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How special is medical conscience?

The vigorous legal and ethical debates over conscientious objection have taken place largely within the domain of health care. Is this because conscience in medicine is of a special kind, or are there other reasons why it tends to dominate these debates? Beginning with an analysis of the analogy between medical conscience and conscientious objection in wartime, I go on to examine various possible grounds for distinguishing between medicine and other professional contexts (taking law and accountancy as examples). The conclusion is that no *principled* difference exists between the military and medical cases, nor between the health professions and other professions. Nevertheless, there are *practical* reasons why medical conscience has distinctive importance, mainly concerning the rapid advance of medical technology. Medical conscience will, for these reasons, continue to drive the debate over conscientious objection, even though legal protection should in principle extend to all professions.

Keywords: conscience; conscientious objection; medicine; health care; professions

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Introduction

Within medical ethics there continues to be a vigorous debate about the role of conscientious objection (CO) in health care.[1] [2] Much of the debate has focused on whether it can be permissible to compromise a health care worker's moral integrity by requiring him to act for or on a patient in a way that violates his principles (Brock 2008; Wicclair 2011: 25-7 and passim; Baylis 2015). There is also disagreement over the extent to which a professedly liberal, pluralistic and democratic state is permitted to coerce practitioners to violate their consciences (Giubilini 2014: 174-5; Murphy and Genuis 2013: 351; Oderberg 2018a, 2018b; Giubilini and Savulescu 2018). Questions of

[1] The literature is extensive, but for a representative sample of writers both for and against, see: Savulescu 2006; Asch 2006; Wicclair 2011; Birchley 2012; Giubilini 2014; Neal and Fovargue 2016.

[2] Note that throughout this article, the terms 'medicine'/'medical' and 'health care' will be used interchangeably to denote the full range of health professions.

dignity, respect, tolerance, and liberalism figure large in the debate.[3] Whether there is something special or peculiar about medicine/health care itself has been less a focus of attention. Is medicine unique, or at least special, in giving rise to problems of conscientious objection? Is the role of the health care worker set apart from those of other professions? After all, that the CO debate has been exclusively about medicine suggests prima facie that there is something particularly sensitive, or perhaps troubling, about the doctor-patient relationship, or about the particular concerns of the profession, such that problems of conscience, and serious ones, are bound to arise.

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In what follows I consider in detail the question of whether medicine is a special case when it comes to conscientious objection. First, I will examine the most familiar reason for thinking that it is *not* special: the case of military conscientious objection. I will then move on to analyse a series of other features that might be thought to give health care a special status in the 'conscience wars'. My answer to the question will be mixed: I will conclude that, although health care is not special in principle, in practice it almost certainly is.

In principle, conscience cases can arise in any profession. The conscientious objections that are raised will be particular to the subject matter of the profession in question. Nevertheless, conscience cases will arise across professions for the same *generic* reason: conflict between required action and deeply held ethical principles. In practice, however, given that health is a universal good, and given rapid advances in biotechnology, medicine is always likely to stand out as far as the *prevalence* of conscience objection cases is concerned.

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[3] An interested recent discussion, in the Australian context, that defends medical conscience on liberal, pluralistic grounds is Howe and Le Mire 2019.

This suggests a two-pronged approach to the defence of professional conscience rights. While health care should remain the focus of attention, and indeed take on even greater urgency for practical reasons, advocates should also pursue the development of a general legal framework for protecting conscientious objection. How this might apply *outside* the professions altogether, in non-professional walks of life, is a topic for separate investigation.

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The military analogy

As soon as one begins to think of medicine as somehow special when it comes to conscience rights, one is confronted with an obvious counterexample – the long tradition of conscientious objection in wartime. (For an overview, see Goodall 2010.) Does the fact that military CO is embedded in the political and legal traditions of many if not most liberal democracies, make it easier to accept CO in medicine? The simple argument is that *if* we accept the permissibility of military CO, which occurs at a time of supreme national emergency, surely we should be prepared to accept medical CO which does not arise in such a dire social circumstance – although the situation may be dire for an individual patient or group of patients. The weakness of this simple argument is that its persuasive force relies on the critic's acceptance of military CO in the first place. The critic might consistently reject both military and medical CO, though it is worth noting that, in line with the widespread acceptance of conscientious objection in wartime, even the most strident opponents of medical CO stop short of condemning the military equivalent (see, e.g, Giubilini and Savulescu 2018). The strength of the argument lies in its appeal to consistency: if a person may permissibly opt out of some practice in the most extreme of social circumstances, how could they be denied an opt-out in less extreme circumstances when then general ground of the opt-out request is the same? In both cases, the conscientious objector believes that the behaviour being

required of them (military or medical activity of some kind) violates deeply held ethical principles. If society or the state accommodates the objector even when the survival of the society or state might be at risk, surely the society or state must accommodate the objector in less onerous circumstances?

