

If You Love the Forest, then Do Not Kill the Trees: Health Care and a Place for the Particular

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There are numerous ways in which “the particular”—particular individuals (whether patients or physicians), particular ideologies, values, beliefs, and perspectives—are sometimes overlooked, ignored, or even driven out of the healthcare profession. In many such cases, this is bad for patients, practitioners, and the profession (or so I argue). Hence, we should seek to find a place for the particular in health care. Specific topics that I examine in this essay include distribution of health care based on the particular needs of patients, the importance of protecting physicians’ right to conscientious objection, the value in tolerating a plurality of moral and medical perspectives within the field, and more. Ultimately, as the imagery in the essay’s title suggests, I argue that if one cares about the “well-being” of the medical profession (generally), then one should seek to avoid destroying the many diverse and particular entities that constitute it.

Keywords: *autonomy, conscientious objection, effective altruism, moral pluralism, principlism, public reason*

I. INTRODUCTION

In this issue of *The Journal of Medicine and Philosophy (JMP)*, the authors explore ways in which “the particular” is viewed and treated within health care. The particular—particular individuals (whether patients or physicians), particular ideologies, values, beliefs, and perspectives—are sometimes overlooked, ignored, or even *driven out of* the healthcare profession. Often enough, this leads to negative consequences for patients, providers, and the

profession (or so I suggest). Specifically, in section 2, I unpack this issue's theme (health care and the particular). In sections 3–7, I outline (and comment on) each of the other essays in this issue. I end each section by relating that section's essay back to the theme of this issue.

II. HEALTH CARE AND THE PARTICULAR

There are many ways to explore the relationship between health care and the particular.¹ For the sake of space, I focus on one: the relationship between (a) a generalized perspective of bioethical principles, medicine, health, and well-being grounded in “public reason” and (b) unique perspectives regarding those same concepts, as grounded in particular traditions.

To begin, consider [Malek's \(2019, 101\)](#) argument that the unique religious perspectives (i.e., “religiously-based beliefs and values”) of clinical ethics consultants (CECs) should play virtually “no role” in their consultative work. “Eliminating individual religious perspectives from ethical reasoning,” she argues ([2019, 96](#)), “would reduce variation and make consistency more likely” between CECs. That is, some CECs are religious, some are not. If we restrict religious CECs from letting their unique perspectives shape their work, they are more likely to provide the same services, recommendations, etc., as their secular counterparts.² This, in turn, promotes “consistency” in the “product” offered by CECs everywhere ([Malek, 2019, 96](#)). Put simply, CECs do a better job if they leave their unique moral perspectives at the door.

[Greenblum and Hubbard \(2019\)](#) go further, arguing that physicians, nurses, clinical ethicists, and ethics committee members should not cite religious considerations (beliefs and values) as relevant to medical decision-making at all (even if patients claim that religious considerations are relevant).³ For [Greenblum and Hubbard \(2019, 707\)](#), medical professionals are “akin to” public employees, and so should cite only “public reason” when explaining the rationale behind medical decisions. “Private” reasons—those only relevant within the context of particular traditions or moral frameworks—should be set aside.

Supposedly, this approach has no major costs for people committed to particular moral and religious perspectives.⁴ The tenets of each perspective, after all, can usually be “translated into” public-reason-speak anyway ([Greenblum and Hubbard, 2019, 709](#)). Thus, particular differences between practitioners (in terms of moral and religious commitments) seem irrelevant to their work.

The problem, as [Eberly and Frush \(2019, 718\)](#) put it, is that

In making the claim that such a public reason exists, that it serves as a normative foundation for ethics and that it excludes substantive religious content, the authors assume an epistemological framework that is highly contested, neglecting altogether

the traditioned nature of any such truth claims . . . Every form of reason is grounded in particular persons, places and contexts.

Put differently, authors like [Greenblum and Hubbard \(2019\)](#) mistakenly conceive of “public rationality” as “universal and general,” when in reality it is “relative and particular” ([Eberly and Frush, 2019](#), 718).

This debate reveals two narratives. First, by the power of “public reason” we can discover, establish, and enforce the tenets of a secular, “common” morality. “Common morality”—to quote [Beauchamp and Childress \(2013, 3–4\)](#)—binds “all persons in all places” and is “not merely *a* morality” among others. This means we are morally justified in condemning and curbing actions that violate the common morality. [Beauchamp and Childress \(2013, 4\)](#) do not mince words when making this point: “No particular way of life qualifies as morally acceptable unless it conforms to the standards in the common morality.”

The second narrative, in contrast, maintains that concepts like “common morality” and “public reason” are grounded in some *particular* philosophical perspective(s), despite being masqueraded as “general and universal.” As [Engelhardt \(1996, 9\)](#) argues, a secular, canonical morality “does not exist.” Instead, “one finds numerous visions, a chaos of voices, a legion of beckoning goods, alternative lifestyles, and diverse communities” ([Engelhardt, 1996, 10](#)). In such a world, “legitimate secular morality” may “only be created through . . . the actual agreement of actual persons to cooperate in common projects” ([Cherry, 2017, 88](#)). That is, people who subscribe to differing visions of the good may establish a kind of “secular moral authority” through “mutual consent” ([Engelhardt, 1996, 69](#)). What they *cannot* do, however, is resolve moral disagreement by “sound rational argument” alone ([Engelhardt, 1996, 68](#)).⁵

On the second narrative, what should we say about projects like those presented by [Malek \(2019\)](#), [Greenblum and Hubbard \(2019\)](#), and [Beauchamp and Childress \(2013\)](#), which impose the standards of “common morality” on others? They may *think* that no real imposition occurs, since “common morality” is allegedly consistent with all moral perspectives. But it is not. Thus, on the second narrative, when a particular moral perspective is described as “common morality” and is subsequently imposed on others (without their consent), this is done without any legitimate *moral* authority. Naturally, people may impose their own vision of the good on others by means of force, threats, political pressure, sanctions, public shaming, etc., but doing so involves nothing more than one moral community (forcibly) vying for control over another.

