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Individualised claims of conscience, clinical judgement and best interests  
Stephen W Smith

I. Introduction

Conscience is an important subject in medical law and ethics. We debate its impact and influence on some of the most crucial and controversial issues in healthcare. However, we often do so in a limited fashion. We consider only a particular type of conscience claim and our understanding of conscience and conscience-based decision-making is likewise limited. For example, in a pair of famous articles, Julian Savulescu argues that doctors and other healthcare practitioners should not be entitled to make a conscientious objection to treatment that a patient might want [22], [23]. He argues that doctors are required to perform a professional duty and therefore should undertake all tasks which might be clinically indicated, even if it offends their conscience to do it [22], [23]. If doctors or other health care professionals do not want to provide particular treatments for conscience-based reasons, then they can either specialize in a medical field which does not require that particular treatment (e.g. those who object to abortions should specialize in something other than obstetrics or gynaecology) or, if the complaint is substantial enough, leave the medical profession altogether. Ultimately, he argues that a doctor's conscience is never sufficient reason to override the best interests of the patient [22], [23].

Savulescu does not indicate specifically which kinds of conscience claims he means to address in his articles. However, it appears that the kinds of claims he is discussing are those most standardly considered within medical law and ethics: conscientious objections to performing abortions, IVF, or assisted dying. These are usually generalizable, predictable, rule-based claims in which an individual practitioner objects to what is otherwise standard medical treatment. They are, thus, the kinds of objections which are recognised in the Abortion Act 1967 [1] or the Human Fertilisation and Embryology Act 1990 [12].<sup>4</sup> Those who hold this kind of conscientious objection usually object to a particular treatment as a matter of principle and individual circumstances do not matter in the calculation. Treatment, then, is objected to as a class of action rather than a specific instance. Sometimes, an individual might object to only one kind of a more general class (e.g. a doctor might object to providing abortions in cases of foetal abnormality) but they are still based upon generalised characteristics rather than individual circumstances.

Not all conscience claims, however, fit within this mould. Some conscience claims are, instead, based upon how a set of rules apply in a particular case at a particular time [25]. These might be instances where a treatment, which usually does not generally raise a conscience claim for the particular practitioner in question, becomes problematic due to circumstances which might not have been predictable or subject to a single rule easily applied in advance. For example, a doctor might not object to a patient receiving a particular treatment when the patient first presents. However, it may reach a point where the doctor believes that treatment, which was not previously objectionable, has become so due to changes in the patient's condition, the effectiveness of the treatment or simply because the doctor believes the treatment has reached 'a bridge too far' [25]. Thus, for example, a doctor might have no systematic objection to the use of a particular life-sustaining treatment, but objects in a particular case with a particular patient

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<sup>4</sup>The Abortion Act 1967 specifies in section 4 that doctors may refuse to participate in the provision of abortion services. The Human Fertilisation and Embryology Act 1990 in section 38 allows doctors to conscientiously object to providing any activity governed by this Act. This would include providing, for example, IVF services.

because the standard side-effects in this specific case are too distressing. These cases are not covered by Savulescu's claim, nor are they generally considered when healthcare lawyers discuss conscientious objections [25]. Consequently, it may ~~not~~ be ~~un~~clear how these sorts of objections should be characterised, ~~either~~ within a legal ~~or ethical~~ framework ~~or within any ethical system that we might wish to consider~~.

This article will explore these more individualised claims in two ways. First, it will explore whether these kinds of claims should properly be considered claims of conscience as opposed to ~~a different sort of claims~~ ~~something else~~. Second, it will explore how, ~~if these are truly conscience claims~~, these claims might interact with the other sorts of judgements that we expect doctors to make in these sorts of cases. In other words, it will look at how we might address Savulescu's concerns about the role of conscience in conjunction with professional standards, clinical judgment and the best interests of the patient.

