HEC Forum (2009) 21(3): 293–306
DOI 10.1007/s10730-009-9106-9

Credentialing Strategically Ambiguous and Heterogeneous Social Skills: The Emperor Without Clothes

H. Tristram Engelhardt, Jr.

Credentialing ethics consultants promises to convey an enhanced professional standing, greater power in negotiation with employers, and the possibility of protection from competition from those working under alternate service paradigms, as well as against those who might compete against "orthodox" ethics consultants. A core difficulty associated with credentialing lies in the circumstance that clinical ethics compasses a cluster of services with only a minor relation to normative ethics. This state of affairs can lead to false expectations regarding clinical ethicists and the benefits of an ethics consultation. The paper reviews the various cultural forces that supported the emergence of clinical ethicists. It explores as well how a heterogeneous and protean cluster of services became bundled under the term "clinical ethics". The paper argues that, although moral pluralism is real, although we disagree about which morality is normative, about which ethics ought to be applied, nevertheless, there is a bundle of services associated with clinical ethics consultation. This evolving collage often gains its credibility from a supposed expertise regarding normative moral matters. Credentialing will likely increase the chance that patients, their families, and physicians will be misled by the description of ethics consultants as *ethics* consultants, since so many of the services consultants provide are not strictly those of offering normative ethical guidance. Given these ambiguities, the interest of clinical ethics consultants in enhancing their own social, professional, and economic status will in some cases involve a conflict with the interests of patients, families, and practicing physicians.

I. The Background History: Uncovering Hidden Cultural Agendas

The proposal to credential clinical ethics consultants must be put in context,

H. Tristram Engelhardt, Jr., Ph.D., M.D., Dr.h.c., is Professor, Department of Philosophy, Rice University, and Professor Emeritus, Department of Medicine, Baylor College of Medicine, Houston, Texas. P.O. Box 1892, Rice University, Department of Philosophy, Houston, Texas 77251-1892; email: htengelh@rice.edu.

a context shaped by a complex of interacting forces and agendas. Clinical ethics consultation, the existence of clinical ethicists, and the drive to credential them arose out of a number of changes in the cultural and ideological landscape of America. One must remember that bioethics was made in America and then exported across the world, something like Coca-Cola and McDonald's. For clinical ethicists and ethics consultation to exist presupposes a set of moral and social assumptions that make clinical ethicists the persons to consult when having an "ethics question" in health care rather than a health care lawyer, the head of a family, the chief of a medical service, a priest, a minister, or a rabbi. Health care lawyers in particular are as well trained as, if not better trained than, clinical ethicists in most, if not all, the competencies outlined in *Core Competencies for Health Care Ethics Consultation* (American Society for Bioethics and Humanities, 1998). The point is that the very existence of clinical ethicists and ethics consultation presupposes a rich set of local cultural expectations that are much more ingressive in the constitution of "the field" than is the case with regard to physicians and surgeons who as such can be identified as service providers across societies and over history.

The existence of clinical ethicists and ethics consultation is the result of a set of developments and commitments rooted in Enlightenment assumptions about the possibility of discovering through rational analysis and argument a canonical morality or at least a normative moral consensus. The difficulty is that these Enlightenment assumptions have proven false. Secular sound rational argument cannot resolve the important moral controversies we face, nor is there a non-controversial understanding of when consensus and by whom would be normative and for what (Engelhardt, 1996). These disagreements are reflected in what has come to be termed the culture wars (Hunter, 1991). Ethics consultation is itself a matter for disagreement.

Any assessment of the phenomenon of ethicists and ethics consultation, as well as the plausibility of credentialing clinical ethicists, requires at the very least first appreciating the remarkable phenomenon of the genesis of the medical humanities and of bioethics in the late 1960s and early 1970s. This genre was driven by five different clusters of concerns and interests. First, there remained after the Second World War remnants of the commitments that shaped what was in Europe the Third Humanism[1] and in America the New Humanism (Hoeveler, 1977). Already at the end of the 19th century and the beginning of the 20th, there was a view that the new sciences and technologies needed to be nested within an appreciation of the values and concerns that should be normative for humans. These reflections engendered explorations of the proper relationship between the culture of science and technology and the culture of the humanities. Abraham Flexner (1866-1959),

famed for his role in reshaping American medical education (Flexner, 1910), opined in his 1928 Taylorian Lecture that humanism should support a critical appraisal of values. "[T]he assessment of values, insofar as human beings are affected, constitutes the unique burden of humanism" (Flexner, 1928, p. 12). C.P. Snow's (1905-1980) influential 1959 Rede lecture, which drew on an ancestral paper (Snow, 1956), was first published as an article (Snow, 1962) and then developed into a book (Snow, 1964). This lecture and the associated publications gained wide currency. These publications reflected themes prominent in the Rede Lecture of Matthew Arnold (1822-1888) (Arnold, 1882). They also spoke to a deep concern to be able to comprehend in human terms the force and significance of the new sciences and technologies.

