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"Just do your job": technology, bureaucracy, and the eclipse of conscience in contemporary medicine

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Abstract
Market metaphors have come to dominate discourse on medical practice. In this essay, we revisit Peter Berger and colleagues' analysis of modernization in their book *The Homeless Mind* and place that analysis in conversation with Max Weber's 1917 lecture "Science as a Vocation" to argue that the rise of market metaphors betokens the carry-over to medical practice of various features from the institutions of technological production and bureaucratic administration. We refer to this carry-over as the *product presumption*. The product presumption foregrounds accidental features of medicine while hiding its essential features. It thereby confounds the public understanding of medicine and impedes the professional achievement of the excellences most central to medical practice. In demonstrating this pattern, we focus on a recent article, "Physicians, Not Conscripts—Conscientious Objection in Health Care," in which Ronit Stahl and Ezekiel Emanuel decry conscientious refusals by medical practitioners. We demonstrate that Stahl and Emanuel's argument depends on the product presumption, ignoring and undermining central features of good medicine. We conclude by encouraging conscientious resistance to the product presumption and the language it engenders.

Keywords Conscience · Medical metaphors · Philosophy of medicine · Modernity · Modernization · Professionalism

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Introduction: the product presumption

Over the past generation, the language for referring to medicine and its practitioners has shifted.[1, 2] Physicians and other medical professionals have become "providers," their practices have become health care "services," and the provision of these services has become ever more bureaucratically organized within a massive healthcare "industry" [2, 3]. These shifts in language disclose a changing of the guard, a transition from one dominant metaphor for medical practice to another. As Ruth Malone puts it, "the market metaphor has assumed a prominent place in U.S. discourse on medicine and health policy, displacing an early military metaphor … still in use but now considerably less prominent" [3, p. 17]. How did this happen, and what are the consequences for the practice of medicine?

In this essay, we retrieve and reexamine the prescient analysis of Berger, Berger, and Kellner, in their 1973 book *The Homeless Mind*, suggesting that—just as Berger and his colleagues anticipated—the practice of medicine has come, in our time, to be construed as the technological production and bureaucratically administered provision of goods and services to be used according to the individual's preferences. What Berger and colleagues foresaw was the further working out of dynamics in modernization that Max Weber identified in his famous 1917 lecture "Science as a Vocation" [4]. Specifically, Weber observed that citizens of modernity have come to imagine all of reality as knowable through scientific study and in terms of scientific categories. Our world has been rationalized and rendered "disenchanted" [4, p. 139]. Weber asked how scientists' work remains worthwhile in such a disenchanted world; Berger and colleagues give an account of how other domains of human activity, including the practice of medicine, come to be construed under the terms and logic of science and the market—the market through which goods and services are technologically produced and bureaucratically administered. We have chosen to call this commonly (if often tacitly) adopted construal the *product presumption*.

The product presumption was adopted for intelligible reasons. In correcting unjustified medical paternalism, critics of medicine deployed new ways of speaking about medical practitioners, patients, and the relationships between them. In addition, novel technologies made possible unanticipated clinical interventions, many of which did not so obviously realize—and in some cases seemed to contradict—physicians' traditional commitment to the maintenance and restoration of patients' health. Nevertheless, patients valued these interventions and strove to expand access to them. Some have argued that the oral contraceptive was the most important of such technologies [5]. The availability of "the pill" and other new interventions that fit awkwardly under medicine's traditional orientation toward health further

[1] We have chosen the language of "practices" and "practitioners" in order to ally ourselves with Alasdair MacIntyre's discussion of "practices" [1, p. 187]. Since our primary concern in this article is the critique of current ways of speaking and thinking, we are attempting to hew to a less familiar way of speaking and thinking in order to provide contrast for our contemporary readers.

[2] This shift is explicitly recognized as early as 1982, as can be seen in Rashi Fein's "What is Wrong with the Language of Medicine" [2].

fragmented the already dissolving consensus on what medicine is for, exposing a developing vacuum that the product presumption neatly filled. In the midst of this morally fragmented and somewhat turbulent context, the product presumption seemed to inject a healthy dose of (scientific) objectivity and clarity. By drawing all practitioners under the umbrella of providers, all patients under the implicit category of consumers, and all interventions into the well-worn concept of goods and services, the product presumption seemed to dissolve a host of unresolved difficulties. With the proliferation of interventions aimed at a wide variety of desirable ends only loosely related to health, it became increasingly difficult to preserve a public vision of medical practice as principally directed at health, and the product presumption provided a convenient avenue for sidestepping this growing inconsistency.

We propose, however, that the product presumption and the market metaphor that both discloses and nurtures this presumption have come to distort and confuse public understanding of the practice of medicine. One site where these distortions and confusions manifest today is in arguments advocating for states and professional bodies to discipline clinicians who conscientiously refuse to provide legal health care services requested by patients. With Berger and colleagues, we argue that a central ethical task for practitioners of medicine is to resist this inclination and other carry-overs of the product presumption wherever that presumption undermines and contradicts the central goods and practices of medicine.

Metaphors

In their brief exploration, *Metaphors We Live By*, George Lakoff and Mark Johnson claim provocatively that "our ordinary conceptual system, in terms of which we both think and act, is fundamentally metaphorical in nature" [6, p. 3]. For Lakoff and Johnson, "the essence of metaphor is understanding and experiencing one kind of thing in terms of another" [6, p. 5]. To illustrate their thesis, they focus on the metaphor ARGUMENT IS WAR, noting that this relatively common metaphorical frame conditions the way in which people think and act with respect to argument [6, pp. 4–6]. We do not merely "*talk* about arguments in terms of war. We can actually win or lose arguments" [6, p. 4]. We view our interlocutors as "opponents," we find propositions "indefensible," and we can "fortify" our own positions or "attack" those of our opponents. The metaphor of war opens certain avenues for constructing an argument and closes others; it shines light on particular features of argument and casts others into the shadows. One may remain blind to the power of this metaphor until and unless one encounters a society in which the dominant metaphor for argument is something else, like dance. Yet, in encountering such a society, Lakoff and Johnson write, "we would probably not view them as arguing at all: they would simply be doing something different" [6, p. 5].