For my purposes, I argue that on either narrative, we must attend to a plurality of moral perspectives (i.e., “the particular”). On the second narrative, this claim is obviously true. We must attend to particular moral perspectives because at base, that is all there is. In attending to these particulars, we may

(a) take stock of our own moral commitments, values, and beliefs, (b) attempt to get others to “convert” to our perspective, and (c) seek to establish common agreements with those who do not share our vision of the good.

What about the first narrative? If the first narrative is accepted, why not simply focus on general principles (“common morality”), while ignoring deeper philosophical disputes about the foundations of those principles? Here is a quick response. Assuming the first narrative is correct, people (even experts) may not be reliable at distinguishing between what is generally/universally true and what is particular to their own (unique) moral perspectives. This becomes apparent when examining ways that “bioethics has attempted to broaden its reach beyond North Atlantic culture . . . to East Asian and South Asian contexts” (Solomon, 2014, 89). In those cases, the “individualistic commitments” central to Western bioethics—which, from a Western perspective (even among experts), seemed unquestionably to be part of “common morality”—did not “translate well” into Asian cultures.⁶ As such, Solomon (2006, 336–7) explains that attempts to “export” these bioethical principles—even those *presumed* to be part of “common morality”—was (it seems) just a kind of “ethical imperialism,” rather than an initiative to increase global awareness regarding the implicit moral “consensus” between worldviews. Even within Western culture, disagreement over the content of “fundamental” principles—such as “respect for autonomy”—should make us hesitant to bracket all discussions of particular moral perspectives.⁷

In sum, by failing to acknowledge the role of particular perspectives, the great temptation for disciples of the first narrative is to treat the particularities of their own moral perspectives as part of the “common morality.” Now when that happens, they may improperly impose their own vision of the good on others. When people fail to distinguish between “common” and “particular,” therefore, this may lead to their forcing others to accept their own particular moral perspectives, despite their having no moral justification or authority to do so. So even those who accept the first narrative should carefully attend to the particulars of diverse moral perspectives.

In the remainder of this essay, I describe how each of the other essays in this issue touch on the relationship between health care and the particular, albeit in different ways than discussed here. Despite these differences, one unifying factor is that in each case, failure to attend to the particular invites troubling consequences.

III. SPECIAL OBLIGATIONS AND HEALTH CARE: PRIORITIZING ACTUAL NEEDS OVER POTENTIAL ONES

First, Benedict Rumbold argues that we (society) should provide health care to all people (whether they can afford it or not), and we should treat health care differently from other social goods (e.g., education). Specifically,

Rumbold (2021, 288) claims, we have “special obligations to assist those unable to help themselves.” Often, sickness (or injury) directly undermines an individual’s ability to meet his or her own needs. Hence, we have a special obligation to help sick and injured individuals.

More carefully, we must distinguish between “*actual* health needs” and “*potential* health needs” (Rumbold, 2021, 278). An individual with an *actual* health need is “presently experiencing a particular pathology” (where “pathology” is understood as “a harmful deviation” from “normal functioning” that “requires correction”) (Rumbold, 2021, 278, 279). Alternatively, if subjects are experiencing some *potential* health need(s), then there is something about their situations (e.g., living arrangements) that merely place them “at risk” for developing some actual health need(s) (Rumbold, 2021, 278).

All else being equal, people afflicted by *actual* health needs are (generally) less able to ensure that their own needs are met. Our special obligation to assist people that are unable to help themselves, therefore, implies that we have a special obligation to assist people affected by actual health needs. Further, the goods that alleviate actual health needs just *are* the goods of health care (Rumbold, 2021). Hence, healthcare goods are special (when compared to other social goods), in that we have some extra (or unique) obligation to provide them. So, even if we are generally obligated to provide people with a broad range of social goods (like food, shelter, etc.), we have some additional (special, unique) obligations to provide people with the goods of health care.

This result, Rumbold (2021, 277) notes, runs contrary to what “most philosophers in the field” maintain. After all, according to “most philosophers,” healthcare goods are just one type of social good among others (Rumbold, 2021).⁸ On this view, even if we have a general obligation to provide health care, that obligation is no different from our obligation to provide other social goods (Rumbold, 2021). Although Rumbold does not challenge the claim that we are generally obligated to provide a variety of social goods, his argument shows that healthcare goods are special (i.e., we have some added reason(s) to provide them to people in need of them). It is a mistake, therefore, to treat healthcare goods as one type of social good among others.

Rumbold’s essay squares with this issue’s theme, since he emphasizes the importance of attending to the particulars of individuals’ situations when assessing our obligations toward them. As the details of their situation change, so might our obligations to them. Rumbold (2021) also defends the importance of assessing the particular *degree* to which individuals are (un)able to help themselves. “Some actual health needs are more debilitating than others” he writes (Rumbold, 2021, 284), and so, “there is a further level of granularity at which we might assess the normative significance of different needs.” If we ought to help others (in proportion to their inability to help themselves), then in order to determine the extent of our obligations to particular people, we then need to assess the particular degree to which they

are (un)able to help themselves. Most importantly, should we fail to account for these particulars—and, say, live as though we have the same general obligations to everyone—we will likely neglect the unique duties we have toward people who are especially in need of our assistance.

IV. CONSCIENTIOUS OBJECTORS AND THE GREAT AND UNMATCHED WISDOM OF THE “PROFESSIONAL CONSENSUS”

Next, Tiernan Kane defends a place for conscientious objection against [Stahl and Emanuel \(2017\)](#). [Stahl and Emanuel \(2017, 1382–3\)](#) argue that through discussion and debate—Rawls’ “reflective equilibrium”—medical professionals arrive at a “consensus” regarding the services they ought to provide. When the profession deems a procedure, *P*, to be an “appropriate medical intervention,” individual practitioners should not be permitted to refuse to provide *P* ([Stahl and Emanuel, 2017, 1382–3](#)). This is because refusing to provide *P* means defying one’s “fundamental obligation . . . to ensure patients’ continued well-being” ([Stahl and Emanuel, 2017, 1383–4](#)). Lastly, [Stahl and Emanuel \(2017, 1382\)](#) note that working in medicine is “a voluntary, individual choice.”⁹ Hence, providers who refuse to perform consensus-approved procedures (e.g., abortion) should “select an area of medicine . . . that will not put them in situations that conflict with their personal morality or . . . leave the profession” ([Stahl and Emanuel, 2017, 1383](#)).