The military-medical analogy does not fail due to any relevant difference between the *professional* status of soldier and doctor. The military profession has as much right to that name as the medical profession. Both involve kinds of work that require long and intensive training for the work to be performed skilfully. Both are heavily regulated. The practice of medicine is governed by national and international codes and by domestic laws. Military activity is governed by widely accepted international conventions and rules of conflict supplemented by country-specific regulations. Involvement in either profession can, of course, lead to delicate, complex, life-or-death decision making – but I hasten to emphasize that in my view this is not a necessary condition for CO to apply to a profession.

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Critics of medical CO have said the following about the medical-military analogy: just as CO in warfare has often led to punishment and ostracism, so in medicine the objector must be prepared to bear the consequences of being allowed an opt-out. As Giubilini and Savulescu (2018) put it: '[c]onscientious objectors to conscription to war were incarcerated or experimented upon. Today's conscientious objectors pay no such costs.' This echoes in much stronger terms the views to which these authors signed up along with a number of other academics in the 'Consensus Statement on Conscientious Objection in Healthcare' (Consensus Statement 2016). For these opponents of medical CO, objectors should only rarely have an exemption, but when they do they 'should be required to compensate society and the health system for their failure to fulfil their professional obligations by providing public-benefitting

services' (Consensus Statement 2016, point 7). How might the defender of medical conscience respond?

One must with charity assume that Giubilini and Savulescu are not suggesting that medical objectors should be incarcerated or experimented upon, and in any case this has not been the norm for military objectors at least in the UK, USA, and other English-speaking countries. To be sure, a certain amount of social ostracism and general hostility was once directed toward people who were often regarded as mere cowards. Nevertheless, most military objectors took on useful and even vital roles such as medical care for the wounded, agricultural and factory labour, and so on. Some were simply left alone to live in their small, self-contained and often religious communities. As a defender of medical CO, I acknowledge that objectors should expect to be treated with a certain animosity on the part of the wider profession or population at large for refusing to 'go with the flow'. Such is the price of non-conformity. This is a long way from saying that military or medical objectors should suffer persecution or discrimination *under the law*, rather than accommodation in accordance with their legal rights. If CO is a civil right, then the state must not countenance persecution for its exercise. Ideally, one should also hope for civility and respect at all times, but in such delicate situations as inevitably arise in war and medicine this is not always possible.

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Perhaps, as Giubilini implies, it is in the *involuntary* aspect of military service that the disanalogy with health care lies. The common view among critics of medical CO is summed up by Udo Schuklenk when he says that '[n]obody forces anyone to become a professional. It is a voluntary choice' (2015: ii). Again, as Julian Savulescu puts it: 'If people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors' (2006: 294). Although this is a familiar argument, it is difficult to see the force of the

point. If military CO applied only to conscripts, then ‘career soldiers’ or volunteers would have no exemptions; however, they too can face situations where conscience requires them to refuse to serve and the law allows such refusal (examples might include what is to them an egregiously unjust war, or seriously unjust behaviour within war not covered by existing rules of engagement or international convention). The critic might respond that this is irrelevant, the point being that a military conscientious objector is exempted from serving in a combat role *altogether*, because of his having been conscripted; no volunteer would request an opt-out from serving in a combat role altogether. Such a response would only prove my point, however: no person who voluntarily ‘signs up’ to being a doctor – as all do – objects to practising medicine *altogether*, only to specific acts that they consider violate their ethical principles.