As with the first humanism born of the Renaissance, and the second humanism that took shape before and after the French Revolution (McCloy, 1972; Niethammer, 1808), the New and Third Humanisms had a significantly secular, post-theological character. One goal among others was to articulate a secular moral lingua franca for an increasingly secular society. These interests favored the establishment of the National Endowment for the Humanities through the Humanities Act of 1965. In the 1960s and 1970s, these interests generated an ever-increasing engagement with the question of how the humanities could and should bear on medicine (Pellegrino, 1979; 1966). The attempt to understand the relationship of the humanities to medicine led to the genesis of the Society for Health and Human Values in 1968, one of the antecedent associations, along with the American Association of Bioethics and the Society for Bioethics Consultation, out of which the American Society for Bioethics and Humanities came into being in 1998. This collage of forces formed a significant cultural movement.

It should be noted that by 1998 those involved had become much more secular in their focus of interests than was the case with the Society for Health and Human Values in its early years. At the beginning, there had been a much larger representation of chaplains and theologians. The result of this is that the role of clinical ethics and ethics consultation became much more secular. For example, in the pamphlet *Core Competencies for Health Care Ethics Consultation* there is no serious attention to the issue of whether ethics consultants and ethics consultation should play a different role and have quite a different character in fundamentalist Christian, traditional Roman Catholic, Orthodox Jewish, or traditional Islamic health care institutions. This oversight is what one would expect, given the general embedding of clinical ethicists and their consultations within the Enlightenment/Humanist movements that became salient in the eighteenth century and afterwards.

The cultural movement to establish the humanities as a source of orientation for society and for the appreciation of medicine lay at the basis of a very particular educational movement, one committed to changing the character of medical education and thus recasting the character of the health care professions. It was a movement aimed at both educational and professional "reform". This second movement found important support from the Institute on Human Values in Medicine, an entity associated with the Society for Health and Human Values. The Institute on Human Values in Medicine organized missionary educational groups constituted of philosophers, historians of medicine, theologians, and others bent on convincing medical schools that they should establish teaching positions in the medical humanities (Pellegrino & McElhinney, 1982). Many of the current programs in bioethics and the medical humanities in medical schools can trace their establishment to these visits by zealous proponents of the importance of incorporating the medical humanities and bioethics into medical education. Because Supreme Court rulings had recast medicine from a quasi-guild into a trade (*American Medical Association*, 1943; 1980), the vision offered by the medical humanities and bioethics provided the possibility for a new and more universal identity for health care professionals, as well as a new and non-elitist basis for a sense of professionalism. No longer was their identity to be grounded in the self-certifying and self-protective commitment of a quasi-guild of health care professionals. Instead, the professional identity of physicians was to be found in new commitments to a humane spirit and to the norms of bioethics.

The concerns with the broadly cultural movement to develop the medical humanities, as well as the more focused educational interests of those who proselytized on behalf of establishing the medical humanities in medical schools, were also associated with a quasi-political or ideological impetus. There was a deep consanguinity between the cultural and educational movements and a political movement to secure at law patient rights and to forward what was generally a social-democratic political vision. It was no accident that Sargent Shriver and the Kennedy family found it quite appropriate to support the Kennedy Institute of Ethics, along with its Center for Bioethics.[2] The language of rights to health care and concerns with equality in health care had important resonances with Senator Ted Kennedy's long-time support of a substantial restructuring of American health care. Generally, this inclination to the left did not significantly exclude those of more libertarian, conservative, or classical-liberal commitments. Nevertheless, this ideological orientation expressed itself in tensions manifest in reactions against the President's Council on Bioethics chaired by Leon Kass for President George W. Bush. The Council had a

quite different ideological framework from that underlying Bill Clinton's National Bioethics Advisory Commission. There had been a general silent background assumption that bioethics would support social-democratic agendas. The contrast between the President's Council on Bioethics and the National Bioethics Advisory Commission made salient the extent to which bioethics is also bio-politics. With conflicting ideologies, there were conflicting bioethics, which had been recruited within competing political visions.