[Kane \(2021, 302\)](#) responds that “free choice of association” does not automatically “foreclose all freedom of choice *within* that association.” Freely associating with another person via marriage, for example, does not “foreclose all freedom of choice *within*” the marriage ([Kane, 2021, 302](#)). Thus, for physicians, “consent to join a profession in service of patient well-being does not entail, either logically or empirically, waiver of every right to conscientious objection” ([Kane, 2021, 298](#)).

Furthermore, [Kane \(2021, 305\)](#) grants that healthcare professionals have an obligation to “place the well-being and rights of patients at the center” of their practice. Now from this obligation, it does not follow that the provider must “foreswear any right to non-participation in any particular requested intervention” ([Kane, 2021, 305](#)). In other words, “it is logically possible that a conscientious objector could judge her non-performance of a procedure compatible with serving the well-being and rights of patients” ([Kane, 2021, 305](#)).

To illustrate, [Blackshaw and Rodger \(2020, 180\)](#) recently argued that “the overwhelming majority of abortions . . . provide no significant medical benefit” and so “are not clinically indicated.” As such, they claim, “there seems no compelling reason to *force* doctors” to perform abortions “if they strongly object on conscience grounds, *and* the abortion is not clinically indicated” ([2020, 181](#)).¹⁰ The idea is simple: if physicians must promote patient well-being—like [Stahl and Emanuel \(2017\)](#) claim—and a physician judges

that performing a certain procedure does *not* promote patient well-being, then the physician should not be *forced* to perform that procedure.

Kane (2021) goes further, arguing that when physicians judge that a procedure would *undermine* patient well-being, their “fundamental obligation”—to ensure patient well-being—requires that they *not* perform the procedure. This holds true even if such non-performance means refusing to provide a service that has been approved by the professional consensus. Leiva et al. (2018)—a group of physicians themselves—help illustrate this point. Specifically, they explain how the Canadian Medical Association recently redefined “euthanasia and assisted suicide as therapeutic medical services,” which, in turn, “made physician participation normative for the medical profession” (Leiva et al. 2018, 19). Leiva et al. (2018, 19–21) then describe the current pressures placed on physicians to comply with these professional norms, despite the fact that they, in their judgment *as professionals*, are convinced that “euthanasia is not medicine.” If physicians truly work to promote the well-being of their patients, therefore, then it seems they *must* refuse to yield to the professional consensus when—in their judgment as professionals—they believe the consensus is calling them to provide a procedure that undermines patient well-being.¹¹

Lastly, Stahl and Emanuel (2017, 1382) concede that physicians are not required to promote patient well-being *at all costs*; they may refrain from providing services that, if offered, carry “substantial risks of permanent injury or death.” In response, Kane (2021, 306) argues that the same “principle holds for someone who does not act because of substantial risk of damage to his moral integrity.” So, even in cases where physicians only have a moral (rather than medical) reason to oppose performing *P*, to demand that they perform *P* and sacrifice their moral integrity is something that “patients cannot reasonably expect” (Kane, 2021, 306).¹²

Straightforwardly, Kane’s essay aligns with this issue’s theme because we have a clash between (a) the general, overarching “perspective” of professional “consensus” and (b) the moral and medical perspectives of particular professionals. For Kane (2021), the former should not override the latter. After all, moral integrity is a “basic good,” required for well-being (Kane, 2021, 308). Thus, insofar as the medical profession aims to promote human well-being—of which moral integrity is a *necessary* part—the field should promote the moral integrity of particular individuals, *patients and physicians alike* (Kane, 2021). It would be deeply unsettling if the profession treated individual providers as a mere means to promoting patient well-being, as though professionals are not themselves human beings.

Yet, perhaps this *is* how medical professionals are treated (sometimes). Ariely (2015) describes increasing levels of stress, depression, and “burnout” among medical professionals (as well as decreasing levels of satisfaction). “Loss of autonomy,” “escalating oversight and control,” and increased “micro-management” are among possible explanations for these phenomena (Ariely,

2015, 1594–5).¹³ Thus, as governing bodies exercise increasing control over individual professionals—further eliminating their autonomy, among other things—the well-being of medical providers is diminished. Importantly, [Oaklander \(2015, 43\)](#) notes that reduction in physicians’ well-being often leads to a reduction in the quality of patient care as well. An argument might be made, therefore, that what opponents of conscientious objection call for—greater restrictions on the freedoms of individual professionals—actually makes the profession *worse* at accomplishing its primary goal (the promotion of patient well-being).¹⁴

Returning to the main debate, perhaps [Stahl and Emanuel \(2017\)](#) will accept that physicians—as professionals—*are* a mere means to patient well-being, insisting that this is what they signed up for. If so, then, [Kane \(2021\)](#) seems right: the cost of entering the medical field—self-destruction, in some cases—is unreasonably high. I expect Stahl and Emanuel will object that this cost does not apply to everyone. Those who do not have to pay the cost may enter the profession. To those that must pay the cost, [Stahl and Emanuel’s \(2017\)](#) send a clear message: do not apply!¹⁵

[Stahl and Emanuel’s \(2017\)](#) suggestions seem bad for the profession. By excluding would-be objectors from health care—and pushing actual objectors out of the profession—the “consensus” loses its ability to *self-correct*. This matters because sometimes the consensus gets things *wrong*.¹⁶ In those cases, [Stahl and Emanuel \(2017, 1382\)](#) reassure the reader: the consensus “uses reflective equilibrium to self-correct.” Now if one “side” within the profession is forcibly silenced (or excluded), this is not “reflective equilibrium” occurring. It is repression. When repression occurs—and the controlling voice is *mistaken*—correction must (almost certainly) come from outside of the profession (in which case it is not really *self-correction*). The reason for this is obvious: Echo chambers do not self-correct. And, it seems to me, the construction of an echo chamber—adorned with the label, “Professional Consensus”—is precisely what results from taking [Stahl and Emanuel’s \(2017\)](#) recommendations seriously.