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The point about voluntariness, deployed so often by critics of medical CO against its proponents, needs to be handled with care. The objection usually takes a simple form: ‘The conscript does not volunteer to serve but the doctor willingly enters the profession. This explains why we allow an opt-out for the former but not the latter.’ In my view it explains no such thing. It makes a false comparison: in the former case, what we are really concerned with is the conscript’s status as *citizen*, and their right not to serve in a combat role at all, as opposed to being concerned with a soldier’s conduct *within* a combat role. In the latter case, we are concerned with the health care worker’s status *as* health care worker, and their conduct *within* a profession that they have already signed up to. . Once the structure of the analogy is correctly understood, we can apply it to illuminate the case of medical CO. For it is open to any conscript to renounce their citizenship altogether – as many conscientious objectors do – in order to avoid military service. Similarly, it is open to any health care worker to leave the profession, as critics of CO continuously urge, if their consciences are troubled by what they are

sometimes expected to do. Yet it is by no means commonly held that the price of military CO has to be renunciation of one's citizenship. One could of course be consistent, insisting *both* on this *and* on a medical objector's renunciation of the profession, but one would need to argue in favour of such a solution. On the other hand, if freedom of conscience is a basic civil right in all liberal, pluralistic democracies professing tolerance and respect for diversity in ethical codes and world views – as the international conventions[4] to which such states are signatories make it abundantly clear – then the preferred approach should be to provide conscience-based accommodations in both kinds of case.

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Moral decision making

Perhaps we should consider medicine to be special when it comes to conscience rights because, as Mary Neal puts it, 'the practice of healthcare necessarily (and perhaps routinely) involves decision-making that contains a moral element' (2019). Adrienne Asch also emphasizes the crucial role of moral decision making in medicine. Curiously, though, she states: 'The idea that, *unlike most professionals*, health care providers leave their personal moral beliefs at the door when they go to work and simply provide any service that is safe and legal does not reflect the daily experience of medical practitioners or provide a model that society expects them to adhere to' (2006: 11, emphasis added). On the contrary, one would have thought, given the extent to which health care has dominated recent debates about conscientious objection, that most people considered other professions to be quite different from medicine, and regarded

[4] See Article 18 of the United Declarations Declaration on Human Rights 1948 and the various treaty and convention clauses derived from or similar to it, such as Article 9 of the European Convention on Human Rights.

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lawyers, accountants, and corporate middle managers (to pick at random) as professionals who *do* 'leave their personal moral beliefs at the door' when asked to provide a lawful service. Most people are well aware of the delicate ethical decision making involved in health care, where issues of life, death and health are front and centre. We don't think of this as being true of other professions to the same extent.

That said, Asch is correct about the inescapable role of moral decision making in medicine, and right to hold that society does not and should not expect doctors to park their moral principles before starting work. In principle, however, this applies across the board. In all professional contexts there are moral decisions to be made, whether the professional involved realizes it or not. An introspective person can be made to realize this fact by carrying out a simple thought experiment. All they need to do is ask: 'What is *my* ethical red line?' In other words, at what point would that professional consider that they have been asked to do something that violates their deeply and sincerely held moral principles? Every single professional – unless they are some kind of psychopath or sociopath – will have their ethical red lines, which means that, in principle, problems of conscience might potentially arise for them. Any professional, I submit, should be able to shelter under a general legal framework protecting freedom of conscience in a liberal society. As Asch succinctly puts it: 'We applaud employees who blow the whistle on unsafe or unethical practices in corporations. By conscientiously objecting to practices that are often ingrained in the cultures of their chosen professions, they do society a service'. She goes on: 'A society that accepts pluralism and diversity in its members' religious beliefs and moral commitments should not require people to behave in ways that go against deeply held convictions' (2006: 11).

Note in passing, however, that Asch's elision of whistleblowers and conscientious objectors is a little quick. Whistleblowers intentionally alert others to

practices that are clearly illegal or that society recognizes as uncontroversially wrong (such as fraud and corruption). Conscientious objectors, by contrast, knowingly (although it is unlikely to be their *intention*) alert others to the fact that a particular practice is ethically *contested*, and so is not one that every qualified person should be required to perform. Asch is correct however, that both whistleblowers and conscientious objectors perform a service to society.

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Now, the role of conscience in the professions generally might not loom large in practice or in the public imagination. This occurred to me when I recently suggested the following at a workshop on conscience in health care. Imagine a lawyer were asked by his senior partner to work on a project that involved tax avoidance. The arrangements would be perfectly legal, given various technical loopholes, but would clearly violate the spirit and objective of the law. Shouldn't the lawyer be permitted conscientiously to object without fear of demotion, harassment, or other penalty? No sooner had I presented the scenario than a muffled giggle spread throughout the room. The scenario seemed ridiculous to my audience – a lawyer with a troubled conscience! But what the audience reaction suggested to me was that if professional freedom of conscience *was* taken more seriously across the board, rather than being discussed only in relation to health care, some other professions might claw back some much needed respect. (Even more so if conscience clauses were incorporated into formal, enforceable codes of ethics.) Other examples might include: accountants, who are regularly expected by their employers to sail close to the wind in audits and other work; journalists, who can easily find themselves expected to run with stories that have no evidential basis; and politicians, for whom the expectation to compromise one's principles is a commonplace of climbing the political 'greasy pole'.

