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Global Bioethics: taking moral differences seriously[a]

Bioética global: levando a sério as diferenças morais
Bioética global: considerar seriamente las diferencias morales

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ABSTRACT: Moral pluralism defines all actual bioethical and health care policy debates, although claims are made on behalf of moral consensus and the possibility of a global bioethics. This paper brings such aspirations into question by exploring the roots of the foundational disagreements that separate persons and communities within different moralities with different bioethics. As this paper indicates, the claims to consensus can be accounted for in terms of the sociology of bioethical concerns. Bioethics, which was generated out of moral diversity, must now come to terms with the moral pluralism that characterizes all health care policy concerns.

KEYWORDS: Global bioethics. Health care policy. Moral pluralism.

RESUMO: O pluralismo moral define todos os debates bioéticos e das políticas de cuidados médicos, embora tudo se faça apelando ao consenso moral e da possibilidade de uma bioética global. Este artigo põe em questão essas aspirações, explorando as raízes dos desacordos de base que separam pessoas e comunidades no âmbito de diferentes moralidades dotadas de diferentes bioéticas. Como o indica o artigo, os apelos ao consenso podem ser explicados nos termos da Sociologia das preocupações bioéticas. A bioética, que se desenvolveu a partir da diversidade moral, deve agora chegar a um acordo com o pluralismo moral que caracteriza todas as preocupações de política de cuidados médicos.

PALAVRAS-CHAVE: Bioética global. Cuidados médicos-políticas. Pluralismo moral.

RESUMEN: El pluralismo moral define todas las discusiones bioéticas y de la política de los cuidados médicos, aunque todos remitan al consenso moral y a la posibilidad de una bioética global. Este artículo cuestiona esas aspiraciones explorando las raíces de los desacuerdos fundacionales que separan a personas y a comunidades dentro de diversas moralidades con diversas bioéticas. Como el artículo lo indica, remitir al consenso se puede explicar en términos de la sociología de las preocupaciones bioéticas. La bioética, que fue generada desde la diversidad moral, debe ahora se entender con el pluralismo moral que caracteriza todas las preocupaciones de políticas de cuidado médico.

PALABRAS LLAVE: Bioética global. Cuidado médico-políticas. Pluralismo moral.

I. TAKING MORAL DIFFERENCES SERIOUSLY

Moral diversity defines the human condition. Because we do not have a common pretheoretical morality, much less one account of morality, bioethics is articulated in controversy and in contention. The goal in this paper is to assess this state of affairs. The essay begins by giving an account of the geography of moral pluralism, which shapes contemporary bioethics, as well as why this diversity is denied and instead consensus asserted. It then addresses how the genesis and development of bioethics was tied to, and produced by, this diversity, so that bioethics cannot deliver on some of the core promises it made. Our contemporary cultural context is marked by substantive, secular, moral disagreements not just by controversies separating secular and religious moral views, but by moral disagreements among secular views as well. The essay concludes with an account of how we might go to the future while recognizing the diversity that separates moral communities and constitutes ongoing moral disagreements. A mature recognition of the possibility for cooperation and peaceable interaction requires honestly acknowledging the moral differences that separate persons and define the controversies that characterize contemporary bioethics.

II. MORAL PLURALISM AND ITS INTRACTABILITY

Contemporary societies are fragmented by diverse communities of secular and religious commitments structured by diverse moral and metaphysical understandings. Many of the so-called cultural differences that divide are not just grounded in mere cultural idiosyncrasies tantamount to matters of aesthetic taste, but in foundationally divergent appreciations of the human condition and of proper moral deportment. After all, culture is in its etymology tied to *cultus*. People are among other things separated by disparate views of what and/or whom one should esteem, venerate, or worship, as well as by disparate views of the content and nature of moral obligation. These major cultural fault-lines are grounded in massively divergent moral and metaphysical views of reality, whose collision led to the genesis of bioethics and then to

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BIOETHIKOS - Centro Universitário São Camilo - 2009;3(1):26-32

its fracturing into a plurality of bioethics. The points of moral and metaphysical disagreement lie at the foundation of the disparate views about how to engage medicine and the biomedical sciences. These views divide societies across the world and constitute an impediment to the discovery or creation of a substantive global bioethics[1b].

