidney Diseases* 2000;36:646–61. Boulet LP, Becker A, Bérubé D, Beveridge R, Ernst P. Canadian asthma consensus report. *Canadian Medical Association Journal* 1999;161:S1–61. Petty TL, Casaburi R. Recommendations of the fifth oxygen consensus conference. *Respiratory Care* 2000;45:957–61. Innes G, Murphy M, Nijssen-Jourdan C, Ducharme J, Drummond A. Procedural sedation and analgesia in the emergency department. Canadian Consensus Guidelines. *Journal of Emergency Medicine* 1999;17:145–56.
15. See note 8, Engelhardt 1996, especially chapter 2.
16. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. New York: Oxford, 1979.
17. Marx K, Engels F. *The German Ideology*. New York: International Publishers, 1967:39.
18. See note 17, Marx, Engels 1967:40.

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