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It must be emphasized that accommodation of CO is not supposed to be a substitute for other mechanisms and processes that help to minimize ethical conflict – such as, perhaps, a greater diversity in public and private health care provision. In some cases of conflict, the relevant area of professional practice is so specialized that it is no hardship for the objector to avoid that area and still practice with relative freedom. In medicine, for instance, it should be possible for a conscientious objector to transgender surgery or some other form of extreme body modification to avoid the contested work and still practise cosmetic surgery relatively freely. By contrast, an objector to abortion would have their professional freedom severely restricted by being prohibited from working in an obstetrics ward (see, for example, the case of *Greater Glasgow Health Board v Doogan* [2014] UKSC 68). In general, tacit or perhaps even explicit contractual understandings between employers and employees can obviate the need for external resolution of conscience-based objections. Nevertheless, formal protection for CO within a statutory and common law framework must exist as, to use a currently fashionable term, the ultimate backstop giving real force to the many international agreements recognising freedom of conscience. As a basic civil right in a liberal society, conscience deserves the same explicit legal recognition as other civil rights such as freedom of speech and freedom of association. What could justify differential treatment?

Protecting interests and avoiding harm

It might be argued that health care involves the promotion and protection of other people's interests in a way not found in other professions. It is not for nothing that 'First do no harm' (from Hippocrates' work *Of the Epidemics*) is a cornerstone of medicine, along with such principles as these from the Hippocratic Oath: 'I will use my power to help the sick to the best of my ability and judgement; I will abstain from harming or

wronging any man by it' (Lloyd 1983). Given the centrality in the medical profession of doing good and avoiding harm, we should not be surprised that a health care worker who believes that what they are expected to do will cause harm to their patient, or not do the good that is supposed to be done, might reasonably object to carrying out the task at hand.

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One immediate response to this suggestion is that although doing good and avoiding harm is such a palpable feature of medicine, it is by no means confined to it. The premise here seems to be that members of some professions are more like service providers. Perhaps the question of avoiding harm is more likely to arise when it comes to fixing a leaky pipe or repairing electrical wiring than in the case of auditing one's accounts or arranging a property transfer. Certainly harm – at least in a manifest, bodily sense – is more an issue when it comes to electricity than to accounting, and in the former case the avoidance of harm is hardly likely to give rise to a conscience question. But every profession is dedicated to doing good and avoiding harm, even if the goods and harms at stake are not bodily. A lawyer is bound to avoid putting their client in legal jeopardy, to make all available attempts to keep them from being harmed by state action, or by neighbours, or by business partners. Advancing one's client's legal interests is as much a case of doing good for that client as keeping their blood pressure normal. Avoiding financial injury to a client is the business of an accountant just as avoiding bodily injury is a prime concern of the doctor. An investment adviser, or lawyer, or accountant, should be legally free to opt-out of implementing a scheme – rather, a scam – intended to separate clients from their money with no discernible benefit to the client thereby. We should not, then, be misled by the more spectacular, headline-grabbing nature of medicine into thinking that it has a unique occupation with people's interests.

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The second point is that CO is about more than refusing to do that which might cause harm to one's patient or client. An objector might refuse to do something they consider wrong even though it does not harm, or even benefits, their patient or client. In the legal example, a tax avoidance arrangement is going to *benefit* the client, yet because the arrangement bends the letter of the law and breaks its spirit, the lawyer may have serious reservations about implementing it. The defender of medicine's unique status might draw a distinction here, inasmuch as it is harder to see how a doctor's objection to doing what he believes to be wrong can be separable from his belief that by doing what he objects to he will be harming the patient. Yet here, again, the contrast with other professions is not so clear.

Suppose a surgeon objects on moral grounds to doing purely cosmetic surgery, as opposed to surgery for reconstructive or remedial reasons. In extreme cases, patients ask to be made to look like Barbie or Ken, or like some celebrity. Now, some surgeons *might* object to such surgery because they think it is dangerous, exposing the patient to harm, perhaps in the long term. But they need not. The procedure in question might be safe yet some surgeons might still object on the basis that surgery is not about pandering to vanity, fanning the flames of narcissism, promoting 'celebrity culture', and so on. They might think it wrong to operate for non-medical reasons, and this may represent an ethical 'red line' for them, even though the procedure itself would not be harmful to the patient (not even psychologically, at least as far as the surgeon can tell).