It would be an error to consider the culture wars as merely a conflict between religious and secular moralities and their bioethics. These disputes are as much a conflict among secular moral visions. There is not one secular moral vision or one secular bioethics. Secular moralities and their bioethics are divided by substantive controversies regarding the nature of justice and property rights, to pick only one cluster of issues. Consider the conflict among libertarian, classical liberal, and social-democratic moral and bioethical perspectives and their implications for health care allocation. Apart from any issue of religion, there are substantial moral disagreements with important bioethical implications for the proper structure of health care allocations and the meaning of rights to health care. The diversity of secular morality and bioethics is fully salient without invoking issues of religious morality and bioethics.

The seeming prominence of the division between the religious and the secular, which often obscures the moral disunity and controversy characterizing the secular, is rooted in the history of the West. From at least the 18th century, a ever widening gulf opened in Western European cultures, separating those traditional Christian cultures nested in an already fragmented Europe (e.g., a Western Europe fragmented by the Reformation, the Third Years' War [1618-1638], and the British Civil War [1642-1649]) from a secular, post-traditional culture framed *inter alia* by the Enlightenment, the French Revolution, the Napoleonic interventions, and, finally, by mid- to late-20th-century changes in North American and Western European constitutional law. The public forum in the West was recast from being Christian to being secular so that the dominant culture of the West now bears the marks of having been shaped after and through the disestablishment of Christianity. The secular culture that has emerged seeks not even to see Christianity as integral to the past of its current understanding, although it often attributes moral diversity and disagreement primarily to religious concerns rooted in its past. The thoroughgoing disestablishment of Christianity has led to a secular culture that is *de facto* an adversary culture to Christianity. It has defined an important dimension of the contemporary culture wars in Europe and the Americas. As a consequence, this secular culture underscores the gulf between religious and secular bioethics, while discounting the disagreements that separate the various secular moralities and bioethics.

In assessing the character of the conflicts of morality that fragment contemporary bioethics, it is important to note how and where these commitments to moral and metaphysical differences divide. First, one must distinguish among individuals who affirm a particular morality *cum* bioethics, communities of persons who share a morality, societies spanning diverse moral communities, and states that often tend temporarily to be under the control of one dominant community, its morality, and its bioethics. There are usually also intermediate institutions that may more or less be coincident with a moral community or be marked by a conflict between communities and moralities (e.g., the Episcopal church and its internal disputes about the ordination of priestesses and the blessing of homosexual unions). In short, a state is not a moral community, and moral communities are in conflict one with another about the nature of morality and the content of an appropriate bioethics. At times, the differences are profound. There are as well disputes regarding the space and place for moral difference. For example, there are disagreements as to whether particular institutions (e.g., Roman Catholic hospitals) will be at liberty to maintain their institutional moral integrity and deliver health care in conformity with the particular bioethical commitments of the moral communities to which they belong (e.g., by refusing to provide abortions), or out of purely secular considerations support family-based rather than individual-based consent to medical treatment. There is in fact often little secular toleration of moral diversity, and instead a drive to impose moral conformity and to realize a moral consensus by force.

There is no doubt that an element of the moral diversity and controversy defining the human condition has religious roots. One can appreciate the depth of the cultural divides fragmenting bioethics by considering

b. For a detailed discussion of the moral diversity or plurality that stands as an impediment to a global bioethics, including global claims of human rights, see Engelhardt Jr HT, editor. Global Bioethics: the Collapse of Consensus. Salem, Massachusetts: M&M Scrivener; 2006.

BIOETHIKOS - Centro Universitário São Camilo - 2009;3(1):26-32

the gulf between those who are theists and those who are atheists. This gulf is not simply one separating the religious from the secular, but it involves a foundational philosophical disagreement regarding the meaning of morality and existence. Theists recognize reality as having ultimate meaning, while atheists will regard reality as ultimately coming from nowhere, going nowhere, and for no ultimate purpose. Agnostics and atheists, unlike theists, lodge human life and health care policy fully within the horizon of the finite and the immanent. This difference of perspective can support fundamentally divergent views of how, for example, to care for persons in danger of death. Those who as traditional Christians recognize the transcendent goals of humanity will find themselves committed to aiding patients to repent and to confess their sins as integral to giving care in Christian hospitals and health care facilities (e.g., Christian hospices and long-term-care facilities). They will not regard physicians who ask their patients to repent before they die as acting unprofessionally, but rather as acting in conformity with the appropriate norms of medical professionalism exemplified in the medical practice of the Holy Unmercenary Physicians such as Saints Cosmas and Damian, who sought to cure their patients through converting them. Those who do not recognize the transcendent destiny of humans will focus first and foremost on death with dignity, not repentance. They may even underscore the kindness of voluntary active euthanasia. In this cultural context, attempting to bring patients in the face of death to reflect on their sinful lives so that they may be able to repent will be considered maleficent and, if undertaken by physicians and nurses, unprofessional, in that the medical profession has for secular morality been defined within the horizon of the finite and the immanent.