V. A UNIFIED EXPLANATION OF THE PLACEBO EFFECT: PEIRCE’S PRAGMATICISM AS FOUNDATION

The Placebo Effect (PE) needs no introduction, though [Chiffi, Pietarinen, and Grecucci \(2021, 314\)](#) note that a complete analysis of the terms, “placebo” and “placebo effect,” has proven elusive. As [Chiffi and Zanotti \(2017, 70\)](#) remark, “there is no general agreement in medicine and in philosophy” regarding how to define these terms. Hence, in this issue, [Chiffi, Pietarinen, and Grecucci \(2021, 315\)](#) present “a new theoretical framework for the analysis of” PE, to serve as the foundation for a unified and informative explanation of PE (and its various facets).

The authors begin by arguing that a theory of PE should account for (a) physiological “mechanisms” involved in PE, (b) “its epistemology and pragmatic meaning,” and (c) should remain “sensitive to . . . recent findings in neurophysiological research” (Chiffi, Pietarinen, and Grecucci, 2021, 314). So, understanding the physiological mechanisms involved in PE is only part of the story. PE also involves a kind of “meaning relation” between the patient’s environment, mind, and body (Chiffi, Pietarinen, and Grecucci, 2021).¹⁷ With this in mind, the authors argue that “Peirce’s pragmatism” may serve well “as a theoretical foundation for PE” (Chiffi, Pietarinen, and Grecucci, 2021, 318).

For Peirce, the “meaning of signs comes from what conceivable consequences they have upon our conduct” (Chiffi, Pietarinen, and Grecucci, 2021, 318). Furthermore, “general rules of action, or habits, are generalizing tendencies that lead us to action in conceivable situations” (Chiffi, Pietarinen, and Grecucci, 2021, 318). In the case of PE, therefore, when given a placebo, “the patient’s present state of health may undergo a modification because the patient is capable of perceiving” relevant (positive) future changes as “*being real possibilities that may become actual*” (Chiffi, Pietarinen, and Grecucci, 2021, 319). So, with a change in perception regarding conceivable situations (i.e., what is possible), the patient (potentially) undergoes a change in habit (i.e., a change in their tendencies toward particular actions). In short, placebo administration involves a type of “sign” that “give[s] rise to habits of behaviour,” which, in the case of PE, are associated with an improvement in the patient’s health (Chiffi, Pietarinen, and Grecucci, 2021, 320). Importantly, this process is fully general. As the authors put it, there is “nothing peculiar in consciously taking placebo and its being effectual” since that phenomenon “is just another manifestation of the kind of meaning that has a robust pragmatic dimension” (Chiffi, Pietarinen, and Grecucci, 2021, 321).

Next, the authors ask, “How does the placebo affect the brain to produce PE?” (Chiffi, Pietarinen, and Grecucci, 2021, 322). We saw that placebo administration leads (potentially) to a change in habit. This, the authors argue, connects with “emotion regulation” (Chiffi, Pietarinen, and Grecucci, 2021, 323). The relevant change in habit or “*meaning changing*” that occurs when a patient is given a placebo “has been widely shown to regulate emotions at a psychological, neural, and bodily level” (Chiffi, Pietarinen, and Grecucci, 2021, 323). More importantly, the emotions that are *altered* during this process are those “elicited by the clinical conditions that may worsen the physiological response to the illness itself” (Chiffi, Pietarinen, and Grecucci, 2021, 324). So, with a change in habit (in Peirce’s sense), there is a potential change in emotion (on both a phenomenological and physiological level), which directly (and positively) impacts a patient’s health (in *some* cases).

Chiffi, Pietarinen, and Grecucci’s essay is the latest in a series of articles at *JMP* dedicated to examining aspects of PE in careful detail.¹⁸ The project also serves as a compliment to the more mainstream discussion of PE, where

ethical questions—like “does administering a placebo involve any sort of deception?”—are central.¹⁹ If intentionally causing PE is morally permissible—and PE stands to benefit patients—then understanding the mechanics of PE (e.g., how to produce it regularly and effectively) will be of great instrumental use. Hence, Chiffi, Pietarinen, and Grecucci (2021, 326) conclude by anticipating “new lines of research” that will explore how their model may “[be applied] to clinical practice.”

The *particular* in this case concerns specific aspects of PE and human psychology that often go overlooked (or underdiscussed) in theoretical analyses of PE. For instance, Chiffi, Pietarinen, and Grecucci (2021, 315) argue that their interlocutors focus attention on “conditioning and expectation” but fail to explore the connection between PE and “affect theory.” Now, they argue, you cannot capture (or explain) PE in terms of conditioning alone. Nor can you explain it as a process in which patients take a placebo—while expecting to get better—and then get better simply as a kind of “self-fulfilling prophecy.”²⁰ Each of these views would be reductive in a way that omits important details about how human beings interact with others and their environment (especially in terms of meaning and emotion). What Chiffi, Pietarinen, and Grecucci aim to do, in contrast to others, is find a place for all the particular factors involved in PE (i.e., the diverse ways in which placebos affect our perception, emotions, psychology, and physiology).