This sort of case, I submit, provides a better illustration than the example of abortion of how CO and harm can come apart in medicine. Most physicians who oppose abortion believe that it involves not only taking the life of the unborn child but also that it harms the patient, at least psychologically and in the long term. Still, it is hardly inconceivable that a physician might have a conscientious objection to abortion *solely*

because it involves taking a life and not because they believe it harms the mother in any way. Therefore, it is plausible to think that there is no principled difference between medicine and other professions when it comes to promoting a patient's or client's interests and avoiding harm to them.

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Trust and integrity

Alternatively, it might be argued that the doctor-patient relationship involves a unique bond of trust. The patient relies on the practitioner's integrity – their commitment to doing what they consider right for the patient and also right 'all things considered'. Given this, no patient would want a practitioner to provide a service or treatment to which the latter had a serious ethical objection, if for no other reason than doubt about whether the practitioner would be sufficiently practised or sufficiently committed to providing it with the utmost skill (Savulescu and Schuklenk 2016: 163).

The thought that medical objectors might be half-hearted in their provision of treatments to which they object does not, of itself, distinguish medicine from other professions. On the contrary, a client ought perhaps to be *more* worried about having a lawyer or accountant implement a tax avoidance scheme to which they ethically objected than about a medical conscientious objector. It is unlikely the sanctions on a lawyer or accountant in such a situation would match the severe discipline meted out to a health care worker who allowed their ethical objections to interference with the actual quality of the service they provided, with all the attendant dangers such interference would produce.

When it comes to trust and integrity, the difference between medicine and other professions, if there is any, can only be a matter of degree. It is of the essence of most professions that clients and patients rely heavily on the knowledge and expertise of the professional. The reason we engage professionals in the first place is that we are unable

to manage our own situation unaided, whether it be our health, our financial affairs, or our legal difficulties. We expect the professionals we engage to act with integrity in our case: we expect them to be honest, reliable, helpful at all times, on our side, and – we hope – of sufficiently upright character not to let us down. Do we care as much about what is sometimes called 'moral integrity', in the sense of fidelity to one's own principles? Does it matter to us whether our doctor only does what she believes to be ethically correct (whether or not potential harm to the patient is at issue)? Do we worry about whether our lawyer or accountant provides only those services with which *they* feel ethically comfortable? I doubt that such concerns are high on the list of most patients or clients, but if they have a place then it would presumably apply across the board. If we expect our health care professionals to behave with a certain amount of autonomy, acting on a mixture of ethical and professional judgment rather than as our personal valets, then I do not see why we ought not to think the same way about other professions. If it is more common to see one's doctor as an autonomous professional than one's lawyer – who, we might think, is a mere highly paid functionary there to do our bidding – this says more about our respective attitudes to the medical and legal professions than about the nature of those professions.

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Intimate and delicate decisions

Perhaps what is special about medicine is the uniquely intimate and delicate decisions that patients and doctors make in consultation with each other. There are things a person will tell their doctor that they would not tell anyone else except perhaps a priest. Health care professionals are often privy to the most secret and sensitive information about another human being. The potential consequences of acting wrongly on that information are huge, even a matter of life and death.

Supposing that all of this is true, it is hard to see how it means that there is no place for CO in other professions. In fact, there is a logical gap between the intimacy and delicacy of the doctor-patient relationship and the need for conscience protection in *that* profession. How does this aspect of the relationship give rise to conscience rights? Maybe the idea is that the very sensitivity of the matters often discussed between doctor and patient implies the possibility of doctors being pressured or expected to do something they regard as seriously wrong. Perhaps, due to the intimacy of the relationship, there is a risk of doctors blurring the need to help with the expectation of doing whatever the patient wants them to do as long as it is legal, practicable, and does not involve any wrongdoing from the patient's perspective.