Taking moral diversity seriously requires recognizing what it is that divides moralities. If one understands a morality as a generally coherent set of settled judgments about what it is to act rightly, about how to pursue the good, and about what it means to be virtuous as well as to have a good character, then moralities are separated by foundational disagreements regarding such issues as the moral propriety (i.e., the goodness, rightness, and virtue) of abortion, homosexual acts, social-welfare states, capital punishment, claims regarding rights to health care, and physician-assisted suicide. Moralities are different when they support discordant views about cardinal elements of human life, such as about when it is obligatory, permitted, or forbidden to take human life, have sex, and re-distribute property. Characterizing libertarian free-market approaches to health care allocation as unfeeling or indeed as unjust reflects a difference in secular moralities. Moral diversity is real and manifest. Moral diversity is reflected in polarized political-moral discussions across the world, which reflect the viewpoints of different moral communities and constitute the culture wars that drive health care policy disputes internationally[2].

We are separated by different moralities because within divergent moralities and bioethics, key human goods are ordered in different fashions. Depending on how one ranks liberty, equality, prosperity, and security, either one will endorse a social-democratic morality and polity, or one will affirm an elitist, capitalist-Confucian polity, such as Singapore. In addition, some moralities may even involve special values or concerns, such as holiness and obedience to God, which are not shared with other moralities. Disparate moralities, as already noted, will support different bioethics, so that across the world we find the human condition understood in terms of different moralities and bioethics.

There is, for example, a growing Chinese bioethical literature that focuses on understanding bioethical decision-making in terms of sources of authority different from those dominant in many American and Western European circles[3c]. There is in particular a growing body of Chinese bioethical reflection that would replace individual consent with family consent[4d]. One should note that this moral diversity does not entail a moral relativism. Recognizing moral pluralism does not involve denying a moral truth. It may only be that secular moral reflection is unable to determine the nature of that truth. That is, although one may be forced to accept a secular moral epistemological skepticism, these considerations do not justify a metaphysical moral skepticism[5].

Within philosophy, the intractable character of moral pluralism has been well recognized for some two millennia.

c. For a sampling of the moral diversity exemplified within East Asian moral and bioethical reflections, see Tao Lai Po-wah J, editor. Cross-Cultural Perspectives on the (Im)Possibility of Global Bioethics. Dordrecht: Springer; 2002; Engelhardt Jr HT, Rasmussen LM, editors. Bioethics and Moral Content: National Traditions of Health Care Morality. Dordrecht: Springer; 2002, Ren-Zong Qiu, editor. Bioethics: Asian Perspectives. Dordrecht: Springer; 2004.

d. See too: Fan R, Tao J. Consent to Medical Treatment: The Complex Interplay of Patients, Families, and Physicians. Journal of Medicine and Philosophy. 2004;29:139-48.

BIOETHIKOS - Centro Universitário São Camilo - 2009;3(1):26-32

Agrippa, a 3rd-century philosopher, observed that there are five reasons (his *pente tropoi*) to hold that philosophical argument cannot resolve foundational moral disputes: (1) after 800 years (i.e., by the third century A.D.), no one had succeeded in conclusively resolving the disputes at hand. (2) Disputants argue from their own perspective and therefore past each other. Absent common basic premises and rules of evidence, disputants (3) argue in a circle or (4) beg the question or (5) engage in an infinite regress[6]. Bioethics is irreducibly plural, because different bioethics are grounded in different moral and metaphysical views between which there is no way to choose by secular sound rational argument[7e]. As a consequence, we are destined to live in the culture wars, struggles to define the public forum and shape health care policy, because the advocates of disparate positions in major moral and public policy controversies do not share common moral and metaphysical premises or rules of evidence that should give structure and context to morality and bioethics.