Because humans comprehend metaphorically in this way, humans are susceptible to distortions and confusions that follow from metaphorical construal, and this is no less true in the medical domain. This susceptibility has a series of important ramifications. First, no metaphor perfectly suits the reality it represents; some features of reality will always be excessive, will be left behind in the move from reality to

metaphor. Indeed, any metaphor that manages to capture all the features of a concept will simply be that concept. To say that argument is argument is to fail to use a metaphor. This claim may seem obvious, but its truth is easily overlooked with respect to metaphors that are thoroughly established within a particular field of discourse. Presently, for example, it is hard to imagine a medical practice that is not described and comprehended through the lens of the market metaphor. As such, it is increasingly difficult to see or develop the aspects of medicine that cannot be captured by this frame.

Second, metaphors not only focus our attention on and open our imagination to certain features of reality; they also concurrently limit our attention to and avert our imagination from other features of reality [3]. So, as Weber notes, when we come to imagine that, in principle, all of reality can be known and explained through the methods and concepts of modern science, we come to ignore—we fail to see—features of reality that cannot be known or explained in this way. We fail to see the features that, in Weber's terms, make our world *enchanted*. Moreover, we can propose solutions only to problems that are recognized as problems. If our metaphors systematically foreground particular features of our context, then those features will attract attention when one looks for problems and attempts to devise solutions. Regarding the problems found in modern medicine, George Annas writes, "the market metaphor leads us to think about medicine in already familiar ways: emphasis is placed on efficiency, profit maximization, customer satisfaction, the ability to pay, planning, entrepreneurship, and competitive models. The ideology of medicine is displaced by the ideology of the marketplace" [7, p. 745]. This happens, Malone would suggest, because the "kinds of problems that can be identified *as* problems are constrained by the language we have at our disposal" [3, p. 18].[3] Put differently, our language about medicine conditions what we see, and what we see sets the parameters for how we act. Evoking the thought of Iris Murdoch [8], Stanley Hauerwas has succinctly summarized this inescapable feature of the human condition as follows: "you can only act in the world you can see, and you can only come to see what you can say" [9, 10].

As such, a central ethical task for our culture is to scrutinize and curate our metaphors, choosing those that highlight the most important features of reality and discarding those that obscure such features. Insofar as the culture fails in this task, its inhabitants will inevitably fail in other ethical obligations, which brings us back to the product presumption. How does seeing (and speaking about) medicine in this way—as the technological production and bureaucratically administered provision of goods and services to be used according to the individual's preferences—focus our attention, constrain our imagination, and shape our actions? How does this particular metaphor shape our language (saying), our vision (seeing), and our acting? What does this particular construal foreground? What does it systematically hide from view? Do the families of metaphors that undergird the product presumption

[3] Malone provides an erudite explanation of some of the types of assumptions underpinning the notion of products, which are deeply inimical to many of the goods of medicine as they have been understood conventionally [3].

hinder physicians and patients from achieving the central goods of medical practice [3]? We believe they do, and we consequently believe that medical practitioners should resist the product presumption and work earnestly to recover or contrive more adequate metaphors for medicine, as more adequate metaphors will occasion more adequate forms of seeing, and seeing medicine rightly will permit medical practice to achieve the goods befitting it.

The product presumption, *The Homeless Mind*, and conscientious refusals

In formulating the core argument of our essay, we borrow from the work of Peter Berger, Brigitte Berger, and Hansfried Kellner to argue that the product presumption reflects "carry-over"[4] to medicine of a consciousness (imagination) formed by two constitutive features of modernization: technological production and bureaucracy [11]. We contend that although the product presumption fits the features that medicine shares with technological production and bureaucracy, these features are accidental to medicine, and in foregrounding them, the product presumption simultaneously distorts and obscures several of medicine's essential characteristics.

We begin by concisely summarizing the work of Berger, Berger, and Kellner to show how their analysis powerfully predicts the product presumption. We then turn to contemporary debates about conscientious refusals by clinicians, focusing on an essay recently published in the *New England Journal of Medicine*, in which Ronit Stahl and Ezekiel Emanuel decry such refusals and call for professional organizations to sanction those who refuse to provide services that patients lawfully seek [12]. Stahl and Emanuel's arguments, as we show, depend upon and display the characteristic features of a consciousness that is captive to the product presumption and the various commitments that this presumption entails. Thus, we contend that their arguments presuppose a construal of medical practice that requires features accidental to medicine and is incompatible with features that are essential to medicine.

If the product presumption and its entailments distort and confuse public and professional understanding of the practice of medicine, then medical practitioners and medical ethicists have reason to resist this presumption and should seek to displace market metaphors with more suitable metaphors for medicine. Toward that end, we call for practitioners and ethicists to resist the continued carry-over of imaginaries shaped by the institutions of technological production and bureaucracy, which are ill-suited to the practice of medicine. Consistent with this broad call for resistance, such practitioners and ethicists would accordingly resist the specific arguments made by Stahl and Emanuel and others who seek, unjustifiably, to constrain the scope of physicians' conscientious judgments in the practice of medicine through tacit appeals to the product presumption and its entailments.

[4] Berger, Berger, and Kellner use the term carry-over "to designate any diffusion of structures of consciousness from their original institutional carriers to other contexts" [11, p. 22].

The Homeless Mind

In *The Homeless Mind*, Berger, Berger, and Kellner appraise "modernization as the institutional concomitants of technologically induced economic growth" [11, p. 9]. Like Weber before them, these sociologists examine modernization as a historical phenomenon, asking, "in what way is this period or phenomenon distinctive?" [11, p. 3]. In order to identify the "parameters of choice," they distinguish features of modernization that more readily accommodate change from those that are deeply linked with larger, less labile structures [11, p. 20]. Moreover, they are particularly interested in understanding the subjective consciousness characteristic of modernization and the primary institutions that create and perpetuate this consciousness:

> The *consciousness of everyday life* is the web of meanings that allow the individual to navigate his way through the ordinary events and encounters of his life with others. The totality of these meanings … makes up a particular *social life-world*. [11, p. 12]

Medicine, in Berger, Berger, and Kellner's framework, is one prominent domain within which the subjective consciousness characteristic of modernization is experienced and displayed. We argue that this consciousness is displayed generally in the product presumption and is displayed specifically in calls to constrain the scope of conscientious refusals by medical practitioners. Before turning to make those arguments, we first need to identify the primary carriers of modernization and sketch their distinctive features.

