



# Bioethics: An International, Morally Diverse, and Often Political Endeavor

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## Abstract

Bioethicists often remind health care professionals to pay close attention to issues of diversity and inclusion. Approaches to ethics consultation, where the perspective of the bioethicist is taken to be more morally correct or necessarily authoritative, have been critiqued as inappropriately authoritarian. Despite such apparent recognition of the importance of respecting moral diversity and the inclusion of different viewpoints, authoritarianism is all too often the approach adopted, especially as bioethics has shifted evermore into concerns for public policy. Yet, secular values and philosophical principles are not morally neutral; nor are the private moral convictions of bioethicists. Such analysis is always grounded in particular understandings of the right and the good, the virtuous and the just. Critical examination of common treatments and new alternatives is essential for the careful scientific practice of medicine. The same is true with regard to bioethics. Stagnating in customary or accepted claims of a common secular morality or a standard set of bioethical principles out of an unwillingness to explore the real diversity of moral thought, including traditional religious and cultural worldviews, fails to tap the human capacity to find innovative solutions to the complex challenges facing medicine.

**Keywords** Bioethics · Moral diversity · Inclusion · Clinical ethics

## Bioethics as Biopolitics

Bioethicists often remind health care professionals to pay close attention to issues of diversity and inclusion, to be sensitive to cultural differences, utilize interpreters when necessary to support patient understanding, and appreciate that values, goals, and interests differ among persons. Ethics consultations, where the perspective of the bioethicist is taken to be more morally correct or necessarily authoritative, have been critiqued as inappropriately authoritarian. As the American Society for

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Bioethics and Humanities (ASBH) argues: “This assumption may lead to minimizing or excluding the values of key stakeholders (e.g., patients, surrogates). It may create the impression that the consultant’s expertise in ethical analysis amounts to moral ‘hegemony,’ which is problematic because it usurps the authority of primary decision makers” (American Society for Bioethics & Humanities Task Force, 2011, 6–7).<sup>1</sup> Yet, despite such apparent recognition of the importance of respecting moral diversity and the inclusion of different viewpoints, authoritarianism is all too often the approach adopted, especially as bioethics has shifted evermore into concerns for public policy.<sup>2</sup>

As H. Tristram Engelhardt, Jr. (1941–2018) documented, contemporary American bioethics grew out of the educational, professional, and ideological interests of those who worked to establish the role of the medical humanities in the medical schools. This social and cultural movement was for the most part grounded in a secular social-democratic political vision.<sup>3</sup> Following the secularization of American society, widespread beginning at least in the 1950s, for many it no longer seemed appropriate to trust the paternalistic judgments of physicians, priests, ministers, and rabbis for moral guidance. Bioethicists stepped into this gap as a new professional service designed to fill the cultural void and provide medical moral guidance (Engelhardt, 2009, 297). Widely adopted, *The Principles of Biomedical Ethics* (Beauchamp & Childress, 1979, currently in its eighth edition, 2019), outlined a methodology that has by-and-large become the established American bioethics. Practitioners in North America are taught to speak what appears to be a common language, referencing four basic principles (autonomy, beneficence, nonmaleficence, and justice), even when they may not agree on the significance, meaning, content, or appropriate context of such terminology. Such usage, moreover, presupposes the existence of a common morality as well as that reflection on these four principles permits bioethicists correctly to resolve concrete cases and properly to guide public policy. Professional associations, such as ASBH, reinforce this image of moral

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<sup>1</sup> “The defining characteristic of this approach to HCEC [health care ethics consultation] is its emphasis on the consultant as the primary moral decision maker. It may suggest to participants in the consultation that the moral values or perspectives of the consultant are more correct or important than the moral perspectives of other participants in the consultation. This assumption may lead to minimizing or excluding the values of key stakeholders (e.g., patients, surrogates). It may create the impression that the consultant’s expertise in ethical analysis amounts to moral ‘hegemony,’ which is problematic because it usurps the authority of primary decision makers. We do not support this approach” (American Society for Bioethics and Humanities Task Force 2011, 6–7).

<sup>2</sup> Here, one might consider attempts to treat minor children as independent decision makers and thereby separate parents and their children (Barina and Bishop 2013; De Lourdes-Levy et al., 2003; Cherry, 2013; see, generally, Cherry 2016). Or, when clinical ethicists seek to sideline religious parents altogether (see Brummett, 2021).