The complexity of this state of affairs is compounded by the circumstance that at the pretheoretical, prenormative level, moral inclinations, dispositions, and intuitions are likely diverse. As with other in part biologically-based characteristics from skin color to the balance among such traits as "normal" hemoglobin, sickle-cell trait, and thalassemia, moral dispositions have likely differentially conveyed inclusive fitness in different environments. Insofar as moral and bioethical dispositions and intuitions have a biological basis, one would expect a diversity of disparities. The matter to which moral reflection turns is likely itself plural.

Despite both foundational disagreements and divergent views of the meaning of human life, the controversies that characterize our contemporary situation are widely denied. There is a failure to appreciate an impassioned denial of the moral diversity that defines the fallen human condition. As a consequence, our contemporary culture has the following paradoxical character: (1) we disagree about foundational moral and metaphysical issues, (2) these disagreements spill over into the culture wars (i.e., public moral controversies), (3) there appears no way to resolve the disputes through sound, rational argument, yet, (4) nevertheless, there are steadfast declarations of consensus and assertions of a common moral agreement and lists of indubitable human rights, evidence to the contrary notwithstanding.

The remarkable phenomenon of the assertion of consensus in the face of foundational disagreement can be accounted for by a number of factors. First, the assertions of consensus may in part be due to a self-deception on the part of those who claim the existence of consensus. That is, those who assert consensus may be captured by their own ideology or false consciousness, which is in part reinforced by the circumstance that they and their close associates are of like mind, so that they discount without noticing the views of those who disagree. Second, consensus may in part also be invoked because asserting the existence of a consensus can serve as a rhetorically useful device when claiming to have moral and political authority. As an element of *Realpolitik*, it is often harder for some to deny a claim when it is advanced as a human right about which there is supposed or alleged consensus. Third, claiming to represent the bioethics that reflects the consensus of rational persons as such can advantage one's endeavors to market oneself as a bioethical consultant. That is, one may gain an advantage for one's moral/political position and therefore one's services in the market of bioethics consultants by not simply holding that, among the plurality of bioethics, one's own bioethics is the only true bioethics, but by also claiming that (i.e., advertising that) it is the only bioethics endorsed by reason and/or rational persons. Fourth, the very logic of the creation of ethics committees favors supporting the illusion of consensus through the appointment of persons who share common ideological commitments. Were one to establish an ethics commission or committee that reflected the moral diversity that actually marks the human condition, the debates of such commissions or committees would be interminable, although perhaps engaging, but not productive of any content-full policy conclusions. The creation of commissions and committees productive of recommendations rather than controversy presupposes the possibility of, and the belief in, consensus and thus leads to the advantages noted above. Last but not least, the original bioethics likely favored the mirage of consensus because it had its roots in a Roman Catholic institution (Georgetown University), where the universalist claims of natural law were recast in terms of Enlightenment commitments to human rights and human dignity. There was the assumption that rational reflection would lead to agreement about moral matters. In summary, although a consensus regarding morality and bioethics does not exist

e. I have developed this point regarding the intractability of moral disputes in Engelhardt HT. The Foundations of Bioethics. 2nd ed. New York: Oxford University Press; 1996. ch. 2.

BIOETHIKOS - Centro Universitário São Camilo - 2009;3(1):26-32

and cannot be established by sound rational argument, there are strong forces that favor denying the facts of the matter and asserting the existence of consensus in the face of the reality of moral and bioethical controversy.

III. THE EMERGENCE OF BIOETHICS

The emergence of bioethics was itself tied to the moral controversies that marked mid-20th-century American society. Bioethics was engendered by the mid-20th-century culture wars in the United States. Bioethics emerged in the early 1970s as an attempt to provide secular moral guidance for health care and the biomedical sciences in a newly normatively secular society undergoing rapid change, while at the time the society lacked authoritative secular moral guides. The movement to create bioethics was tantamount to an attempt to realize Enlightenment hopes and set aside traditional, in particular religious moral frameworks in a period of moral disorientation. The changes were driven by powerful social forces. Although the term bioethics is at least eighty years old with roots in a concept of a moral obligation to living things[8], with Van Rensselaer Potter having re-engaged the term in 1970, bioethics took on its contemporary significance in 1971 with the beginnings of the Center for Bioethics at Georgetown University and its focus on providing a basis for guiding health care policy and health care decisions by grounding them in general philosophical reflections. Georgetown sought to provide both intellectual and practical moral direction by creating a new moral lingua franca along with a new moral discipline.