Technological production

Berger, Berger, and Kellner locate the primary *carriers* (a Weberian term) of modernization in the institutions of technological production and bureaucracy [11, p. 9]. Between the two, technological production most influences modern consciousness. Technological production calls for a scientific organization of knowledge and assumes a hierarchy of experts [11, p. 25]. Its style of work is mechanistic, reproducible, measurable, and dependent upon a sequence of production in a large organization [11, p. 26]. Its cognitive style is centrally patterned on the notion of *componentiality*: the presumption that "the components of reality are self-contained units which can be brought into relation with other such units—that is, reality is *not* conceived as an ongoing flux of juncture and disjuncture of unique entities" [11, p. 27]. Componentiality is required for production processes to be reproducible and for human workers and machinery to partner efficiently. As we discuss below, componentiality also opens the possibility of severing the means to a particular end from the moral evaluation of this end.

Bureaucracy

Bureaucracy, the second principal carrier of modernization, finds paradigmatic expression in the modern state, but the distinctive consciousness engendered by its institutions transfers widely to other domains of modern life. Whereas technological production always aims at a particular goal (the thing produced), bureaucracy often aims at nothing at all, apart from satisfying the needs of the bureaucracy [11, p. 41]. This fact often makes bureaucratic processes seem arbitrary when they are overlaid on various portions of social life [11, p. 42]. Bureaucracy's organization of knowledge centers on competence: "each jurisdiction and each agency within it is competent *only* for its assigned sphere of life and is supposed to have expert knowledge appropriate to this sphere" [11, p. 43].

Bureaucracy's organization of knowledge engenders a distinctive consciousness in which people expect *comprehensiveness* and *coverage* (everything can be handled by someone in some niche of the bureaucracy) [11, p. 44]. The expectation of coverage disposes bureaucracies toward never-ending expansion; this expectation also generates the concept of referral, since a given case must be directed to the agency competent to handle that case—a factor that shapes arguments about conscientious refusals by physicians [11, p. 44].

Anonymity plays a critical role in bureaucracy, as "bureaucratic competences, procedures, rights and duties are *not* attached to concrete individuals *but* to holders and clients of bureaucratic offices" [11, p. 46]. At best, the concrete and particular characteristics of these holders and clients introduce friction into bureaucratic processes. At worst, they corrupt the bureaucracy (as when a familial relation of an employee receives special treatment), threatening its pretense to orderliness and predictability [11, p. 46].

Carry-over, stoppage, and packages

Berger, Berger, and Kellner coin several terms to capture the ways that the distinctive features of technological production and bureaucracy are exported to other domains of social life. They use the term *carry-over* to designate "any diffusion of structures of consciousness from their original institutional carriers to other contexts" [11, p. 17]. They use the term *stoppage* to denote "the arresting of such diffusion" [11, p. 17]. And, they borrow the term *package* to describe "an empirically given combination of institutional processes and clusters of consciousness" [11, p. 17]. Deploying these terms, we can now summarize our argument:

> The flowering of the market metaphor in medicine is a symptom and amplifier of the carry-over of various packages from the institutions of technological production and bureaucracy. The product presumption, an expansive package of institutional processes and clusters of consciousness that has been carried over to medicine, fits poorly with central intrinsic features of the practice of medicine and fits particularly poorly with respect to the phenomena that give

rise to conscientious refusals. As such, we advocate for stoppage between medicine and the institutions of technological production and bureaucracy, stemming the carry-overs that engender the product presumption. That presumption threatens the attainment of the excellences that constitute good medical practice, which requires—among other things—refusal to engage in practices that one believes to contradict good medicine.

Conscientious refusal and the captive imagination

We turn now to Stahl and Emanuel's recent essay published in the *New England Journal of Medicine*. The essay, entitled "Physicians, Not Conscripts—Conscientious Objection in Health Care," argues that medical organizations should no longer tolerate conscientious refusals by clinicians [12]. As we attempt to show, Stahl and Emanuel's arguments in this paper depend upon a wholesale embrace of the product presumption and all that it entails. Moreover, their essay tacitly argues for further carry-over from technological production and bureaucracy to the domain of medical practice, thereby neglecting and distorting features central to the practice of medicine.

Stahl and Emanuel begin by observing that unlike military conscripts, physicians have taken on their roles voluntarily [12, p. 1380]. They then argue that medical practitioners who refuse patient requests abdicate the professional obligations they have voluntarily taken on—namely, the obligation "to provide, perform, and refer patients for interventions according to the standards of the profession" [12, p. 1380]. This "professional role morality," Stahl and Emanuel contend, requires practitioners to "subordinate their self-interest and personal beliefs to patients' well-being and professional decision-making" [12, p. 1382]. Recognizing no objective standard for patient well-being, Stahl and Emanuel call for seemingly unchecked allegiance to "the standards of the profession," which can be relied on, they argue, because those standards are continuously evaluated and revised through Rawlsian "reflective equilibrium" [12, p. 1382].

Further drawing on Rawlsian criteria for public discourse, they call for debates to "focus on medical value and suitability, not political or cultural acceptance" [12, p. 1382]. While conceding that, in the past, professional standards have endorsed eugenics and other such "mistakes," they nevertheless assert that the profession's self-correcting processes establish "professional obligations for health care providers regardless of their personal beliefs" [12, p. 1382].

Stahl and Emanuel conceal a surprising number of problematic assumptions behind the façade of so-called professional role morality. Indeed, their claims depend on several features of the consciousness of technological production and bureaucracy. These features supply a series of warrants undergirding Stahl and Emanuel's argument—warrants requiring that one *already* see medicine as dependent on carry-over from technological production and bureaucracy. We address each of these features in turn by describing them in language borrowed from Berger, Berger, and Kellner. We then critique them for failing to capture and for diverting attention away from the constitutive features of good medical practice.

Componentiality

Componentiality, perhaps the most defining feature of the consciousness of technological production, entails seeing reality as made up of components that, in principle, can be brought together and taken apart at will [11, p. 27]. This assumption gives rise to a demand for predictability, as every sequence of events, once broken down into its component parts, is expected to give rise to the same result given the same initial conditions [11, p. 27]. The componential world is organized by the logic of scientific knowledge, and this knowledge is stewarded by a hierarchy of experts [11, p. 25]. This world fosters and demands mechanisticity, predictability, reproducibility, and measurability (e.g., outcomes and quality control in medicine) [11, pp. 26, 51]. When componentiality is carried over into the practice of medicine, physicians and patients themselves become components, and each patient is conceptualized as a collection of increasingly minute components to be tinkered with at will. At each level of organization, these components are expected to serve the ends of mechanisticity, predictability, reproducibility, and measurability. As such, each component's function must be identical to that of its corresponding components. Unique entities are inimical to the componential mindset, as they threaten the aforementioned goods of mechanisticity, predictability, reproducibility, and measurability.