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If so, I submit that the difference between the medical scenario and other professional relationships will, again, only be a matter of degree. Perhaps, overall, medical decisions are more delicate and sensitive than the decisions made in the context of other professional relationships (legal or accounting decisions, for example). This does not exclude the possibility that a lawyer, for example, might find herself being asked – by her client or by her senior partner – to do legal work of a particularly sensitive nature, sailing very close to the wind of what she considers ethical practice. To be sure, in law, or accounting, or finance, or other related professions, decisions are rarely a matter of life and death or of bodily health and well-being. Yet they can still be highly sensitive, involving the most intimate details of how a person arranges their financial or legal affairs. Delicate judgments regarding what is professionally acceptable can and often do arise.

Mark Wicclair queries the supposedly unique status of health care in relation to other professions. He finds 'questionable' these two claims: (i) '[t]he infringement of an agent's moral integrity is much more serious in the case of physicians than in the case of

employees of accounting firms and advertising agencies'; and (ii) '[t]he impact of the choices and actions of physicians is much greater than that of employees of accounting firms and advertising agencies' (2000: 215). Perhaps he overstates the case a little inasmuch as, *in general*, the impact of decision making in medicine is probably more serious than in other professional contexts. Further, when moral integrity – acting according to one's principles – is at stake, the issues that arise are likely to be more serious in health care than in law, accounting, or advertising. Still, Wicclair is right not to see anything *unique* about medicine, meaning that CO for other professions should not be ruled out ab initio. Wicclair himself considers an advertising executive tasked with the promotion of smoking. The impact of such involvement can be as significant as in any doctor-patient relationship, if we are looking at contribution to harm. The advertising executive is not, of course, directly harming anyone or producing a palpable injury through their participation in the advertising campaign, but such involvement still gives rise to a serious question of conscience. The executive might be troubled by their *indirect* contribution to harming public health if the campaign were successful, which might be every bit as troubling for the executive as it would be for a doctor asked to do something they believed would indirectly harm their patient.

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If not in principle, then in practice

It has proven difficult to find a line of demarcation between medicine and other professions such that CO should be available in the former context and not in the others. I have argued that there is nothing about medicine *per se* that sets apart CO in that profession from the long-accepted availability of CO in wartime. Further, what is true of health care is true also of other professions; I have focused on the legal and financial professions, but the same can be said for others such as advertising (Wicclair 2000). All are concerned with promoting the interests of their clients and avoiding harm to them.

Moral decision making is found in all of them; sometimes the decisions to be made are of great significance for the client or for third parties. All professional relationships involve trust, integrity, reliability, and the sharing of sensitive information. Intimate aspects of a client's life are the subject matter of many professional relationships – whether it be physical or mental health, family life, business or legal affairs. But even when sensitive or intimate information is not involved, professionals may find their consciences troubled by the expectations of their clients, or of their superiors, or by the requirements of the recognized code of practice of their profession. Every member of a profession will have their 'red lines' – the boundaries they will not cross, as a matter of ethical principle, in the conduct of their clients' business. The question should be not *whether* there should be legal protection for CO across the professions, but *how* it should be implemented and what the limits should be.

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Nevertheless, despite the lack of a principled line of demarcation between health care and other professional fields, it is no accident that health care dominates debate among ethicists about conscientious objection. High-profile legal cases, such as *Doogan*, are partly responsible. These, however, reflect a more general preoccupation with beginning- and end-of-life decision making that goes back to the explicit conscience protection of section 4 of the Abortion Act UK (1967), as well as the Church Amendments in the USA (1973) which allow for extensive accommodation of CO to abortion by workers in federally-funded hospitals.

There is, however, a far broader concern that distinguishes the medical profession – and the health care professions in general – from the other professions. This is the rapid, seemingly unstoppable march of technology and the opportunities it creates for treatments, procedures, and services that we can still barely imagine. Indeed, I would go as far as to suggest that it is no more than an *historical accident* that abortion

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and euthanasia have been the triggers for debate about conscientious objection. Although beginning- and end-of-life issues will continue to occupy much of the debate over medical conscience rights, the possibilities that will be afforded by medical technology over the coming decades make it certain that increasing numbers of medical practitioners will find their own ethical red lines being challenged by patient demand for lawful services, and by their managers' expectations.

Consider some of the procedures and services that are currently available and becoming increasingly widespread. We already have transgender surgery – once a rarity, now more easily available. There is extreme body modification,[5] cognitive enhancement,[6] the increasing popularity of microchip implants,[7] and various kinds of body integrity disorders leading to requests for the removal of health body parts.[8] Then there is the rapid development of gene editing,[9] personalized genetic testing,[10] and an as-yet unimagined range of medical treatments and services that better understanding of the human genome will bring. It would be short-sighted and insouciant to insist that the kinds of activity listed here will be confined to the private sector, where health care professionals might have greater autonomy over whether they wish to participate.