<sup>3</sup> Engelhardt recalls, for example, that “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. 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” (Engelhardt, 2009, 296).

agreement through the creation of professional credentialing services and the publication of official bioethics consultation manuals.<sup>4</sup>

This number of *HEC Forum* illustrates, however, just how broad the field of bioethics has become, as it encompasses an internationally rich conversation, marked by substantial moral, political, and religious diversity.<sup>5</sup> Writing from Norway, for example, Cornelius Cappelen, Tor Midtbø, and Kristine Bærø explore ways in which healthcare systems might permissibly hold individuals responsible for what others judge to be unhealthy consumer choices and personal behaviors (2022). Sanwar Siraj, in turn, provides a detailed analysis of cultural and religious challenges to deceased organ donation in Bangladesh (2022). From the Netherlands, Laura Hartman, Guy Widdershoven, Eva van Baarle, Froukje Weidema and Bert Molewijk assess the development of a national system of clinical ethics support designed to foster the quality of ethics consultation (2022). Finally, Charlotte McDaniel and Emir Veledar draw the reader into an analysis of the perception of racial-ethnic work disparities in long-term care (2022). Together, the authors illustrate just a few of the myriad ways that working through difficult bioethical issues requires careful attention to the inherent challenges of moral diversity in modern medicine.

## Freedom and Responsibility for Health-Risky Choices?

Cappelen, Midtbø, and Bærø begin the issue by exploring whether it is fair or just to hold citizens responsible for their lifestyle choices when those decisions adversely impact their own health. They note, for example, that smoking, alcohol consumption, lack of exercise, and poor eating habits, contribute to the risk of illness and premature death. Such health-risky choices, consequently, impact the cost and availability of healthcare. Since funding is never unlimited, all health care systems must find ways appropriately to control and allocate resource usage so as to contain costs. Rationing often includes restrictions on access to expensive services, such as requiring patients to wait in queues to see specialists or to access important diagnostic tests (such as CT scans or MRIs), restricting life-sustaining and life-enhancing care, or insisting on narrow lists of preferred pharmaceuticals.<sup>6</sup> Financial challenges facing healthcare systems are only increasing as populations age and fewer younger

<sup>4</sup> Consider the American Society for Bioethics and Humanities' self-publication of their bioethics consultation manual: *Core competencies for health care ethics consultation* (1998), now in its second edition (2011).

<sup>5</sup> Such diversity includes significant disagreement regarding which moral principles matter (Veatch 2020; Campelia & Feinsinger, 2020), and when they are authoritative (Porter, 2020; Trotter, 2020), as well as whose morally content-full claims ought to frame public policy (Engelhardt, 1996). It also impacts moral assessment of particular controversial issues, such as lethal injection (Sawicki, 2022), ecological concerns (Katz, 2022), conscientious objection (Cantor 2009; Gamble & Gamble, 2022; McConnell 2021), euthanasia (Raus et al., 2021) and human challenge trials (Hausman, 2022).

<sup>6</sup> Consider, for example, the Fraser Institute's annual report on the Canadian healthcare system, documenting increasing wait times for access to specialist treatment and important diagnostic tests. Patients experience significant waiting times for diagnostic technologies. Mackenzie Moir and Bacchus Barua document that "The wait for a computed tomography (CT) scan has decreased to 5.2 weeks in 2021 from 5.4 weeks in 2020. Saskatchewan, Ontario, Quebec, and Newfoundland & Labrador had the shortest wait for a CT scan (4.0 weeks), while the longest waits occur in Alberta (10.0 weeks). The wait for a

taxpayers are available to pay into the system. Fashioning health care policy requires finding ways to encourage consumers, physicians and patients alike, to utilize restraint when expending resources, and to shift their behaviors away from riskier activities that will adversely impact the health care system. Laws requiring automobile passengers to utilize seat belts, motorcycle riders to wear helmets, cancer warning labels on cigarettes, or nutritional labels on packaged foods are just a few examples of more or less paternalistic laws designed to limit individual freedom to promote more healthful, responsible choices. How should patients be held responsible if their lifestyles negatively impact the health care system?