Stahl and Emanuel's embrace of componentiality is evident in their denigration of the "personal" and the "religious" and their elevation of the "professional" [12]. In their construal, the personal and the religious intrude upon and threaten reproducibility and predictability, while the professional, insofar as it is considered standard, preserves these goods by absorbing the individual clinician into the general professional paradigm, by transforming the concrete human into a medical component [12]. At no point do Stahl and Emanuel entertain the possibility that a diverse community of religiously, morally, and ethically engaged medical practitioners might be preferred to a rank of interchangeable providers. Neither do they consider the possibility that what they shelve under the headings of personal and religious might be essential to the ethical practice of medicine. These possibilities are hidden from view in the componential mindset, which entails strong adherence to the logic of scientific knowledge and the hierarchy of experts; dimensions of medical practice that resist componential description and control via scientific expertise tend to fall away. *Medical* comes to mean merely that which can be described in terms of scientific knowledge and technical competence. Less standard, less measurable, less reproducible features of medical practice (e.g., compassion, integrity, friendship, and judgment) become intrusions of the personal or religious into what should be standard professional practices—those practices amenable to the logics of technological production and bureaucratic organization.

The carry-over of componentiality into medicine fails to account for or cultivate the enchantment that comes from understanding medical practice as a vocation [4]. We use the word *enchantment* advisedly; while medicine is a practice that depends upon scientific modes of reasoning and certain features of the scientific consciousness, it is decidedly "not a science" [13, p. 25]. Rather, "it is a rational,

science-using, interlevel, interpretive activity undertaken for the care of a sick person" [13, p. 25]. While presupposing a "disenchanted" world may fit the work of the sciences that medicine utilizes,[5] doing so seems to undermine virtues central to caring for the sick (e.g., concern, care, trust, and solidarity) and impoverish ethical or political discussions about such care [4]. Disenchantment need not and should not be carried over from the sciences to the vocation of medicine.

Vocation, often translated as calling, has roots in the Christian belief that God calls human persons to various and distinct lives of good works. On this understanding, one may be *called* to be a physician rather than simply deciding to be one, and in accepting the call, one constitutes oneself in the deepest way, not simply as a physician but also as a person responsive to and responsible before something higher than mere standards. Although the concept of calling stems from Christianity, today the majority of United States physicians, with diverse religious affiliations, use this term to describe their practice of medicine.[6] Indeed, even among those who say they have no religion, one in four strongly agrees with the statement "For me, the practice of medicine is a calling" [15].

In their seminal book, *Habits of the Heart*, Robert Bellah and colleagues contrast work done as a calling with work done as a job [16]. Practicing medicine as (merely) a job fits the demands of componentiality but at the cost of reducing health care to its instrumental value, as yet another series of reproducible, mechanistic, amoral processes performed to bring about benefits (e.g., income for physicians and satisfaction for patients) that are not intrinsically related to medicine. In contrast, practicing medicine as a calling involves working for the fulfillment that comes from the work itself—its internal or intrinsic rewards. Practitioners called to medicine experience their work as inseparable from who they believe they are called to be. The language of calling better fits the enchantment that so many physicians seem to experience and value in their work, but it does so at the cost of violating the demands of componentiality. It requires physicians to see their practice as a whole, to evaluate the means in relation to the ends, and to see how particular practices of deploying particular means toward particular ends align with the work to which the physician understands herself to be called. Particularities and concreteness abound. Enchantment contradicts componentiality; one must give way to the other.

When enchantment gives way to the reign of componentiality, the practice of medicine is diminished, as the rates of burnout among today's physicians might suggest. If medical practice can be reduced to the features that are amenable to componential logic, it is hard to see why medicine is worth practicing at all—though it is

[5] Physicians do, of course, presuppose that there are no mysterious incalculable forces with respect to the sciences that they utilize in their clinical practice, but this disenchanted way of thinking and acting fails to adequately describe and support either the physician–patient relationship or the ethical and political concerns that pervade clinical practice. In these latter domains, "mysterious incalculable forces" abound [4, p. 139].

[6] A 2003 survey of United States physicians from all specialties found that 71% agreed (32% strongly) with the statement "For me, the practice of medicine is a calling" [14]. A 2010 survey of United States primary care physicians and psychiatrists found that more than 80% of both groups agreed (approximately 40% strongly) with the same statement; even among those who indicated they have no religion, or never attend religious services, one in four strongly agreed that, for them, the practice of medicine is a calling [15].

worth considering whether it is even possible to practice under componential logic.[7] If the physician must genuflect to the supposed standards of the profession, even when she believes that doing so contradicts good medicine, then it becomes quite strange for our medical schools to select students on the basis of features such as diversity, integrity, moral vision, compassion, and civic responsibility. Of what use is a diverse body of practitioners if the richness of their diversity is to be subjugated to a bland, denuded version of professional role morality? Stahl and Emanuel fail to recognize that when physicians conscientiously refuse to participate in some intervention, they do so precisely because they believe that to participate in the intervention would contradict their "primary interest" in "patients' well-being" [12, p. 1381]. The goods of diversity are found in the contributions that diverse, concrete practitioners—including their plurality of personal and religious commitments—can make to perpetual and fraught debates about what medicine requires. As Wayne Booth has asserted, "to think together in politics[8] is to uncover different interests and discover different interpretations of what is happening and what should happen. It follows that tolerance of many different views is never enough; we should insist on them, seek them out" [17, pp. 364–365]. The contributions of diverse practitioners are unavailable unless the profession allows concrete humanity (the personal) to intrude into the practice of medicine, and this means that the goods of reproducibility, predictability, and mechanisticity will be threatened by the goods available to a diverse body of ethically engaged practitioners.

Separability of means and ends

Componentiality brings another expectation with revolutionary implications for the practice of medicine—namely, the "separability of means and ends" [11, p. 27]. Componentiality entails that "there is no necessary relationship between a particular sequence of componential actions and the ultimate end of these actions" [11, p. 28]. The skills relevant to a given portion of the production process are in no way necessarily linked to the moral features of the ends of this process. An ability to weld two parts can be put to use in the construction of either a magnetic resonance imaging machine or a missile, but the welder need not know which one. Carried over into medical practice, this separability manifests in a distinction between the realm of the personal—where means and ends can be more tightly linked to meet the psychological needs of the individual—and the realm of the professional—where the ends are dislocated from the means in order to preserve the anonymity and reproducibility necessitated by the reigning systems. Within the realm of the professional, the creed becomes "just do your job."