Transgender surgery is available on the NHS; why should we think other procedures will not be, should there be sufficient demand and vigorous lobbying? Nor should we think that such treatments and services will only ever remain niche and are unlikely to trouble the consciences of the vast majority of doctors. First, it is not a question of numbers. Protection for conscience was built into UK abortion legislation

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[5] For a list of currently available modifications, see https://shrtm.nu/yq4D [last accessed 15/02/19].
[6] See https://shrtm.nu/GqMS for some examples [last accessed 15/02/19].
[7] On which, see https://shrtm.nu/7oYn [last accessed 15/02/19].
[8] See https://shrtm.nu/fjuD [last accessed 15/02/19].
[9] See https://shrtm.nu/dHSD [last accessed 15/02/19].
[10] For background, see https://shrtm.nu/kQG2 [last accessed 15/02/19].

from the beginning, when access to such services was limited and expected by many to remain limited. The question is one of principle: in a liberal, pluralistic democracy that does not profess a single, comprehensive ethical or religious code, may *any* doctor be compelled to act in violation of their deeply and sincerely held ethical boundaries? Secondly, we should expect most if not all of the treatments and services I have mentioned to become increasingly accessible and affordable. For now, genetic testing is a minority pursuit. Reduced costs, increased accuracy and ease of use, demands from insurance companies, expectations from government and employers, and sheer popular interest, will make it a virtual commonplace within a few decades. This will make it harder for doctors to avoid the expectation that they offer the service themselves or refer patients to another practitioner who will, that they provide information about laboratories where the testing is done, and so on. If we know anything about the history of medicine, it is that what starts off as niche, expensive, difficult, and therefore unpopular, usually becomes widespread, affordable, and much easier to implement. Hope correspondingly metamorphoses into expectation; and expectation has the potential to lead to CO and the desire for an exemption on the part of those of whom demands are made.

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This is not to say that rapidly advancing medical technology will lead to an epidemic of CO in medicine. Taking all medical treatments, procedures, and services as a whole, it will continue to be the case that the vast majority are either beneficial, or at least not harmful, nor likely to trouble the consciences of any medical professional. That said, it is certain that we will find large areas of health care where conscience cases become increasingly common. Technology has a habit of pushing ethical boundaries, which inevitably leads to questions of conscience for people involved in implementing the technology. The overall direction of travel in society might seem distinctly

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permissive, but in a highly pluralistic society where people hold to various ethical codes (religious or secular), we should not expect everyone to 'go with the flow', least of all the health care practitioners who will have a primary role in the application of the new technologies.[11]

Nor should we confine the issue to those with primary roles. On my view of CO, it is essential that the ethics of *cooperation* be given full weight.[12] It is the lack of a civil jurisprudence of cooperation, and the overly narrow wording of the Abortion Act UK, that led to the failure to protect the midwives in *Doogan* from having to assist on an abortion ward. Legal protection for CO should not be reserved solely for those tasked with performing the objected-to act itself, but should also extend to those who object to *assisting* with performance of the act in ways that are sufficiently direct and proximate to implicate them morally. For all of the treatments and procedures listed above, made possible by advances in medical technology, the question of cooperation will be relevant. In the case of DNA testing, for example, a conscience issue might arise for the doctor with whom the initial consultation takes place, for a technician in the laboratory where such tests are performed – he might conscientiously object to *some* kinds of DNA tests and not others – or for other professionals, such as consultants or surgeons, who are asked to provide various services based on the test results. The question of cooperation can, in principle, arise at many locations in the causal chain of health care provision.

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[11] None of which, of course, excludes the important further question of conscience protection for those involved in the design, production, and marketing of technology in respect of which conscience questions might arise.

[12] For full discussion, see Oderberg 2018a. For detailed analysis of specific issues, see Oderberg 2017.

Conclusion

When it comes to the question ‘how special is medical conscience?’, then, my answer is twofold: not special in principle, but special in practice. Health care will always be a universal concern of the deepest kind. Nearly all of us need the services of a lawyer or accountant at some time in our lives; but no one, without exception, can live without the need for medical care, and we often need it on more than an occasional basis. This basic, universal need, coupled with extraordinary advances in the scope and variety of what medicine can do, makes it unsurprising that the conscience of a health care professional is more likely to be challenged than the conscience of a lawyer. The lack of *principled* difference between the professions means that society needs a wholly general legal framework for conscience protection, combining both statute and case law. At the same time, the clear difference in *practice* between health care and the other professions means that, with such a framework in place, the details of its interpretation and implementation would, at least in the early stages, be hammered out almost exclusively in the context of medical cases. As such, a serious commitment to legal protection for conscientious objection, in line with international commitments, will make medicine the driver of protections that all professions will be able to enjoy.