VI. THE HISTORY OF “AUTONOMY”: TRADING ONE TYRANT FOR ANOTHER

Next, Quentin Genuis (2021, 345) argues that as the concept of “autonomy” has evolved, “autonomy discussions within bioethics are becoming increasingly fragmented—lacking common content or narrative—and increasingly shrill—lacking effective means of dialogue.” Against this background, Genuis (2021, 343) provides a “genealogy of autonomy” while promoting a “careful sifting of the meanings and inconsistencies in the way the term is used.”²¹

Genuis’ genealogy covers four stages: “Autonomy” as understood by Kant, Mill, Beauchamp and Childress, and Savulescu, respectively. For Kant, an “autonomous act is a rational and actively-chosen one that conforms to a principle of universality” (Genuis, 2021, 335). To be autonomous, therefore, is to act in accordance with universal moral law (Genuis, 2021). Fast forward to Savulescu, however, and we are told that “a doctor’s task is not a task of caring for a patient’s health as much as serving consumer desire” (Genuis, 2021, 344).²² The physician merely facilitates patient choice in whatever ways are “consistent with the [patient’s] life plans” (Hope, Savulescu, and Hendrick, 2008, 41). Thus, the claim that autonomous action is *action in accordance with universal moral law* has been replaced with the claim that autonomous action is *pursing whatever vision of the good one sets for oneself*.

Genuis (2021, 346) concludes with a reflection on how the “autonomy movement” over the last few decades was (plausibly) a corrective to “the tyranny of the doctor.” He claims that medical experts had adopted a “hyper-paternalistic orientation,” seizing control over patients’ “general well-being: a holistic state that includes social, spiritual, and moral aspects” (Genuis, 2021, 333). The autonomy movement was a rebellion against such paternalism. Yet, as the autonomy movement has progressed—and the concept of “autonomy” has evolved—the movement has replaced the “tyranny of the doctor” with the “tyranny of patient choice” (Genuis, 2021, 346). And both tyrannies are corrosive to the physician-patient relationship (Genuis, 2021).

Genuis’ essay cautions against overemphasizing the particular in health care. Allowing patient choice to go unchecked, for example, requires that physicians facilitate decisions that undermine patients’ health.²³ This would not only be harmful to the patient, but might also cause widespread “moral distress” among medical personnel. In fact, if tenets of the profession required that physicians do whatever patients want, then the only professionals that would *not* become distressed (regularly) would be those with no moral reservations about performing whatever tasks were asked of them. It seems doubtful that a profession full of such individuals would be good for anyone.

Furthermore, as Entwistle et al. (2010) note, overemphasizing patient autonomy may be distressing for patients. Suppose “respecting autonomy” means providing an individual with “sufficient information to make a well-educated choice” and then leaving them to make a decision (Genuis, 2021, 332). Doing this, Genuis (2021, 332) argues, amounts to abandoning patients “to the terror of their own self-rule.” Entwistle et al. (2010, 742) make the same point, noting that patients may feel “abandoned rather than autonomous” when physicians “refuse to do more than inform [patients] about options and insist that they choose” (2010, 742).

Lastly, there is something *dehumanizing* about a total emphasis on autonomy. As Lysaught (2004) and Saad (2018b, 134) explain, somewhere in the history of medical ethics, “respect for persons” was replaced with “respect for autonomy.” But people are not mere wills. As Saad (2018b, 134, n. 14) argues, it is likely that when autonomy—a person’s will or capacity to make choices—becomes the object of respect, rather than *the person* themselves, medical ethics will “default” to a kind of “preference utilitarianism.” On that view, physicians are compelled to do whatever patients want, even if what they want is clearly “against the patients’ best interests” (Saad, 2018b, 134, n. 14). Lastly, “respect for autonomy” may do nothing to protect the interests of persons *without* autonomy.²⁴ After all, if autonomy is what warrants our respect, when a person lacks it, what is left to respect?

In sum, Genuis’ essay and the discussions surrounding it suggest that treating each *individual* as an undisputed authority (over his or her own

life) risks allowing substantial harm to befall patients, medical professionals, and the profession itself. Projects like Genuis' essay—which aim to strike a balance between professional judgment and patient choice—are essential, therefore, if we wish to construct approaches to health care that leave sufficient room for variation among particulars while also resisting a descent into autonomy-crazed anarchy.

VII. GOT A SPARE KIDNEY? SELL IT! (AND GIVE THE PROCEEDS TO CHARITY)

Finally, Ryan Tonkens examines the “organ-shortage problem” through the lens of “Effective Altruism” (EA). EA is about doing good in the most effective (e.g., cost-effective) way possible.²⁵ Centrally, EA holds that “one ought to help others in need, if one is in a position to do so without causing oneself or one’s dependents significant harm, or sacrificing anything of comparable moral worth” (Tonkens, 2021, 350). EA, applied to the organ shortage problem, goes like this. Some people will die without a kidney transplant. Others have spare kidneys. If someone can donate a spare kidney—*without “sacrificing anything of comparable moral worth”*—then, by EA they should donate.

The problem is that although organ donation is altruistic, it is not an *effective* way of doing good (Tonkens, 2021). Saving *one life* at the cost of (approximately) US\$150,000 is wildly inefficient because that money could save *far* more lives if applied elsewhere (Tonkens, 2021). Nonetheless, Tonkens (2021) explains that EA requires, at a minimum, that altruists (a) ensure that at death their organs are harvested for donation if possible, (b) ensure that their family members do not interfere with (a), and (c) treat their own organs well (e.g., by not damaging their lungs or livers through substance abuse).

Beyond these minimal requirements, EA might *someday* require that people donate their spare kidneys. Suppose, for instance, that kidney transplants are made possible at virtually no cost (financially or otherwise) (Tonkens, 2021). In that case, EA would likely require that people donate their spare kidney (Tonkens, 2021). Moreover, supposing EA requires live donation, Tonkens (2021) argues, people should *sell* their kidneys (rather than donate them freely). “The money earned through the organ sale” he argues, could be used to “donate to effective charities” (Tonkens, 2021, 364). Plus, by creating a legitimate market in human organs,²⁶ the “would-be sellers” of the black market would be taken out of harm’s way (Tonkens, 2021, 370).