[7] Medicine here might be best understood as a term describing one of MacIntyre's practices; in other words, medicine is a "coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended" [1, p. 187].

[8] In this case, we mean professional politics understood in its best light.

This overriding focus on just doing one's job (the means) removes entirely from the scope of the medical practitioner's consideration what the job is good for (the ends). Stahl and Emanuel depend on and affirm this stance throughout their essay [12]. They do not see the practitioner as a particular moral agent working to discern the ethical way forward in complex and particular circumstances. Rather, they dissolve the clinician into the means to various desired medical ends. The medical practitioner, now the provider, is simply the anonymous locus of a certain set of competencies, and, assuming these competencies can be put to use as means to legal, desired, and professionally tolerated ends, Stahl and Emanuel see no place for the practitioner's judgments about those ends. It seems to us that this construal of medicine makes at least two serious errors: first, Stahl and Emanuel neglect to mention several aspects of soldiering—their central analogy for medical practice—that are inconvenient for the success of their analogy; and second, they uncritically carry over a feature necessary for excellence in science (i.e., specialization) into medical practice, where that feature fits much more awkwardly. We address these errors in turn.

Recall that Stahl and Emanuel start their argument by distinguishing between conscientious objection to military service and conscientious refusals in medical practice. In their portrayal, they implicitly claim that if a soldier enters military service voluntarily, she agrees to obey any command of her superiors. She agrees, that is, to be wielded as a tool by those in command. Stahl and Emanuel's argument regarding conscientious refusals by clinicians is wholly dependent on this claim, but this portrayal of soldiering neglects a long and storied military tradition of soldiers who refuse to follow unjust commands—that is, commands that contradict the moral commitments which make just war possible [18]. The soldier is trained and obligated to distinguish commands that are congruent with her professional commitments from commands that contradict those commitments, obeying the former and conscientiously refusing to obey the latter [18]. This is not to say that the soldier gets to make up what being a soldier requires—if she cannot follow what being a soldier reasonably requires of her, she must decline to be a soldier. Our point is simply that being a soldier is not a matter of simply following orders, checking one's (personal) moral judgment at the door. Rather, being a good soldier means both taking on the commitments of soldiering and personally carrying out those commitments, using one's best judgment, in all of the particular situations that one encounters.[9] This is a complex act requiring constant improvisation, which must account for the novel particularities of the current context and the history of many competing commitments; "situations are all highly concrete, and they do not present themselves with duty

[9] Mark Osiel investigates this feature of soldiering by appealing to the notion of courage: "Courage itself, the quintessential martial virtue, is best understood not as a sudden and unthinking outburst of will, but as a form of practical judgment under especially exigent circumstances. …Courage in battle, then, can never be simply a matter of following orders unreflectively. Instead, it entails a process of interpreting orders wisely, in light of current conditions, which may alter rapidly and radically as a particular confrontation develops. … Courage thus entails the exercise of practical judgment, and practical judgment involves a specifically moral element. … This is to acknowledge that moral considerations are never alien to tactical deliberations of the most seemingly pragmatic, instrumental sort" [18, pp. 1071–1072].

labels on them" [19, p. 156]. It is impossible, in principle, to predict the appropriate soldierly act that will result from this improvisation, as it is impossible to know how novel particularities will interface with standing obligations [19, 20].[10]

Stahl and Emanuel's misunderstanding of soldiering bleeds into a misunderstanding of doctoring. If physicians surrender evaluating the ends to which their skills are directed, it is hard to see how they do not thereby surrender the pretense of belonging to a profession altogether. A professional, by definition, professes to direct her energies and powers toward particular goals (ends). Stahl and Emanuel concede that medical practitioners face the question: "should health care professionals provide or refuse specific interventions?" [12, p. 1382]. They recognize that, in at least some cases (e.g., eugenics), the answer must be "refuse." Their criterion for discerning such cases, however, is accordance with the standards of the profession, which, as the example of eugenics makes clear, have often affirmed unethical practices. In their appeal to Rawlsian *reflective equilibrium*, they ignore Rawls' own point that reflective equilibrium "is not necessarily stable. It is liable to be upset by further examination of the conditions which should be imposed on the contractual situation and by particular cases which may lead us to revise our judgments" [20, p. 18]. Ongoing revision—and an honest effort at charitably imagining the positions of others—is constitutive of Rawlsian modes of deliberation [21].

Ultimately, Stahl and Emanuel appeal to a putatively stable criterion (the standards of the profession) that turns out either not to condemn that which they want to condemn—with the longstanding standards of the profession permitting and even affirming the legitimacy of conscientious refusals—or to condemn that which they want to affirm—repudiating, for example, the physician who conscientiously refused to perform forced sterilizations in an era of widespread eugenics.

Finding moral stability (reproducibility) is clearly one of the motivating forces behind the product presumption: if one can separate means and ends, then perhaps one can identify means that are always appropriate for professionals. We suggest that this is a utopian dream. The advance of medical technology is constantly unveiling new ways to achieve both unethical and ethical ends. Means that are accepted today may be rightfully rejected tomorrow, and those that are justifiable in one case are often not justifiable in another. This is a feature of the human condition, not a bug to be patched.

Part of a physician's moral education involves encountering clinical cases that force her to question her prior judgments. Conscientious refusals by individual physicians mark some of these cases and alert the profession as a whole to regions of practice that require further deliberation. Conscientious refusals, therefore, invite the profession to reevaluate the appropriateness of a given intervention in such cases. Stahl and Emanuel, by embracing the product presumption and the features

[10] For an elegant investigation into the inadequacy of rules and duties when they lack the assistance of well-tutored perception and an ability to improvise successfully, see Martha Nussbaum's essay "Finely Aware and Richly Responsible: Literature and the Moral Imagination" in her collection *Love's Knowledge* [19].

it foregrounds, fail to see this critical safeguard role that conscientious refusals play. The history of medicine is littered with examples of medical means being put to deeply unethical ends, and it seems unlikely that this history is over. We contend that actively fostering space for physicians to practice conscientiously, even when one might disagree with them, preserves an important defense against medicine's unfortunate propensity for inventing and participating in unethical acts. Medicine's checkered past should decisively rule out any appeals to professional standards as final words.