The original bioethics was made in America. It came into existence in response to local socio-cultural circumstances, which took its character from a collision of traditional versus post-traditional cultural aspirations. Medical ethics in the United States had been marginalized as the medical profession was transformed in its standing at law from a quasi-guild to a trade by a number of Supreme Court decisions[9f].

These changes, along with widespread societal suspicion of elites, characterized the dominant culture of the time. In the process the status of traditional medical ethics was marginalized[10g], as the various rights movements of the 1960s and 1970s undermined the status of traditional moral and social authorities (e.g., the authority of medical professionals). The result was that the medical profession could no longer impose its own ethos where this constituted a restraint on market activities. As a further reflection of the growing secular societal suspicion of traditional authority figures, the professional standard for the disclosure of information for consent to medical treatment was replaced by the reasonable-and-prudent-person or objective standard[11h].

These various anti-traditionalist forces combined with strong secularist agendas. In particular, in the mid-20th century the *de jure* and *de facto* establishment of Christianity in the United States was abolished, as the Supreme Court secularized American law and public policy[12i]. These wide-ranging and dramatic changes occurred as traditional moral, religious, and social structures were brought into question by other social forces, leading to a sense of anomie and a call for a new ethics for a culture and its new medicine[10]. The character of these changes was further complicated as the various Western Christianities fell into contending internal controversies. This circumstance was in great measure driven by the chaos that ensued when the Second Vatican Council (1962-1965) precipitated a major rupture in Roman Catholic established pieties and liturgical practices.

These developments engendered moral and theological uncertainty. Among the results was the abandonment of a three-century-long Roman Catholic manualist moral tradition that had produced texts in medical-moral theology. The chaos in Roman Catholicism tended to influence the theologies and bioethics of other mainline Western Christianities. As the proponents of a secular morality and bioethics advanced, the usual defenders of traditional Christian understandings in the West withdrew in confusion. A significant cultural vacuum was engendered.

Medicine and the biomedical sciences had become a dramatically effective and influential scientific, academic, and industrial complex, raising questions about how

f. In the United States, as the medical profession gained a new scientific status, there were attempts to restrict its power as a virtual guild. E.g., anti-trust litigation against the AMA: The United States of America, Appellants, vs. The American Medical Association, A Corporation; The Medical Society of the District of Columbia. A Corporation, et al.1943; 317 US :519.

g. See holdings against medical-ethical restraints on advertising, such as American Medical Assoc. vs. Federal Trade Comm'n, 638F.2d 443 (2d Cir. 1980).

h. See, for example, Canterbury vs. Spence, 464 F.2d 772, 797 (D.C. Cir. 1972).

i. See, for example, School District of Abington Township v. Edward L. Schempp et al., William J. Murray et al., v. John N. Curlett et al., 374 US 203, 10 L ed 2d 844, 83 S Ct 1560 (1963).

BIOETHIKOS - Centro Universitário São Camilo - 2009;3(1):26-32

health care costs should legitimately be contained and resources allocated, about how one should understand the moral propriety of traditionally morally problematic medical interventions, which had become significantly safer (e.g., abortion), about how to determine the definition of death and proper character of end-of-life decision-making, and about how to determine the moral propriety of new bio-technological interventions (e.g., cloning and human genetic engineering). As these questions were pressed upon society, there was an absence or vacuum of moral leadership because the traditional sources of moral direction had been marginalized or otherwise culturally disabled. The established moral governance of the medical profession had been brought into question, traditional societal norms were under assault, the authority of individuals gained salience over that of medical professionals, and society's religious-theological framework were privatized and marginalized, thus challenging the moral authority of physicians, priests, ministers, and rabbis, with the result that government bodies, hospitals, health care professionals, patients, and their families called for moral guidance as to how properly to engage the promises of medicine and the biomedical sciences. There was a call for a moral vision that could direct, as well as provide concrete guidance. Bioethics emerged to fill the cultural and moral vacuum engendered by the marginalization of traditional moralities.