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References

Abortion Act. 1967. Abortion Act UK (http://www.legislation.gov.uk/ukpga/1967/87) [last accessed 29/07/19].

Asch, A. 2006. Two cheers for conscience exceptions. *Hastings Center Report*, 36, pp.11-12.

Baylis, 2015. A relational view of conscience and physician conscientious action. *International Journal of Feminist Approaches to Bioethics*, 8, pp.18-36.

Birchley, G. 2012. A clear case for conscience in healthcare practice. *Journal of Medical Ethics*, 38, pp.13–17.

Brock, D.W. 2008. Conscientious refusal by physicians and pharmacists: who is obligated to do what, and why? *Theoretical Medicine and Bioethics*, 29, pp.187-200.

Church. 1973. The Church Amendments (https://shrtm.nu/BdZD) [last accessed 29/07/19].

WARNING – AUTHOR'S DRAFT ONLY!

Consensus Statement 2016. Consensus statement on conscientious objection in healthcare. *Practical Ethics: Ethics in the News* blog, at https://shrtm.nu/PgQv [last accessed 29/07/19].

Giubilini, A. 2014. The paradox of conscientious objection and the anemic concept of 'conscience': downplaying the role of moral integrity in health care. *Kennedy Institute of Ethics Journal*, 24, pp.159-185.

NOT FOR CITATION OR CIRCULATION.

Giubilini, A. and Savulescu, J. 2018. Against Conscientious Objection In Health Care: A Counterdeclaration And Reply To Oderberg. *Practical Ethics: Ethics in the News* blog, at https://shrtm.nu/pbzE [last accessed 29/07/19].

Goodall, F. 2010. *We will not go to war: conscientious objection during the world wars*. Stroud, Gloucestershire: The History Press.

SEE ABOVE FOR OFFICIAL PUBLISHED VERSION.

Howe, J. and Le Mire, S. 2019. Medical referral for abortion and freedom of conscience in Australian law. *Journal of Law and Religion*, doi:10.1017/jlr.2019.14 [last accessed 29/07/19].

Lloyd, G.E.R. ed. 1983. *Hippocratic Writings*. London: Penguin Books.

Murphy, S. and Genuis, S.J. (2013) Freedom of conscience in health care: distinctions and limits. *Bioethical Inquiry*, 10, pp.347-54.

Neal, M. 2019. Conscientious objection, 'proper medical treatment', and professionalism: the limits of accommodation for conscience in healthcare. In J. Adenitire ed. *Religious Beliefs and Conscientious Exemptions in a Liberal State*. London: Hart Publishing.

Neal, M. and Fovargue, S. 2016. Conscience and agent integrity: a defence of conscience-based exemptions in the health care context. *Medical Law Review*, 24, pp.544-570.

Oderberg, D. S. 2017. Further clarity on cooperation and morality. *Journal of Medical Ethics*, 43, pp.192-200.

Oderberg, D.S. 2018a. *Opting Out: Conscience and Cooperation in a Pluralistic Society*. London: Institute of Economic Affairs.

Oderberg, D.S. 2018b. Response from David S. Oderberg to "Against Conscientious Objection In Health Care: A Counterdeclaration And Reply To Oderberg". *Practical Ethics: Ethics in the News* blog, at https://shrtm.nu/wLmC [last accessed 29/07/19].

Savulescu, J. 2006. Conscientious objection in medicine. *British Medical Journal*, 332, pp.294-297.

Savulescu, J. and Schuklenk, U. 2016. Doctors have no right to refuse medical assistance in dying, abortion or contraception. *Bioethics*, 31, pp.162-70.

Schuklenk, U. 2015. Conscientious objection in medicine: private ideological convictions must not supercede public service obligations. *Bioethics*, Editorial, 29, pp.ii-iii.

Wicclair, M.R. 2000. Conscientious objection in medicine. *Bioethics*, 14, pp.205-27.

Wicclair, M.R. 2011. *Conscientious objection in health care*. Cambridge, UK: Cambridge University Press.

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