These cultural, educational, and political movements were supplemented by a set of significant and independent intellectual interests. Scholars, puzzled by the nature of medical explanation, by the role of values in concepts of health and disease, and by how foundational moral-theoretical issues surface in bioethics, came to have significant interest in philosophical issues in health care and the biomedical sciences. Work by those who would later be regarded as bioethicists had strong connections with concerns bearing on the philosophy of science (Brody, 1970; Engelhardt & Caplan, 1987). Among other things, the history and philosophy of science was brought to compass the history and philosophy of medicine. The result was a rebirth of interest in the philosophy of medicine,[3] as well as foundational explorations of normative issues raised by medicine. Unlike those with a cultural, educational, or political agenda, these scholars had at most a disciplinary or sub-disciplinary agenda. Their goal was to establish the philosophy of medicine and/or bioethics as a legitimate sub-discipline of philosophy (Engelhardt, 1973). Theirs was an undertaking in educational micro-politics focused on supporting their intellectual and surely also their professional interests. Here one finds a cluster of undertakings primarily driven by epistemic, non-moral commitments (Engelhardt & Erde, 1980). These interests led to such defining publications for the field as *The Encyclopedia of Bioethics* (Reich, 1978). However, such scholarly achievements surely also gave an intellectual authority to the cultural, educational, and ideological movements.

In addition to these clusters of interests in cultural, educational/professional, and political reform, along with intellectual and scholarly investigation, there emerged what I have elsewhere characterized as a cadre of secular chaplains (Engelhardt, 2002). Because of the widespread secularization of American society in the 1950s and throughout the 1970s,[4] and because of the deflation of the moral authority of paternalistic physicians, a moral vacuum was created. The guidance that in the past had been provided by priests, ministers, rabbis, theologians, and physicians generally no longer seemed appropriate for an increasingly secular, non-elitist public culture. A new service group emerged to fill the cultural

ecological niche abandoned by priests, ministers, rabbis, and paternalistic physicians. These new service providers were variously termed clinical bioethicists, clinical ethicists, or ethicists. They offered to provide ethical direction for institutional review boards, hospital ethics committees, government, physicians, patients, and the families of patients.[5]

Despite the diversity of their educational background, which ranged from philosophy, literature, theology, medical humanities, and bioethics, to medicine, nursing, and chaplaincy, clinical ethicists were able to exploit the abandoned cultural niche they entered. This heterogeneous group was often aided in gaining a perceived sense of "professional" unity by intensive courses ranging from a week to six weeks that helped direct them to adapt to this cultural niche. Clinical ethicists found that they could sell their services to a wide range of employers, despite their heterogeneous character, because the employers themselves had a heterogeneous and protean set of services they hoped clinical ethicists would provide. Even if clinical ethicists had different backgrounds and even if they disagreed in substantive ways as to what ethics and clinical ethical consultation should be, they were generally sufficiently intelligent and/or personable so that they could convince their would-be employers of their value, especially given the perceived cultural need for moral orientation. Yet, many realized that their identity as a service group and their capacity to sell their services would be strengthened if they received some form of social recognition. The proposal for credentialing is directed to this issue: the desire of these new service providers for social standing and the job security that comes with it.

II. Searching for an Illusive Essence: What is a Clinical Ethicist, After All?

The difficulty is that there is quite a challenge in carefully and precisely defining the services that these service providers are to provide, and in showing how it constitutes a single unified discipline. This is partially due to the protean and ambiguous character of expectations regarding clinical ethics and clinical ethics consultation on the part of the providers of the services, the recipients of the services, and those who pay for the services. The background complex of the cultural, educational, and political agendas already noted tends to convey a general plausibility. Employers such as hospitals are themselves embedded in a culture that affirms that it is good to treat patients, physicians, nurses, and family members in an ethical fashion. It would seem plausible from the designation "ethics consultant" that such service providers could aid in this task and thus convey a secular moral blessing to the undertakings of the health care institution. There is usually