Bioethics was engendered to fill this cultural and moral vacuum on two levels. First, it sought to produce the secular equivalent of a theology, a moral vision, as a source for cultural orientation. Bioethics promised an intellectual moral framework for intellectual guidance as well as a person with the moral expertise to guide concrete secular culture, public policy, and individual choices. Bioethics promised the secular equivalent of a cadre of priests and chaplains to function as culturally ordained experts who could be authorized to provide bioethics consultation, serve on ethics committees etc. Given the moral disorientation of the time, few noticed or dared to give voice to doubts regarding the unsecured claims at the foundations of bioethics. The difficulty is that bioethics is now confronted with a moral diversity it cannot deny or set aside. As a secular field, diversity, not consensus, ever more defines bioethics.

Given our actual moral diversity, the mirage of consensus notwithstanding, clinical bioethics provides relatively little actual bioethics in the sense of normative guidance[11]. That is, given that there is no moral or bioethical consensus, clinical bioethicists relatively infrequently give normative moral guidance. Instead of normative guidance, they usually provide legal advice, mediate conflicts, clarify concepts, and analyze arguments. Straightforward normative advice would often be disruptive. This is the case because core moral disputes regarding matters of life and death, from abortion and euthanasia to the allocation of scarce medical resources, remain as points of cultural conflict, thus placing bioethics at the center of the culture wars. As with the secular revolution of the Enlightenment, so, too, with regard to bioethics, the hopes for a uniformity of moral vision have gone aground on an intractable moral pluralism. Bioethics is a battleground in the culture wars, because bioethical concerns define the major dimensions and passages of life, and we disagree about their significance, moral pluralism has decisive implications for bioethics and health care policy. The controversies marking bioethical disputes are interminable in the absence of common premises and rules of evidence.

IV. WHERE DO WE GO FROM HERE? FINDING ONE'S WAY THROUGH THE BATTLE LINES IN THE CULTURE WARS

At the beginning of the 21st century, a reassessment of bioethics, its foundations, and its capacities is in order. Bioethics as theoretical and practical enterprises was undertaken on the basis of false assertions. At the very least, as a matter of intellectual honesty bioethicists should face and acknowledge our moral diversity as an element of this re-assessment of the nature and capacities of bioethics. The moral diversity that defines the content and character of bioethics may now be more easily recognized due to the circumstance that the bioethics that was made in America in the early 1970s is no longer alone. Competing secular projects in bioethics are being launched across the world, grounded in moral visions different from that which was at the roots of the original American bioethics[12j]. Over the period of the development of bioethics, even persons such as John Rawls came at least to recognize that reasonable humans do not and will not share one comprehensive doctrine[13]. As he retreated from the strong claims that were in, or could be read into, *A Theory of Justice* (1971)[14],

j. See, for example, Alora AT, Lumitao JM, editors. Beyond a Western Bioethics: Voices from the Developing World. Washington, DC: Georgetown University Press; 2001.

BIOETHIKOS - Centro Universitário São Camilo - 2009;3(1):26-32

a volume that had the advantage of being published just as bioethics was founded, he came to abandon his original account, one that appeared primarily to be a moral account, in favor of one that is political. His retreat from the morally rational to the politically reasonable reflects an attempt to re-secure an edifice that had been undermined by moral pluralism[15]. However, this default position of Rawls is more expansive than is justified[16]. There is not one sense of the morally or practically reasonable, or for that matter of the politically reasonable.

In the face of intractable moral diversity and as a strategy of prudence, some general conclusions can nevertheless be drawn. First, it will be important to avoid totalizing approaches by engaging such devices as conscience clauses and through the avoidance of all encompassing bioethical policies that coerce those in the minority or in less empowered communities to submit to the morality of the dominant community. For such impositions, there is no general moral justification. Second, one will need to explore the sparse morality that can bind moral strangers on the basis of mere consent, bare permission, as through the market and through contracts. Finally, in the face of moral controversies, we will need critically to reassess claims of consensus, as well as documents that claim such consensus (e.g., UNESCO Declaration on Bioethics and Human Rights, 19 October 2005). We will even need critically to re-examine such taken-for-granted notions as human dignity and human rights. It is unlikely that the taken-for-granted moral assumptions of the bioethics of the 1970s will remain without serious challenge.

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