Stahl and Emanuel make a second significant error in their construal of the physician as simply the anonymous locus of a certain set of competencies to be put to use as means to legal, desired, and professionally tolerated ends. This error is best understood in reference to Weber's lecture "Science as a Vocation," which suggests that "a really definitive and good accomplishment" in contemporary science can only be "a specialized accomplishment" and that "whoever lacks the capacity to put on blinders, so to speak … may as well stay away from science" [4, p. 135]. Stahl and Emanuel uncritically carry this feature of contemporary science over to the practice of medicine, where putting on blinders severs the medical practitioner from excellences that are uniquely open to her. While one may succeed in scientific discovery by "just doing one's job"—putting on blinders[11]—one cannot succeed in medical practice except by attending to a startling, and always unique, constellation of ineliminable considerations that matter in particular clinical situations. Medicine, that is, forces even its specialists into general waters. Every physician uses science, and many also practice science, but the excellences of scientific practice and the excellences of medical practice diverge in many respects; physicians who possess only the former will be lousy practitioners of the latter.

Human engineering of anonymous social relations

While componentiality and the separability of means and ends are carried over primarily from technological production, both are buttressed by the anonymity that is so characteristic of bureaucracy [11]. For humans to be treated as components of a reproducible and mechanistic process, they must be treated as "anonymous functionaries" [11, p. 31]. Consequently, modernization includes a built-in ambiguity and "double consciousness" with respect to social relations: others are to be treated as if they "are *both* concrete individuals *and* anonymous functionaries" [11, p. 32]. The person performing a given task must be an irreducibly unique person as well as an anonymous component whose function is to complete the given task [11, p. 32]. Bureaucracy fosters the anonymity required to sustain this double consciousness, as

[11] Blinders, in this passage, should not carry a pejorative connotation. Many human practices demand the capacity to limit one's view in order to achieve the requisite depth for the attainment of the excellences proper to these practices. While this is certainly true of certain aspects of medical education and training, it is not true of the daily practice of medicine. The goal, as always, is the preservation of appropriate distinctions.

"bureaucratic competences, procedures, rights and duties are *not* attached to concrete individuals *but* to holders and clients of bureaucratic offices" [11, p. 46]. In a bureaucracy, the only relevant features of particular persons are those that mark them either as holders of a given bureaucratic office or as clients (actual or potential) of such an office: "It is not concrete individuals but abstract categories that interact in the bureaucratic process" [11, p. 47]. All particularities are irrelevant to the exchange between holder and client. This gives rise to speech in which clients are "files" or "cases" and to a world constituted by a flurry of "papers in motion" [11, p. 47].

Anonymity takes on moral weight when associated with *proper procedures* [11, p. 46]. Whereas the intrusion of concrete humanity into the process of production threatens its efficiency, the intrusion of concrete humanity into the process of bureaucracy threatens its pretense to fairness and is perceived as "corruption" [11, p. 46]. To mitigate the ubiquitous threat of concrete humanity interfering with proper procedure, bureaucracies deploy "human engineering" of various sorts, and individuals learn to police themselves to avoid reprimand [11, p. 32]. This "self-anonymization" leads to a "componential self," a self simultaneously constituted by a unique, irreducibly particular individual and by an anonymous bureaucratic functionary [11, p. 33].

Stahl and Emanuel demonstrate the carry-over of bureaucratic anonymization in their hostility toward the influence of "personal religious or moral beliefs" and in their call for "professional associations" to "resist sanctioning conscientious objection as an acceptable practice" [12, p. 1380]. Their suggestion that "health care professionals … must subordinate their self-interest and personal beliefs to patients' well-being and professional decision-making" both presumes and affirms the double consciousness that Berger, Berger, and Kellner describe [12, p. 1382].[12] In effect, Stahl and Emanuel presume that clinicians should indeed be construed as anonymous functionaries or bureaucrats. Their desire to exact some type of "penalty" for the transgression of conscientious refusal displays the moralized quality of bureaucratic anonymity, which motivates human engineering to remove the concrete and particular from the domain of medicine [12, p. 1384].

This carry-over of a "moralized anonymity" and the human engineering that supports it fails to account for several critical features of medical practice [11, p. 53]. First, this anonymity hides the fact that the most basic aspects of caring require concrete humanity in all of its embarrassing particularity. Patients do not feel cared for when they are treated as a number. Physicians do not feel morally engaged when they check their personal values at the door. Moralized anonymity directly engenders the depersonalization that has evoked countless critiques of medical practice. Berger, Berger, and Kellner note that the depersonalization that fosters fair treatment for all clients of a bureaucracy also stunts the development of any relationship between bureaucrat and client [11, p. 47]. While depth of relationship might be

[12] A question worth considering is whether we want to entrust ourselves, in our most vulnerable moments, to so-called providers who habitually subordinate their deepest moral convictions. What types of people are capable of this sort of subordination?

readily sacrificed at a passport office, sacrificing such depth of relationship between patient and physician eviscerates the very heart of medical practice. We cannot have our cake and eat it too. Either concrete humanity will enable real relationships at the cost of potential discrepancies in fairness, or anonymity will enable bureaucratic fairness at the cost of stunted relationships. In our view, it is a Faustian bargain for the profession of medicine to forego the trust and integrity forged in particular relationships in favor of the pretense to fairness secured by anonymity between patient and physician.

Justice as proper procedure

As noted above, anonymity takes on moral weight when it is linked to the fairness brought about by proper procedure. Within a bureaucracy, "it is expected that everyone in the relevant category … will receive equal treatment" [11, p. 51]. This expectation kindles anxiety when a case does not fit neatly into a relevant category, and this anxiety leads to the constant extension and multiplication of bureaucratic categories and their corollary competencies in order to achieve the aforementioned goods of comprehensiveness and coverage [11, p. 44]. Someone in the bureaucracy must be able to handle any request. Furthermore, since any individual bureaucrat's competencies are limited to her specific office, *referral* becomes a critical feature of proper procedure [11, p. 44].