also a hope that a body of "ethics consultants" will help resolve tension among physicians, nurses, patients, and family members in certain problematic care decisions and thus increase the efficiency and perceived quality of care. Hospital administrators usually appreciate that good administration includes "the ability to facilitate formal and informal meetings" (American Society for Bioethics and Humanities, 1998, p. 15), as well as "the ability to listen well and to communicate interest, respect, support, and empathy to involved parties" (p. 15). Ethics consultations can thus become an extension of a good health care administration. In addition, there is the hope that ethics consultation may protect against malpractice concerns. For example, the use of such ethics consultants may help demonstrate that employers have shown due-diligence by bringing ethics consultants to address controversial or troubling cases. Ethics consultation may also help ameliorate disputes that can in the end lead to lawsuits. In this fashion, clinical ethicists can function as an implicit element of risk management. The result is that clinical ethicists serve as jacks of enough trades to be of interest to employers such as hospitals.

The general status of ethics consultants and the plausibility of hiring such ethicists depend crucially on how much of a protean bundle of services such service providers can offer a particular health care institution. In different institutions, different constellations of services may be more or less plausible. There need be no essence to the role "clinical ethicist" or to the character of ethics consultation. Rather, a number of tasks with a family resemblance is all that is needed. This family resemblance is tied to various requests to address conflicts that center on moral, health care policy, and legal norms. The resolution sought need not always concern directly addressing legal policy and moral conflicts. At times the services can be aimed at ameliorating emotional, personal, and professional conflicts that advance themselves under the color of an ethical dispute. If this protean character of clinical ethics and its consultations were frankly acknowledged, one could more easily evaluate the social status sought by clinical ethicists through formal credentialing.

A difficulty is that this heterogeneous and protean set of tasks has been formally baptized under the rubric of ethics. This baptism may convey to the unwary (vulnerable patients and family members, as well as confused physicians) the sense that ethicists will usually provide normative guidance. That is, the impression may be conveyed that clinical ethicists have moral expertise, expertise about normative ethics, so as generally to be able to provide appropriate normative guidance. In some cases, this may be the case. In health care institutions with a strong religious affiliation or with very particular morally concrete mission statements, ethics consultants may very

well be expected to play a frankly normative moral role by giving actual normative moral direction. However, this is rather infrequently the case. In most institutions, normative advice, especially first-order normative advice (e.g., "abortion is immoral;" "a woman's free choice with respect to abortion clearly outweighs any moral status of a fetus") is rare. Instead, the focus is usually on the grammar of a procedural morality (e.g., the intricacies of gaining consent). Indeed, the focus here is often not on resolving moral controversies, but at best on reaching a fairly tolerable *modus vivendi*. Here one might think of Nancy Dubler's substitution of the phrase "ethics mediation" for "ethics consultation", although the question arises as to what extent matters of ethics *sensu stricto* are at all involved (Dubler & Liebman, 2004).

If what has been described above is the case, namely, that moral pluralism is real and intractable, and that ethics consultants rarely give frankly normative guidance, but nevertheless they are generally taken to be ethics experts, then free and informed consent to society, patients, their families, and physicians would need to include an acknowledgement of the centrality of the non-normative functions of clinical ethicists. It would appear, for example, that clinical ethicists for the most part (1) play the role of health care lawyers, but at a much lower cost (and generally lower expertise); (2) play the role of mediators when there are conflicts among physicians, nurses, patients, families, etc.; and (3) play the role of values clarifiers (but not usually the role of normative ethicists) by laying out what is at stake in particular moral controversies and disputes. The difficulty is that there is a background tacit assumption that ethicists possess a normative moral expertise that can enable them to know what ethics ought to be applied. The plausibility of this assumption for its part depends on whether scholars reflecting on matters moral give good grounds for the view that they are able or have been able to discover a canonical morality or ethics for the applied ethicist to apply.

III. The Scandal: No One Can Show Which Ethics Clinical Ethicists Should Support

There is neither a canonical secular ethics to apply nor a coherent understanding of consensus in moral matters. First, secular, sound rational argument cannot establish a canonical morality. This is the case because moral theorists are separated one from another by foundationally disparate paradigms of the nature and content of morality. For example, Kantians see morality structured by certain deontological, right- and wrong-making conditions that are independent of and prior to any understanding of the

good. The pursuit of the good is therefore placed within constraints set by the right-making conditions. Teleologists, in contrast, hold that all claims about right and wrong can be reduced to understandings of the good. The result of these differences is displayed in the differences between Kantian and utilitarian understandings over a wide spectrum of moral issues ranging from the prohibition against lying and the obligation to keep promises. At stake are different paradigms of what it is to be moral, somewhat as Aristotle and Einstein are separated by different paradigms of physical reality.