It may seem that Tonkens—or, rather, EA—advances a general moral perspective, one that is totalizing and threatens to undermine justification for pursuing many particular ways of life.²⁷ EA, it seems, makes it impossible to justify a wide range of particular ways of life—those that involve studying philosophy, creating art, spending time with one’s family, etc. In each case,

the time, energy, and other resources spent on those “projects” could have been spent on saving lives.

In response, EA is only totalizing (in a worrisome way) when it is married to crude forms of utilitarianism, but it need not be. [Singer \(2013\)](#) argues, for instance, that the tenets of EA should appeal to consequentialists and non-consequentialists alike. EA’s central tenets, he claims (2013, 199), “cannot lead to the kinds of actions of which non-consequentialists strongly disapprove—serious violations of individual rights, injustice, broken promises and so on.” This is because EA’s main principle commands us to do good *unless* doing so requires too great a “sacrifice.” So, EA need not be totalizing, particularly when joined to a *non-consequentialist* perspective. Thus, EA is (potentially) compatible with a range of particular ways of life.

Lastly, the reader may think that EA’s central principle is proof that a “common morality” exists. After all, [Singer \(2013, 200\)](#) asserts that this principle “is not denied by any plausible ethical theory.” Suppose the principle *is* acceptable to virtually every moral perspective. The principle does not gain moral authority in virtue of this fact. Rather, the principle is justified within each particular moral perspective, given the features of that system. The principle’s authority, therefore, stems from different foundations for different people. Put differently, sometimes trees grow together, despite having separate roots.

VIII. CONCLUSION

The essays in this issue of *JMP* encourage us to attend to (a) the unique struggles of those with actual healthcare needs, (b) differing moral (and religious) perspectives of medical professionals, (c) various aspects of the human experience relevant to the PE, (d) the perils that come with over-emphasizing autonomy, and (e) the particular ways in which effective altruism might call us to combat the organ-shortage problem. Hence, each essay encourages us to find a proper place for the particular in health care. I close by commending these essays to the reader. I invite them to explore this issue of *JMP*; both in light of the theme I have established here and by looking at the many other ways in which each essay enriches contemporary bioethical literature.

NOTES

1 In discussions of disability, for example, there is often an emphasis on the disconnect between abstract concepts of disability and the particular ways in which disability shapes the lives of individual people. See, for example, [Silvers \(2003\)](#), [Barnes \(2016, 106–7\)](#), and [Kaposy \(2018\)](#). Furthermore, as [Davis \(1983, 181\)](#), [Triano \(2006, 476–7\)](#), and [Barnes \(2016, 119–42\)](#) illustrate, the testimony of people with disabilities is sometimes used to “correct” conceptualized/general pictures of disability.

2 For responses, see [Parker \(2019\)](#) and [Colgrove and Evans \(2019\)](#).

3 For responses, see [Bibler \(2019\)](#), [Schüklenk \(2019\)](#), [Griffin \(2019\)](#), [Colgrove \(2019\)](#), [Eberly and Frush \(2019\)](#), and [Gill \(2019\)](#). For a rejoinder, see [Hubbard and Greenblum \(2019\)](#).

4 Cf. [Malek \(2019, 95\)](#) and [Greenblum and Hubbard \(2019, 709\)](#).

5 This narrative does *not* entail “moral relativism.” [Engelhardt \(1996, 421–2\)](#) clearly believed that there *is* a particular vision of the good that is *correct*. From the claim that one particular vision of the good is correct, it does not follow that the details of the correct perspective will be discoverable via “public reasoning” or consistent with other (competing) visions of the good. So, denying “common morality” does not commit one to moral relativism.

6 [Solomon \(2014, 89–91\)](#). See also [Solomon \(2006\)](#) regarding the “export problem” facing bioethics, as well as [Engelhardt \(2006\)](#), [Wang and Wang \(2010\)](#), and [Cherry \(2010\)](#) for more on bioethical “consensus” and clashes of culture.

7 For [Beauchamp and Childress \(2013, 101\)](#), this principle “runs as deep in the common morality as any principle.” But [Engelhardt \(1996, 57–8\)](#) and [Genuis \(2021\)](#) reveal that there *is* no single “autonomy” principle.

8 Rumbold cites [Stern \(1983\)](#) and, especially, [Daniels \(2008\)](#) as representing the majority view.

9 Cf. [Schüklenk and Smalling \(2017, 238\)](#).

10 Cf. [Saad \(2018a, 650\)](#).

11 [Kane \(2021, 302\)](#) compares such a “command” to a military order that “lacks valid military purpose” (i.e., “an unlawful order”). Soldiers, [Kane \(2021\)](#) notes, have no obligation to obey unlawful orders. In fact, they may have “a duty to disobey” such orders ([Kane, 2021, 302](#)). Something analogous applies in cases where “professional consensus” pressures physicians to offer services that lack valid *medical* purpose; physicians have no obligation to comply and may actually have a duty to “disobey.” See [Cowley \(2016, 362\)](#) for a similar argument.

12 See also [Wicclair \(2000\)](#) and [Magelseen \(2011\)](#) for defenses of conscientious objection based on respect for moral integrity.

13 Similarly, [Erde \(2008, 18\)](#) suggests the ethos of “professionalism” might be to blame (as it encourages “quasi-martyrdom” among professionals).

14 See [Thomas and McCullough \(2015\)](#) and [National Academies of Sciences, Engineering, and Medicine \(2019\)](#) for more on these topics.

15 Cf. [Savulescu and Schüklenk \(2017\)](#).

16 See [Stahl and Emanuel \(2017, 1382–3\)](#) and [Kane \(2021, 298\)](#).

17 See also [Brody \(1985\)](#), as well as [Brody and Brody \(2000\)](#).

18 For others, see [Connelly \(1991\)](#), [Frenkel \(2008\)](#), [Miller and Brody \(2011\)](#), and [Chiffi and Zanotti \(2017\)](#).