When carried over into medical practice, these features of bureaucracy manifest as several types of anxieties. On one level, the very possibility that a patient (client) may fail to find a provider (bureaucrat) willing to provide an intervention that the "profession deems to be effective, ethical, and standard" becomes "unjustifiable" [12, p. 1383]. Here, one sees in medicine the anxieties provoked by a failure to uphold bureaucracy's pretense to comprehensiveness and coverage. These anxieties push Stahl and Emanuel to assume their extreme position, but such anxieties also explicitly underlie the so-called conventional compromise with respect to conscientious refusals—namely, that individual physicians are not necessarily obligated to provide anything that patients request, but they are obligated to refer patients to those who will, since the profession (read *bureaucracy*) has a responsibility to make every legal intervention available [22].[13] In the consciousness formed by the product presumption, failure to refer seems to involve unjust discrimination and infringement

[13] In Dan Brock's words:

> According to the conventional compromise, a physician/pharmacist who has a serious moral objection to providing a service/product to a patient/customer is not required to do so only if the following three conditions are satisfied:
>
> 1. The physician/pharmacist informs the patient/customer about the service/product if it is medically relevant to their medical condition;
> 2. The physician/pharmacist refers the patient/customer to another professional willing and able to provide the service/product;
> 3. The referral does not impose an unreasonable burden on the patient/customer. [22, p. 194]
>
> Notice that Brock cannot avoid language dependent on the product presumption.

on patients' rights. This perception underlies, for example, the move by the College of Physicians and Surgeons of Ontario to require that all physicians take positive action to bring about effective referral for any legal intervention [23].

Beneath this anxiety about comprehensiveness, there is another anxiety—that progress will be thwarted by those who resist deploying the latest scientific technologies and techniques. As Weber notes, "scientific work is chained to the course of progress. … In principle, this progress goes on ad infinitum" [4, pp. 137–138]. So, Weber suggests, scientific work is truly end-less; it aims at no end but its own eventual eclipse. This "scientific progress is a fraction, the most important fraction," he continues, "of the process of intellectualization," and intellectualization is the root of disenchantment [4, p. 138].[14]

Just as it is a mistake to equate the practice of medicine with the practice of science, so is it a mistake to assume that medical practice is yoked to technological advancement in the same way that science is yoked to progress. On this mistaken understanding, progress in the sciences that are utilized by medicine translates reliably to progress with respect to the interventions that medical practitioners can and should offer to patients. But medical progress is not wed to scientific progress in this way. To see this, one need only think of the historical "progress" made by using newly developed sterilization and genetic screening techniques. The auspices of progress always present an opportunity for imaginative forms of unethical acts, and to forget this is invariably to invite the flowers of this facet of the human imagination to blossom. Unlike contemporary science, medicine is not end-less. Rather, its practitioners pursue particular ends that can be described and debated, and they must make decisions between benefit and harm, right and wrong, and permissible and impermissible. Thus, medicine will always travel a path of halting steps and surprising reversals. Deploying the latest fruits of science on patients may indeed advance the ends of medicine, but doing so may also undermine and contradict those ends. Once again, it becomes clear how important it is for medicine to sustain a culture capable of ethical deliberation and critique in order to differentiate between moving forward and going astray.

Anxieties about the failure of comprehensiveness and coverage are found wherever conscientious refusals are strongly criticized. Julian Savulescu, for example, appeals to these anxieties in his claim about what it means to be a doctor: "To be a doctor is to be willing and able to offer appropriate medical interventions that are legal, beneficial, desired by the patient, and a part of a just healthcare system" [24, p. 295]. Once again, while Savulescu's claim might hold insofar as the product presumption holds,[15] it breaks down if medicine departs at all from that presumption. Then, one might reasonably ask what defines the category of appropriate medical

[14] Weber defines intellectualization not as an "increased and general knowledge of the conditions under which one lives" but instead as the "knowledge or belief" that if one desired to know these conditions, one could learn them at any time. In other words, "there are no mysterious incalculable forces … one can, in principle, master all things by calculation. This means that the world is disenchanted" [4, p. 139].

[15] For example, one might think of the ways that some elective medications, such as cough medications, seem like simple goods and some elective surgeries, such as knee replacements, seem like simple services.

interventions? How does one know when an intervention is beneficial? What are the benefits medical practitioners properly seek? What are the limits of patient authority, and how does a healthcare system remain just while coercing its practitioners into doing what they believe to be unjust? Savulescu's claim about what it means to be a physician suggests that anxieties surrounding failure of comprehensiveness and coverage have precipitated an existential crisis for the medical profession.

Requiring referral satisfies bureaucracy's expectation of coverage and technological production's expectation of separability between means and ends, but it does so by hiding referral's irreducibly moral character. Physicians often conscientiously refuse an intervention because they believe the intervention would cause harm, not benefit, to the patient. How strange it is, then, to require physicians to facilitate (by referral) harm to patients. If our claim here seems overstated, we encourage the reader to imagine in detail and with depth what it would be like to be required to refer a patient for a practice that is sincerely believed to cause harm. We note that physicians commonly, and without controversy, refuse to refer in such cases—for example, a surgeon may refuse to refer to another surgeon who she believes is incompetent or uses an unjustifiably dangerous procedure. Some will argue that such cases involve refusals for medical reasons, not personal ones, but that only begs again the question of what physicians' professional commitments entail. Where medical practitioners engage in sustained, reasoned, and public disagreements about what their commitments entail, it seems unjust for the profession to impose a blanket requirement of referral. To do so requires physicians to act against their best understanding of what they ought to be doing as medical practitioners.

What the profession requires, some have argued, is for physicians to fulfill their end of a tacit bargain, an implicit social contract, in which society grants a monopoly to the medical profession in exchange for comprehensiveness, coverage, and prompt referral [22, 25–27]. While we agree that physicians must do what they have implicitly professed to do, the terms of this implicit social contract are often misquoted, so to speak. We suggest that a more accurate statement of any implicit social contract would be something like the following: in exchange for a monopoly over the practice of medicine, medical practitioners commit themselves to care for those who are sick in a manner that prescinds considerations unrelated to what the patient's health requires. Note that this implicit contract differs sharply from an agreement to provide any and all interventions that the "profession deems to be effective, ethical, and standard" [12, p. 1383].

The captive imagination

Finally, we conclude with a more general observation regarding the imagination fostered by the product presumption. At several points in their article, Stahl and Emanuel gesture at the kinds of conscientious refusals that they are loath to tolerate within medicine; in each of these gestures, however, they further display an imagination captive to the product presumption. Instead of attending to actual cases that display the deep conflicts and complexities that often lie at the heart of conscientious refusals, Stahl and Emanuel resort to fictional caricatures of refusals that

seem the most *other*, the most alien to the logic of medicine under the product presumption. Citing "the Jehovah's Witness surgeon" who might "refuse to allow blood transfusions during [a] surgery," the "Jewish pharmacist" who might "withhold pills that are made with nonkosher gelatin," and the "Mormon nurse" who might "refuse to treat alcoholics," Stahl and Emanuel ask the reader to view these three different practitioners—each a crudely constructed caricature of a religiously motivated practitioner—as true *others* to the professional practice of medicine [12, p. 1382].