Such differences are made even starker when one observes that there are foundational disagreements expressed in much moral and written controversy regarding when and under what circumstances it is licit, obligatory, or forbidden to have sex, re-distribute property, or take human life. All moralities may be concerned with normative issues bearing on having sex, taking life, and re-distributing property, but they differ as to what moral obligations exist regarding these matters. These differences in moral commitments and understandings express themselves in controversies regarding the morality of abortion, *in vitro* fertilization, human embryonic stem-cell research, cloning, homosexual acts, rights to health care, physician-assisted suicide, and euthanasia. Moral pluralism is real and salient. It cannot be set aside by attempting to establish a wide, reflective equilibrium between moral theories, principles and moral intuitions. Given different moral principles and different moral intuitions, persons seeking a reflective equilibrium will generate different justifications for different moral views. Humans do not share one morality, one understanding of moral rationality, or one understanding of the politically reasonable, nor can those in disagreement set their disagreements aside by sound rational argument if they embrace different foundational moral premises and rules of evidence.

Many do not wish to acknowledge the *de facto* salience of moral pluralism. There are surely many reasons for this denial of the obvious. First, recognizing moral pluralism brings into question the capacity of clinical ethicists and bioethicists to be those who should supply canonical ethical direction, the hunger for which drove the emergence of the field. Recognition of moral pluralism would lead to a professional identity crisis. Second, a frank recognition of moral diversity would undercut marketing efforts to advance the plausibility of hiring clinical bioethicists and ethicists. It would be against the financial and professional standing of many such ethicists to acknowledge this difficulty confronting applied ethics, for it would open up the recognition that secular clinical ethicists belong to different secular moral sects. Last but not least, the very genesis of bioethics was tied to an illusion of consensus, an illusion concerning the existence of a common morality. The seeming success of the National Commission for the

Protection of Human Subjects of Biomedical and Behavioral Research and its *Belmont Report* (National Commission, 1978) supported the assumption that persons with divergent viewpoints could nevertheless come to common agreement, at least on matters of basic policy. Few noticed that the very logic of the creation of ethics commissions and committees requires the selection of members with sufficiently common moral, ideological, and/or political agendas. In addition, the most influential early textbook for the field, *The Principles of Bioethics* (Beauchamp & Childress, 1979), presupposed a common morality that would allow the use of their four principles towards the goal of common agreement about the resolution of concrete cases rather than supporting disclosure of how deeply people disagree regarding the significance of autonomy, beneficence, non-maleficence, and justice.

Finally, there is the problem of appeals to moral consensus. To begin with, there is never moral consensus in the strict sense of unanimity on any moral point. Moreover, even if there were unanimity, much more would have to be said to show how, if at all, unanimity is tied to moral truth. Here lies a cardinal difficulty with the issue of consensus, as well as an implicit disclosure of its non-moral significance. Unless one can show how much of an agreement on the part of whom counts for establishing a moral truth (a matter about which there will never be agreement, given the arguments rehearsed above about the irresolvability of moral pluralism), the status of consensus claims as claims about the establishment of normative truths is problematic at best (Engelhardt, 2002). Why, then, do so many sensible people continue to speak so earnestly about moral consensus. The answer likely lies in the circumstance that the appeal to consensus is not a moral appeal, but a political appeal cloaked in moral terms. It is focused on creating a sufficient agreement, a sufficient coalition of collaborating parties, so as to create a *modus vivendi* that most out of prudential considerations will be well advised to accept. It is usually not prudent openly to defy an overwhelming coalition of persons who wish to enforce a particular policy (although in some circumstances one would surely be morally obliged to do so). Once appeals to consensus are recognized as elements of a political mechanism aimed at creating a level of social commitment to a particular policy so that that policy will need *de facto* to be accepted, many of the puzzles regarding consensus evaporate. Appeals to consensus can serve as a form of *Realpolitik* clothed in the discourse and trappings of normative ethics.