Cappelen, Midtbø, and Bærø utilized a national survey to explore public response to different types of mechanisms for holding patients responsible for unhealthy consumer choices and risky personal behaviors, comparing risk-sharing, backward-looking, and forward-looking mechanisms. Risk-sharing mechanisms include taxes levied on consumer products judged to be unhealthy, such as alcohol, tobacco, or fatty foods, so that those who make such “risky” choices effectively pay additional fees designed to offset treatment costs for medical care associated with their use. Norway, for example, levies a tax on sugar specifically to nudge the national diet away from excessively sugary foods. Another example of risk-sharing would be lower insurance premiums for individuals who participate in preventative health programs or who incur fewer health care costs, much like lower automobile insurance premiums for drivers who complete driver training classes that teach skills designed to reduce motor vehicle accidents. Backward-looking mechanisms seek ways to hold individuals responsible for past choices, such as increased health insurance premiums or requiring patients to pay the full cost of care for lifestyle related medical care. Forward-looking mechanisms, in turn, provide individuals with warnings about future consequences regarding lifestyle-related illness, such as lower organ transplantation priority for alcohol abuse associated liver disease, should they fail to change their personal behavior. The survey results indicated that, at least in Norway, formal mechanisms that penalize individuals for their risk-affirming choices and forward-looking mechanisms for lowering treatment priority for patients with unhealthy lifestyles were more popular. Interestingly, their results indicated that individuals were more likely to apply such official responsibility mechanisms to themselves than to others.

Among the challenges for determining appropriate mechanisms to encourage free and responsible behavior while reducing health care costs include empirical questions regarding which nudges or penalties would actually have a noticeable real-world impact, as well as moral questions regarding which types of behavior to so stigmatize. It may be politically easier, for example, to call for increased costs or

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Footnote 6 (continued)

magnetic resonance imaging (MRI) scan has decreased to 10.2 weeks in 2021 from 11.1 weeks in 2020. Patients in Ontario faced the shortest wait for an MRI (6.0 weeks), while residents of Alberta wait longest (24.0 weeks). Finally, the wait for an ultrasound increased in 2021 to 3.6 weeks from 3.5 weeks in 2020. Alberta, Saskatchewan, and Ontario have the shortest wait for an ultrasound (2.0 weeks), while Prince Edward Island has the longest: 16.0 weeks (chart 7)” (2021, 9).

lower health care priority for those who drink alcohol or smoke, but more difficult to do so for other types of activities that also directly impact the health care system, such as participating in organized sports or various forms of sexual activity. According to Waltzman, Womack, Thomas, and Sarmiento, in the United States between 2001 and 2018, there were some 3.8 million visits to emergency departments for sports-related traumatic brain injuries for children 17 years-of-age and younger. Contact sports accounted for approximately 41% of these injuries (2020). Waltzman and her colleagues recognized, however, that this number very likely underestimated injury rates, because some children would have been treated by a pediatrician, family care doctor, or another primary care physician.<sup>7</sup> Should families whose children participate in organized sports pay a special tax as a risk-sharing mechanism? What about sexual activity? According to the Centers for Disease Control and Prevention (CDC), direct health care costs associated with certain forms of sexually transmitted disease in the United States amounts to approximately 16 billion dollars a year, not including additional future costs of cancers causally associated with some such infections.<sup>8</sup> The CDC estimates that about one in five people in the United States had a sexually transmitted disease on any particular day in 2018 (see CDC. <https://www.cdc.gov/std/statistics/prevalence-2020-at-a-glance.htm>). Men who have sex with other men are at a documented increased risk of contracting sexually transmitted diseases, including higher rates of syphilis and new HIV infections (see Gay Men and STDs | Sexually Transmitted Diseases | CDC <https://www.cdc.gov/std/life-stages-populations/stdfact-msm.htm>). Is there a morally important distinction between the medical costs associated with smoking or alcohol, on the one hand, and sports-related injuries or sexually transmitted diseases, on the other, such that they should be treated differently in terms of health-related risks? Since many advocates understand addictions as a disease, while others argue that penalizing individuals for exposing themselves to sexually transmitted diseases would inappropriately stigmatize particular groups of persons, it may be morally and politically challenging to determine which choices and lifestyles to treat as obvious health risks for the sake of applying official mechanisms to alter personal behavior.

<sup>7</sup> Waltzman, Womack, Thomas, and Sarmiento conclude: “First, injury rates are underestimated because this study only included children treated in EDs. Many children with a TBI do not seek care in EDs (10) or do not seek care at all. Second, the estimates cannot be used to calculate relative risks for TBIs associated with SRR activities because there are limited data on national participation in SRR activities, especially for unorganized sports. Therefore, it is difficult to tell whether decreases in injuries result from interventions, decline in participation, or a combination of both. Third, because NEISS-AIP was not developed to identify specific diagnoses, actual TBIs might have been missed, and some injuries classified as TBIs might not have been. Fourth, because NEISS-AIP only included one diagnosis and body part injured, TBIs might be missed in cases where multiple injuries were present” (2020, 872).