In choosing these idiosyncratic characters to represent the larger category of religiously or otherwise motivated conscientious medical practitioners, Stahl and Emanuel displace actual conscientious refusals with fictional caricatures that almost any medical practitioner would oppose. Readers may reflexively reject these so-called conscientious refusals, but not because Stahl and Emanuel have shown how the refusals fail to fulfill medical practitioners' professional obligations. Rather, these caricatures are easy to reject precisely because most physicians know of no community in which such refusals would have coherence. In more than a decade of studying conscientious refusals within medicine, we have never once encountered a report of a Jehovah's Witness surgeon who refuses to allow blood transfusions, a Jewish pharmacist who refuses to dispense pills made with nonkosher gelatin, or a Mormon nurse who refuses to treat alcoholics, and Stahl and Emanuel fail to cite any such practitioners. In deploying these abject caricatures, Stahl and Emanuel prey rhetorically on humans' reflexive response to otherness.[16]

This way of arguing, we suggest, is itself a symptom of the product presumption, wherein the particular, the personal, and the religious are threats that must be annihilated for the sake of maintaining efficient technological production and stable, comprehensive bureaucracy—that is, annihilated for the sake of sustaining the intellectualization that trades belief for scientific understanding and sustains the pretense that medicine is only, or at least principally, a science. The form of Stahl and Emanuel's argument fulfills the vatic words of Weber:

> The fate of our times is characterized by rationalization and intellectualization and, above all, by the 'disenchantment of the world.' Precisely the ultimate and most sublime values have retreated from public life either into the transcendental realm of mystic life or into the brotherliness of direct and personal human relations. [4, p. 155]

The imagination that is captive to the product presumption cannot tolerate any particular that threatens the logic of componentiality, the separability of means and ends, or the hegemony of anonymity. The internal logic of this presumption prevents recognition or acknowledgment of the unique goods offered by the particular, the personal, and the religious. Thus, Stahl and Emanuel contend that "health care professionals who are unwilling to accept" their construal of medicine "have two choices: select an area of medicine … that will not put them in situations that

[16] Tellingly, rather than caricature the Christian physician, which would be less likely to elicit reflexive intolerance, Stahl and Emanuel choose to focus on the prospect of a religiously motivated practitioner who refuses to treat patients that have committed the "deadly sins" of "gluttony and sloth" [12, p. 1383].

conflict with their personal morality or, if there is no such area, leave the profession" [12, p. 1383].

This strikes us as a glaring failure of imagination on the part of Stahl and Emanuel, a failure to imagine how reasonable people of good will can and do disagree about controversial clinical practices. Their posture aligns well with the logic of the product presumption, but it is deeply incongruous with and intolerant of the prospect of a medical community whose members continuously and critically examine their own practices, asking whether their practices align with what morality requires and whether their practices are consistent with the purposes of medicine. Stahl and Emanuel appeal to Rawls but they directly contradict critical features of his thought. They deploy Rawlsian language when they argue that the profession "elucidates the interpretation and limits" of the practitioner's primary commitment to "promote the well-being of patients" through "a process … characterized as reflective equilibrium" [12, p. 1382]. They fail to mention, however, that this process is fundamentally imaginative—it requires one to step behind the veil of ignorance, where "parties do not know their conceptions of the good" [20, p. 11; 21].

This hypothetical situation demands an intense effort at imagining what it would be like to take up the position of another member of a given society [21]. As Murdoch has asserted, "The more the separateness and differentness of other people is realized, and the fact seen that another man has needs and wishes as demanding as one's own, the harder it becomes to treat a person as a thing" [8, p. 64]. Thus, the difficult task of the imagination called for by Rawls becomes a route toward seeing others as persons demanding respect. That Stahl and Emanuel appeal to caricatures rather than those who actually conscientiously refuse indicates they have not taken Rawls seriously enough. If they did, they might advocate for policies that accommodate conscientious refusals as often as possible while finding ways to secure patients access to the interventions they believe they need. We concur with Daniel Sulmasy when he writes that "given the imperfections of our moral knowledge and reasoning, we must acknowledge that disagreements are inevitable. Call this moral realism tempered by epistemic moral humility. In the end, this is the true basis for tolerance" [28, p. 144].

Stoppage

At this point, we make good on our promise to advocate for stoppage between medicine and the institutions of technological production and bureaucracy, stemming carry-overs that threaten the attainment of the excellences unique to medical practice. We hope our account so far makes clear that the product presumption solves some problems, but it does so at a steep and grave price. It hides or fails to account for (1) the enchantment of the medical vocation; (2) the goods made possible by a diverse body of ethically engaged and morally perceptive practitioners; (3) the inevitable disagreements between reasonable people, on the margins, regarding what it

means to fulfill one's professional obligations as a medical practitioner; (4) the safeguard against unethical acts that is maintained when practitioners ask whether particular actions are congruent with the ends of medicine; (5) the provisional character of any reflective equilibrium regarding morally contested human practices; (6) the violence of sharply bifurcating the self into the personal and the professional; (7) the importance of proximity and particularity to acts of caring; (8) the irreducibly moral character of referral; (9) the distinction between a commitment to care for the sick and a commitment to provide requested goods and services; and (10) the imaginative empathy and epistemic humility demanded by a sincere attempt to understand those with whom one disagrees.

We simply propose that these ten features are more central and more intrinsic to the practice of medicine than the features that the product presumption and its entailments elevate. Thus, we advocate for stoppage in all of the areas that we identify as affected by carry-overs. Due to the pervasive power of the institutions of technological production and bureaucracy, this stoppage will not be achieved easily. Indeed, Berger, Berger, and Kellner are skeptical about our prospects, noting, "we can propose a rule of thumb for any projects that involve a restructuring of consciousness, to wit, such projects have a likelihood of succeeding that is inversely proportional to their closeness to the primary carriers" [11, p. 108]. The product presumption is embedded in webs of reciprocal causality; and each time this problematic presumption is deployed, the metaphors become more deeply entrenched. As a result, medicine has grown accustomed to seeing itself as a bureaucratically organized industry. Nonetheless, efforts at stoppage must persist. Too much is at stake to do otherwise. If the profession is to recover or contrive more fitting practices of medicine, its members must reject the product presumption and the conclusions about conscientious refusals that follow from it.

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