IV. Make Haste Slowly: Before Credentialing Clinical Ethicists, Be Honest and Much Clearer about What is at Stake

The proposal to credential ethics consultants should properly bring one first to explore more deeply not only the roots and agendas of clinical ethicists and ethics consultation, but also how the background culture makes certain undertakings seem plausible and necessary. The phenomena of clinical ethicists and ethics consultation are part and parcel of complex cultural and ideological changes that underlie the contemporary culture wars. A mature judgment concerning the benefits and harms of credentialing clinical ethicists requires better clarification and more careful examination of the forces that have generated the phenomena of clinical ethicists and ethics consultations. In this regard, one needs more critically to appreciate such cultural illusions tied to ethics consultation as the possibility of moral consensus and the purposes this illusion serves. One needs as well to assess the benefits and harms of implying that ethics consultation has a disciplinary unity rather than being constituted out of a heterogeneous and protean bundle of services that address the concerns of different employment contexts. Most importantly, before one moves to give social recognition to the bundles of practices that are gathered under the rubric of clinical ethics consultation, one must first better understand the ways in which strategic misconceptions regarding the expertise of clinical ethicists may misguide vulnerable patients and families, as well as naïve health care professionals. Among other things, this will require a better understanding of what secular moral expertise can mean, given the intractable moral pluralism that characterizes secular morality and bioethics. This recognition of the implications of moral pluralism should be bound to a parallel recognition that health care institutions with particular moral commitments (e.g., denominationally affiliated hospitals), as well as patients, their families, physicians, and nurses, may embrace only one among the many moralities and may even appreciate that the moral pluralism that afflicts us reflects the distorting character of a fallen moral life (Engelhardt, 2000).

It is understandable that clinical ethicists would attempt to advance their interests as service providers through creating a more formal social recognition of their services. Yet, before one positively responds to this self-serving request, which has formed the basis of the creation of quasi-guilds and guilds in the past, one is best advised carefully to consider the likely harms and benefits of such a quasi-formal recognition. As already noted, there is a significant harm involved in not candidly underscoring that the use of "ethics" in clinical ethicists and ethics consultation does not have the moral meaning that most persons associate with the term.[6] Without renaming

the practitioners as well as their consultations, and in addition making provision for access to alternative ethicists, who may be real moralists, there is a conflict between the interest in professional recognition and the interest adequately to inform patients, families, and others of the moral expertise offered by clinical ethics consultation. Patients, families, and others may receive a consultation they did not want and not have access to the moral advice they had sought. There are also possible harms that credentialing would pose to ethics consultation itself. The phenomenon of clinical consultation is by its nature open-ended and evolving, so that credentialing runs the risk of curtailing the natural adaptation of this service enterprise to changing needs and conditions. There is no hard evidence of serious harm to others from the current fluid character of this group of service providers. Maintaining the open-ended evolving character of the current state of affairs allows the field itself to grow as judgments are made concerning its benefits and costs. If things are not seriously broken, it is often best not to try to fix them.

NOTES

[1] "The third humanism is the creation of an ideal sentiment over against the surrounding materialism of post-war times … and against the positivist and historicist understanding given to the ancients by scholars during the last half of the nineteenth century" (Rüdiger, 1937, p. 280, my translation).

[2] For an insight into some of this history, see Reich, 1994.

[3] Interest in the philosophy of medicine is centuries old. See, for example, Berlinghieri, 1801; Grohmann, 1808; Bartlett, 1844. See also Szumowski, 1949.

[4] For examples of court cases tied to the secularization of the American public culture, see Everson, 1947; Zorach, 1952; Torcaso, 1961; Abington, 1963.

[5] It should be noted that in a poorly developed opinion the New Jersey Supreme Court in *In re Quinlan* invoked ethics committees as a way to solve controversial cases in health care. There have surely been criticisms of this turn to committees and ethicists. One might note the argument of Robin F. Wilson built on skepticism regarding "a field as intellectually new as medical ethics" (Wilson, 1998, p. 404).

[6] "ethics 1. A treatise on morals. 2. The science of moral values and duties; the study of ideal human character, actions, and end. 3. Moral principles, quality, or practice" (*Webster's*, 1960, p. 283).

REFERENCES

Abington School District v. Schempp, 374 U.S. 203 (1963).

American Society for Bioethics and Humanities (1998). *Core competencies for health care ethics consultation*. Glenview: ASBH.

American Medical Association v. United States, 317 U.S. 519 (1943).

American Medical Association v. Federal Trade Commission, 638 F.2d 443 (2d Cir. 1980).

Arnold, M. (1882). *Literature and science*. Cambridge: Cambridge University Press.