19 For a small sampling, see [Cohen and Shapiro \(2013\)](#), [Barnhill and Miller \(2014\)](#), [Pugh \(2014\)](#), [Gold and Lichtenberg \(2014\)](#), and [Glackin \(2016\)](#).

20 Cf. [Chiffi, Pietarinen, and Grecucci \(2021, 314\)](#) and [Chiffi and Zanotti \(2017\)](#).

21 Cf. [Saad \(2018b\)](#) who, like Genuis, provides a “history of autonomy in medicine.”

22 See [Hope, Savulescu, and Hendrick \(2008\)](#) and [Savulescu \(2006, 2007\)](#).

23 Cf. [Saad \(2018b, 134, n. 14\)](#).

24 Cf. [Saad \(2018b, 134\)](#) and [Lysaught \(2004\)](#).

25 See [Singer \(2015\)](#).

26 For more on markets in human organs, see [Cherry \(2005\)](#) and [Hippen \(2009\)](#). The latter is an introduction for an issue of *JMP* dedicated to this very topic.

27 [Tonkens \(2021\)](#) is not trying to defend EA, however. He just examines the organ-shortage problem from that perspective.

REFERENCES

- Ariely, D. 2015. Disturbing trends in physician burnout and satisfaction with work–life balance: Dealing with malady among the nation’s healers. *Mayo Clinic Proceedings* 90(12):1593–6.
- Barnes, E. 2016. *The Minority Body: A Theory of Disability*. Oxford, United Kingdom: Oxford University Press.

- Barnhill, A., and F. G. Miller. 2014. Placebo and deception: A commentary. *The Journal of Medicine and Philosophy* 40(1):69–82.
- Beauchamp, T. L., and J. F. Childress. 2013. *Principles of Biomedical Ethics*. New York and Oxford, United Kingdom: Oxford University Press.
- Bibler, T. 2019. Remaining ambiguities surrounding theological negotiation and spiritual care: Reply to Greenblum and Hubbard. *Journal of Medical Ethics* 45(11):711–2.
- Blackshaw, B. P., and D. Rodger. 2020. Questionable benefits and unavoidable personal beliefs: Defending conscientious objection for abortion. *Journal of Medical Ethics* 46(3):178–82.
- Brody, H. 1985. Placebo effect: An examination of Grünbaum's definition. In *Placebo: Theory, Research, and Mechanisms*, eds. L. White, B. Tursky, and G. E. Schwartz, 36–58. New York: Guilford Press.
- Brody, H., and Brody, D. 2000. *The Placebo Response: How You Can Release the Body's Inner Pharmacy for Better Health*. New York: Cliff Street Books.
- Cherry, M. J. 2005. *Kidney for Sale by Owner: Human Organs, Transplantation, and the Market*. Washington, DC: Georgetown University Press.
- . 2010. The illusion of consensus: Harvesting human organs from prisoners convicted of capital crimes. *The Journal of Medicine and Philosophy* 35(2):220–2.
- . 2017. The scandal of secular bioethics: What happens when the culture acts as if there is no God? *Christian Bioethics* 23(2):85–99.
- Chiffi, D., A. V. Pietarinen, and A. Grecucci. 2021. Meaning and affect in the placebo effect. *The Journal of Medicine and Philosophy* 46(3):313–29.
- Chiffi, D., and R. Zanotti. 2017. Knowledge and belief in placebo effect. *The Journal of Medicine and Philosophy* 42(1):70–85.
- Cohen, S., and H. Shapiro. 2013. 'Comparable placebo treatment' and the ethics of deception. *The Journal of Medicine and Philosophy* 38(6):696–709.
- Colgrove, N. 2019. Responding (appropriately) to religious patients: A response to Greenblum and Hubbard's 'public reason' argument. *Journal of Medical Ethics* 45(11):716–7.
- Colgrove, N., and K. K. Evans. 2019. The place for religious content in clinical ethics consultations: A reply to Janet Malek. *HEC Forum* 31(4):305–23.
- Connelly, R. J. 1991. Nursing responsibility for the placebo effect. *The Journal of Medicine and Philosophy* 16(3):325–41.
- Cowley, C. 2016. A defense of conscientious objection in medicine: A reply to Schüklenk and Savulescu. *Bioethics* 30(5):358–64.
- Daniels, N. 2008. *Just Health: Meeting Health Needs Fairly*. Cambridge, United Kingdom: Cambridge University Press.
- Davis, A. 1983. Right to life of handicapped. *Journal of Medical Ethics* 9(3):181.
- Eberly, J. B. Jr., and B. W. Frush. 2019. Doing theology in medical decision-making. *Journal of Medical Ethics* 45(11):718–19.
- Engelhardt, H. T. Jr. 1996. *The Foundations of Bioethics*. 2nd ed. New York: Oxford University Press.
- , ed. 2006. *Global Bioethics: The Collapse of Consensus*. Salem, MA: M & M Scrivener Press.
- Entwistle, V. A., S. M. Carter, A. Cribb, and K. McCaffery. 2010. Supporting patient autonomy: The importance of clinician-patient relationships. *The Journal of General Internal Medicine* 25(7):741–5.