<sup>8</sup> Here one might consider that oncogenic human papillomavirus (HPV) infection has been identified as a major cause of cervical cancer, as well as of other types of oropharyngeal and anogenital cancers (see, e.g., Herrero et al., 2015).

## Use of Deceased Donor Organs for Transplantation

Which moral standards should be taken as definitive for understanding and assessing patient rights and virtues, medical duties and health care outcomes? Should medicine, and thus bioethics, permit the existence of significant social space for the robust expression of diverse philosophical, religious, and atheistic ideological worldviews, where divergent moral visions compete side-by-side? Or, should bioethics move immediately from moral assertions to legal conclusions that such behavior ought to be prohibited or required by force of law? A literature search easily illustrates that there are significant moral divisions among the world's religions, cultures, and philosophical perspectives. Bioethicists from a wide variety of ethical perspectives have utilized many different theoretical concepts and normative judgments in attempts to secure the moral project: appeals to “deep” intuitions, good consequences, proper casuistry, concepts of unbiased choice, middle-level principles, and so forth abound. All such attempts, as Engelhardt argued, confront insurmountable obstacles. A normative perspective must already be presupposed in order to rank consequences, determine which intuitions to follow, judge cases as morally exemplary, or mediate among various moral principles. Otherwise, no rational choice at all will be possible (1996, Chaps. 2 through 4). One is left with numerous rankings of moral concerns, such as justice and equality, in different orders of priority, affirming various moral visions, and, in consequence, divergent understandings of the good life, along with a plurality of senses of what it is appropriately to act.

Consider, for example, organ transplantation policy, which provides another useful arena for exploring the tension between purported respect for moral diversity and forays into authoritarian bioethical public policy. In their eagerness to obtain organs for transplantation, for example, many countries have begun to sidestep voluntary donation in favor of organ conscription from the newly deceased. Such policy is usually framed using the misnomer “presumed consent,” even though there is no actual consent, individual or familial, involved (see Zambrano, 2021; Gill, 2004; Iltis, 2010; Wilkinson, 2012; Taylor, 2012). The goal of such policy is to harvest organs, unless the individual has fulfilled all of the legally necessary steps to deny permission or “opt-out”. When Wales adopted such a policy in 2015, reporting clearly indicated that it was a significant shift away from a prior “voluntary scheme”. Eurotransplant contrasts “presumed consent” with “informed consent”, noting that the later involves a “voluntary system of organ donation whereby relatives give permission at the time of death, usually in the knowledge that the potential donor had expressed a wish to become a donor”.<sup>9</sup> Austria, Croatia, Hungary, Luxembourg, and Slovenia, among other countries, also have presumed consent frameworks for taking organs from the newly deceased, justifying such policy on the utilitarian grounds that it might increase access to potentially life-saving organs. There is, however, no reason to believe that all citizens support such organ confiscation. Many individuals may

<sup>9</sup> <https://www.eurotransplant.org/cms/index.php?page=legislation1>.

object on moral,<sup>10</sup> religious, cultural, or even medical grounds,<sup>11</sup> but find it difficult to work through the bureaucratic procedures successfully to opt-out of organ harvesting.<sup>12</sup> Instead of showing respect for diversity and inclusion, policies such as “presumed consent” simply impose a particular point of view.

As Siraj argues in his contribution to this issue, a complex interplay of faith and culture, religion, rituals and social norms underlie the challenges of obtaining organs for transplantation from posthumous sources. While Siraj’s analysis focuses on Bangladesh, it contains wider lessons regarding the implications of real-world moral diversity for bioethical policy. Obtaining organs from brain-dead or otherwise recently deceased individuals has become relatively common in large parts of the world. Such practices, however, remain a matter of controversy in Bangladesh. As Siraj documents, obtaining vital organs for transplantation from deceased donors was legalized in 1999, following a *fatwa* or religious ruling in support of the practice. Yet, donation of organs after death remains controversial and fairly sparse. According to Siraj, Bangladeshis typically see organ harvesting as violating bodily integrity and wholeness, where the dead should be treated with respect and care, being buried as soon as possible. Also, as he documents, Islamic scholars have raised the concern that since the heart of the patient is still beating, brain-death is not true death. Siraj argues that Islamic scholars generally consider the patient to be dead once the soul has departed the body, where while the heart beats, the human body contains the soul. Brain-dead patients, as a result, are understood to be only in the process of dying, and so it would be seriously wrong to harvest organs. Secular bioethics is not in a good intellectual position authoritatively to mediate such culturally or religious based disputes. Siraj argues, however, that increasing public awareness and perhaps making counselors available, would help more grieving families consent to organ harvesting from their recently deceased loved ones.