Bartlett, E. (1844). *An essay on the philosophy of medical science*. Philadelphia: Lea and Blanchard.

Beauchamp, T. & Childress, J. F. (1979). *The principles of bioethics*. New York: Oxford.

Berlinghieri, F. V. (1801). *La filosofia della medicina*. Lucca, Italy: published by the author.

Brody, B. A. (ed.) (1970). *Readings in the philosophy of science*. Englewood Cliffs: Prentice-Hall.

Dubler, N. & Liebman, C. (2004). *Bioethics mediation*. New York: United Hospital Fund.

Engelhardt, H. T., Jr. (2002). The ordination of bioethicists as secular moral experts. *Social Philosophy & Policy* 19 (2) (Summer), 59-82.

Engelhardt, H. T., Jr. (2002). Consensus formation: the creation of an ideology. *Cambridge Quarterly of Healthcare Ethics* 11 (1) (Winter), 7-16.

Engelhardt, H. T., Jr. (1996). *The foundations of bioethics*, 2nd ed. New York: Oxford University Press.

Engelhardt, H. T., Jr. (1973). The philosophy of medicine: a new endeavor. *Texas Reports on Biology and Medicine* 31 (3) (Fall), 443-52.

Engelhardt, H. T., Jr., & Caplan, Arthur L. (eds.) (1987). *Scientific controversies*. New York: Cambridge University Press.

Engelhardt, H. T., Jr., & Erde, E. (1980). Philosophy of medicine. In P. Durham (ed.), *A guide to the culture of science, technology, and medicine* (pp. 364-461). New York: Free Press.

Everson v. Board of Education, 330 U.S. 1 (1947).

Flexner, A. (1928). *The burden of humanism*. Oxford: Clarendon Press.

Flexner, A. (1910). *Medical education in the United States and Canada, a report to the Carnegie Foundation for the Advancement of Teaching, bulletin no. 4*. New York: Carnegie Foundation.

Grohmann, J. C. A. (1808). *Philosophie der Medizin*. Berlin: Schmidt.

Hoeveler, J. D., Jr. (1977). *The new humanism*. Charlottesville: University Press of Virginia.

Hunter, J. D. (1991). *Culture wars: the struggle to define America*. New York: Basic Books.

In re Quinlan, 355 A.2d 647 (N.J. 1976).

McCloy, S. (1972). *The humanitarian movement in eighteenth-century France*. New York: Haskell House.

National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1978). *The Belmont report*. Washington, DC: DHEW Publication No. (OS) 78-0012.

Niethammer, F. I. (1808). *Der Streit des Philanthropinismus und Humanismus*. Jena: Frommann.

Pellegrino, E. D. (1979). *Humanism and the physician*. Knoxville: University of Tennessee Press.

Pellegrino, E. D. (1966). Medicine, philosophy and man's infirmity. In W. von Bayer & R. M. Griffith (eds.), *Conditio Humana* (pp. 282-284). New York: Springer.

Pellegrino, E. D. & McElhinney, T. (1982). *Teaching ethics, the humanities, and human values in medical schools*. Washington, DC: Society for Health and Human Values.

Reich, W. (1994). The word 'bioethics': its birth and the legacies of those who shaped it. *Kennedy Institute of Ethics Journal* 4 (4), 319-336.

Reich, W. (ed.) (1978). *The encyclopedia of bioethics*. New York: Macmillan Free Press.

Rüdiger, H. (1937). *Wesen und Wandlung des Humanismus*. Hamburg: Hoffman & Campe.

Snow, C. P. (1956). The two cultures. *New Statesman* (October 6): 413-414.

Snow, C. P. (1962). *The two cultures and the scientific revolution*. Cambridge: University Press.

Snow, C. P. (1964). *The two cultures and a second look*. Cambridge: University Press.

Szumowski, W. (1949). La philosophie de la medicine, son histoire, son essence, sa denomination et sa definition. *Archives Internationales de l'Histoire des Sciences* 9, 1097-1141.

Torcaso v. Watkins, 367 U.S. 488 (1961).

Webster's New Collegiate Dictionary (1960). Springfield: G. & C. Merriam.

Wilson, R. F. (1998). Hospital ethics committees as the forum of last resort: an idea whose time has not come. *North Carolina Law Review* 76 (2) (January), 353-406.

Zorach v. Clauson, 343 U.S. 306 (1952).