- Erde, E. L. 2008. Professionalism's facets: Ambiguity, ambivalence, and nostalgia. *The Journal of Medicine and Philosophy* 33(1):6–26.
- Frenkel, O. 2008. A phenomenology of the 'placebo effect': Taking meaning from the mind to the body. *The Journal of Medicine and Philosophy* 33(1):58–79.
- Genius, Q. 2021. A genealogy of autonomy: Freedom, paternalism, and the future of the doctor-patient relationship. *The Journal of Medicine and Philosophy* 46(3):330–49.
- Gill, R. 2019. The importance of prudence within inclusive bioethics. *Journal of Medical Ethics* 45(11):720.
- Glackin, S. N. 2016. Parsing placebo treatments: A response to Barnhill and Miller. *Journal of Medical Ethics* 42(10):687–9.
- Gold, A., and P. Lichtenberg. 2014. The moral case for the clinical placebo. *Journal of Medical Ethics* 40(4):219–24.
- Greenblum, J., and R. K. Hubbard. 2019. Responding to religious patients: Why physicians have no business doing theology. *Journal of Medical Ethics* 45(11):705–10.
- Griffin, H. P. 2019. Public reason's private roles: Legitimizing disengagement from religious patients and managing physician trauma. *Journal of Medical Ethics* 45(11):714–5.
- Hippen, B. E. 2009. Introduction: Symposium on a regulated market in transplantable organs. *The Journal of Medicine and Philosophy* 34(6):545–51.
- Hope, T., J. Savulescu, and J. Hendrick. 2008. *Medical Ethics and Law: The Core Curriculum*. 2nd ed. Edinburgh, United Kingdom: Churchill Livingstone Elsevier.
- Hubbard, R. K., and J. Greenblum. 2019. Physicians' duty to refrain from religious discourse: A response to critics. *Journal of Medical Ethics* 45(11):721–2.
- Kane, T. 2021. Reevaluating Conscience Clauses. *The Journal of Medicine and Philosophy* 46(3):297–312.
- Kaposy, C. 2018. *Choosing Down Syndrome: Ethics and New Prenatal Testing Technologies*. Cambridge, MA: MIT Press.
- Leiva, R., M. M. Cottle, C. Ferrier, S. R. Harding, T. Lau, T. McQuiston, and J. F. Scott. 2018. Euthanasia in Canada: A cautionary tale. *World Medical Journal* 64(3):17–23.
- Lysaught, M. T. 2004. Respect: Or, how respect for persons became respect for autonomy. *The Journal of Medicine and Philosophy* 29(6):665–80.
- Magelseen, M. 2011. When should conscientious objection be accepted? *Journal of Medical Ethics* 38(1):18–21.
- Malek, J. 2019. The appropriate role of a clinical ethics consultant's religious worldview in consultative work: Nearly none. *HEC Forum* 31(2):91–102.
- Miller, G. M., and H. Brody. 2011. Understanding and harnessing placebo effects: Clearing away the underbrush. *The Journal of Medicine and Philosophy* 36(1):69–78.
- National Academies of Sciences, Engineering, and Medicine. 2019. *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-being*. Washington, DC: The National Academies Press.
- Oaklander, M. 2015. Inside the movement to save the mental health of America's doctors. *TIME Magazine* 186(9–10):42–51.
- Parker, J. C. 2019. The clinical ethics consultant: What role is there for religious beliefs? *HEC Forum* 31(2):85–9.
- Pugh, J. 2014. Ravines and sugar pills: Defending deceptive placebo use. *The Journal of Medicine and Philosophy* 40(1):83–101.
- Rumbold, B. 2021. Re-asserting the specialness of health care. *The Journal of Medicine and Philosophy* 46(3):272–96.

- Saad, T. C. 2018a. Mistakes and missed opportunities regarding cosmetic surgery and conscientious objection. *Journal of Medical Ethics* 44(9):649–50.
- . 2018b. The history of autonomy in medicine from antiquity to principlism. *Medicine, Health Care and Philosophy* 21(1):125–37.
- Savulescu, J. 2006. Conscientious objection in medicine. *BMJ* 332(7536):294–7.
- . 2007. Autonomy, the good life, and controversial choices. In *The Blackwell Guide to Medical Ethics*, eds. R. Rhodes, L. P. Francis, and A. Silvers, 17–37. Malden, United Kingdom: Blackwell Publishing.
- Savulescu, J., and U. Schüklenk. 2017. Doctors have no right to refuse medical assistance in dying, abortion, or contraception. *Bioethics* 31(3):162–70.
- Schüklenk, U. 2019. Professionalism eliminates religion as a proper tool for doctors rendering advice to patients. *Journal of Medical Ethics* 45(11):713.
- Schüklenk, U., and R. Smalling. 2017. Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies. *Journal of Medical Ethics* 43(4):234–40.
- Silvers, A. 2003. On the possibility and desirability of constructing a neutral conception of disability. *Theoretical Medicine and Bioethics* 24(6):471–87.
- Singer, P. 2013. *Practical Ethics*. 3rd ed. Cambridge, United Kingdom: Cambridge University Press.
- . 2015. *The Most Good You Can Do: How Effective Altruism is Changing Ideas about Living Ethically*. New Haven, CT and London, United Kingdom: Yale University Press.
- Solomon, D. 2006. Domestic disarray and imperial ambition: Contemporary applied ethics and the prospects for global bioethics. In *Global Bioethics: The Collapse of Consensus*, ed. H. T. Engelhardt, Jr., 335–61. Salem, MA: M & M Scrivener Press.
- . 2014. Bioethics and culture: Understanding the contemporary crisis in bioethics. *International Journal of Chinese & Comparative Philosophy of Medicine* 12(2):87–117.
- Stahl, R. Y., and E. J. Emanuel. 2017. Physicians, not conscripts—Conscientious objection in health care. *New England Journal of Medicine* 376(14):1380–5.
- Stern, L. 1983. Opportunity and health care: Criticisms and suggestions. *The Journal of Medicine and Philosophy* 8(4):339–61.
- Thomas, T. A., and L. B. McCullough. 2015. A philosophical taxonomy of ethically significant moral distress. *The Journal of Medicine and Philosophy* 40(1):102–20.
- Tonkens, R. 2021. The most good you can do with your kidneys: Effective altruism and the organ-shortage problem. *The Journal of Medicine and Philosophy* 46(3):350–76.
- Triano, S. 2006. Disability pride. In *The Encyclopedia of Disability*, ed. G. Albrecht, 476–7. London, United Kingdom: Sage Publications.
- Wang, M., and X. Wang. 2010. Organ donation by capital prisoners in China: Reflections in Confucian ethics. *The Journal of Medicine and Philosophy* 35(2):197–212.
- Wicclair, M. R. 2000. Conscientious objection in medicine. *Bioethics* 14(3):205–27.