## Assessing Clinical Ethics in a Morally Diverse World

Given the challenges of significant moral diversity, how should we judge the quality of clinical ethics consultation and ethics support for health care professionals? As the next two papers explore, assessing our ability to provide and foster quality

<sup>10</sup> Some libertarians might reject, for example, the idea that states are acting in a morally legitimate fashion when they decide to confiscate organs at death without explicit permission. After all, states are not generally morally in authority simply to confiscate all of one’s savings that one has otherwise left to one’s assigns and heirs. That the state claims that it will use the confiscated wealth to benefit others does not thereby make the taking any more morally justified.

<sup>11</sup> Here, some patients may raise concerns regarding inappropriate end-of-life care. Non-heart-beating donors, for example, may be given anticoagulants and vasodilators to support oxygenated blood flow, treatments designed to benefit the organ and future organ recipient, rather than the donor patient.

<sup>12</sup> Indeed, one might even object on economic grounds. State confiscation of organs seems particularly problematic once one realizes how financially valuable human organs can be. Instead of the spouse and family of the recently deceased receiving payment, the organs are confiscated, a practice legalized by the very government that prohibited the selling of valuable human organs in the first place. What a gruesome form of death taxes—a direct levy by the government on valuable property that would otherwise have been entailed to the recently deceased’s estate (see, e.g., Cherry, 2015, 2017).

ethics consultation and organizational ethics seems a useful goal. In their contribution, Hartman, Widdershoven, Baarle, Weidema and Molewijk report on the development of a clinical ethics network in the Netherlands, *Netwerk, Ethiek Ondersteuning Nederland (NEON)*, which brings clinical ethics practitioners together to learn from each other, develop best practices, professionalize clinical ethics activities, conceptualize and foster quality clinical ethics consultation. Through such professional activities as national conferences, websites for sharing information, examples and arguments for best practices, as well as the production of a handbook detailing core competencies and methodologies, they have worked to define and support high impact practices. Instead of beginning with abstract theoretical claims regarding what would count as quality ethics consultation, they utilized responsive evaluation methodology, exploring the diverse experiential knowledge of practitioners, offering contextualized and detailed information about useful practices and case management to support each other. Quality assessment by peers was appreciated as more important than “expert” assessment of the field. Moreover, they recognized the need to be explicit about the underlying normative presuppositions of particular ethical viewpoints critically to conceptualize and to explore quality ethics consultation.

McDaniel and Veledar, in turn, utilized a set of survey questions to assess perceptions of the quality of the ethics environment in long-term care. They surveyed a cross-section of employees, exploring whether perceptions differed among various demographic groups, and whether such perception was also associated with employee personal health and the organization’s ability to manage disagreements, effectively meet goals, and maintain employee satisfaction, while also delivering quality health care. The data, they argue, shows that ethics is an integral element of high quality health care institutions. While such association does not necessarily imply a causal connection, with perceived ethical quality one should anticipate other positive features, such as less employee turnover, high quality of work outcomes, improved productivity, and the ability to care more effectively for patients. McDaniel and Veledar recognize that there are limits to empirical studies that are based on how particular persons self report perceptions about moral issues; however, they argue that respecting the diversity of opinions also provides insight into areas for organizations to engage in policy creation and training, prevention and intervention to redress staffing concerns and improve quality of care. Such empirical data can provide insight into the moral and cultural assumptions that healthcare professionals and bioethicists bring to their work, shedding light on the implications of marginalizing racial, ethnic, political, or traditional religious groups in bioethics consultation. Here also, ethics committees can play a supportive role, providing official mechanisms to assess ethical concerns and needs, institutional decisions, and discussion of complex ethical cases, while also supporting ethics education for staff and administrators.



## Conclusion

Just how committed to diversity and inclusion is the field of bioethics? While ASBH's 2020 statement on injustice and professionalism in bioethics referred to "diverse cultural, ethnic, and racial backgrounds," it failed to reference respect for different religious or political perspectives.<sup>13</sup> Yet, it has become all too typical for religious individuals who object to providing or referring for particular types of treatment to be subject to systemic forms of institutional injustice: to be deemed worthy of dismissal from the profession (Stahl & Emanuel, 2017), discrimination (Zolf, 2019), and other forms of professional or legal punishment (Savulescu, 2006, 296).<sup>14</sup> Yet, taking seriously the diverse moral commitments (conservative, liberal, secular, cultural and religious) of the various stake-holders can significantly aid the development of strategies for mediating complex ethical cases. Seeking to undermine or to dismiss moral perspectives, religious understandings, and political viewpoints with which one disagrees may simply alienate patients, families, and health-care workers (see, e.g., Khushf, 2019), causing more harm than benefit.

Instead of embracing moral diversity and acting as an inclusive intellectual academic field for the robust discussion of diverse opinions, bioethics has all too often become focused on creating authoritarian public policy. As Engelhardt noted, the field has become ever more stridently secular, progressive and focused on political activism (2009). On a more practical note, when working with "ethics experts", it is typically useful to ascertain which morality they will apply to the case at hand, whose moral perspective they will seek to encapsulate in official handbooks or professional manuals, and how their personal views impact the policies for which they advocate. Different moral viewpoints encapsulate divergent accounts of the identification and ordering of basic human values, competing accounts of the right and the good, as well as what it means to be virtuous or just. Bioethicists who earn the Health Care Ethics Consultant certification through official ASBH affiliates,

<sup>13</sup> "ASBH is an educational organization devoted to fostering 'dialogue, collegial endeavors, and membership with persons from diverse cultural, ethnic, and racial backgrounds.' Racism and racial injustice stifle this aim. In 2019, ASBH adopted the following strategic priority: 'Define diversity, equity, and inclusion goals for ASBH as an organization and how those values will be reflected through ASBH programs.' We remain committed to this priority, including supporting a sense of belonging for ASBH members, conference attendees, and communities we serve and providing an environment for free expression of diverse points of view, scholarly exchange, and respectful debate and discussion on difficult questions and issues both within the organization and on behalf of ASBH members" (2020, <https://asbh.org/asbh-statement-on-racial-injustice-and-professionalism>).

<sup>14</sup> See also Julie Cantor: "Medicine needs to embrace a brand of professionalism that demands less self-interest, not more. Conscientious objection makes sense with conscription, but it is worrisome when professionals who freely choose their field parse care and withhold information that patients need. As the gatekeepers to medicine, physicians and other health care providers have an obligation to choose specialties that are not moral minefields for them. Qualms about abortion, sterilization, and birth control? Do not practice women's health. ...Conscience is a burden that belongs to the individual professional; patients should not have to shoulder it" (2009, 1485). Such viewpoints seems to ignore the fact that a Roman Catholic OB-GYN should be able openly to offer Roman Catholic women's health, advertising any particularly limits on her practice, including refusals to provide abortion, sterilization, and birth control. Many patients may welcome such an opportunity.

for example, are not learning how to apply traditional Christian, Jewish, Moslem, or Confucian bioethics. They are being taught a very American, progressive, and secular approach to bioethics, which will fail fully to appreciate the detailed moral nuances of competing cultural or religious accounts.<sup>15</sup> Moral analysis will vary insofar as one draws on an ethics expert from within a particular religion (e.g., Orthodox Christian, Southern Baptist, Roman Catholic, Islamic, Orthodox Jewish, Reformed Jewish, and so forth), or a secular bioethicist, who may represent quite different moral points of view (e.g., liberal, libertarian, conservative, social democratic, progressive, and so forth).

Secular values and philosophical principles are not morally neutral; nor are the private moral convictions of bioethicists. Such analysis is always grounded in particular understandings of the just, virtuous, good and right. Critical examination of common treatments and new alternatives is essential for the careful scientific practice of medicine. The same is true with regard to bioethics. Each of the articles in this issue raise essential questions about the limits of moral agreement to impose a particular bioethics through authoritarian public policy. Stagnating in customary or accepted claims of a common secular morality or a standard set of bioethical principles out of an unwillingness to explore the real diversity of moral thought, whether progressive or conservative, including traditional religious and cultural worldviews, fails to tap the human capacity to find innovative solutions to the complex challenges facing medicine.

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<sup>15</sup> For some insight into the conflicts between standard American bioethics and religion see Parks (2021), Camosy (2021), Goss and Bishop (2021), Engelhardt (2017).

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