## II. The Nature of Conscience

We ~~need to~~ begin ~~with an idea of what~~ ~~by understanding~~ conscience ~~is~~. José Miola has presented an ~~initial~~ definition ~~he believes to be useful in deliberating the place of conscience in medical law~~ [19]. According to Miola, for a decision to be based on conscience, two things are required. First, the decision cannot be based on 'professional judgement' [19]. By 'professional judgement' Miola means technical medical skill.<sup>2</sup> These are matters ~~which are~~ within the exclusive purview of a particular profession – ~~in this case i.e.~~, doctors. Miola argues that ~~for a conscience-based decision to be one of conscience~~, it needs, instead, to be based on values. Second, ~~for Miola~~, a decision is conscience-based if the doctor has 'the liberty to make her own decision' [19]. Miola argues ~~that~~ there must be more than one option available to her so ~~that~~ a choice is possible. There are problems, however, with both of Miola's criteria. The second is problematic because choice does not necessarily require other options.<sup>3</sup> All that it actually requires is an authorial connection to the decision [7], [8]. If the doctor in question would claim ownership of the decision, then we can reasonably call it one where there was a choice, even if there were no other options available. More importantly, the first criterion is missing an essential word – 'moral'. Decisions are only conscience-based if they encapsulate a moral value, not just values in general. A doctor, ~~for example~~, may choose to use green scrubs in preference to blue because of an aesthetic value. That ~~would appear~~ to fit Miola's criterion – it is a choice based upon a value - but ~~it does not seem likely that~~ we would ~~not~~ call such a decision conscience-based. ~~In order for~~ something to be classified as conscience-based, ~~then~~, it must be moral or ethical in nature. It does not, ~~of course~~, have to belong to a particular ethical or moral tradition nor does it need to be based upon religious views. It does, though, have to be moral in character as opposed to being based on values of some other sort.

In addition to these two modifications of Miola's criteria, ~~I should add that~~ there is a third criterion which he neglects. Conscience must be inward-facing. A decision of conscience is about the conduct of the person claiming conscience. Conscience is about ~~my~~ actions, not the actions of other people. A statement that others ought not to lie is a moral claim but it is not conscience-based because it deals primarily with the views of others. A conscience-based claim would be one which argued that I should not engage in lying because it would violate some ethical or moral precept ~~I hold~~. Even ~~in a situation~~ where the conscience-based refusal may appear to be actions of others (e.g. a doctor refusing to perform a termination of pregnancy because of the

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<sup>2</sup> ~~In this~~, Miola follows Ian Kennedy. Miola ~~specifically~~ references *The Unmasking of Medicine* [13] but Kennedy makes a similar point in *Treat Me Right* [14].

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patient's lifestyle), the refusal is still inward-facing because the doctor's claim is that *she* could not perform the termination. Conscience, then, is the subset of ethics and morality that deals with our own conduct and not the conduct of others.

I wish to be clear about what is meant by "inward-facing" and "our own conduct". Carolyn McLeod [16] and Françoise Baylis [4] have both contested what they call the "dominant view" of conscience ~~because that~~ it is individual. They both argue that conscience comes from and is modified – at least in part – by social, community, religious and family factors [16], [4]. In other words, ~~no person is an island and our moral views, like our views on most things,~~ never arise spontaneously out of ourselves but have a host of influences. ~~Whether or not~~ Even if this is a sufficient basis for attacking what they term the dominant view,<sup>4</sup> it does not mean that conscience is not inward-facing. Inward-facing means that a claim of conscience is specific to the speaker. The individual in question is the object of the statement and not other people. ~~In other words,~~ the statement 'I cannot act in that way because it violates my conscience' makes sense; 'you should not act in that way because it violates my conscience' does not. My conscience is only a compelling reason for *me* to act in particular ways. It does not, without more, provide a reason for others. ~~Thus, We~~ we can talk about ~~the idea of~~ respecting conscience as a justification for me to act in particular ways, but a decision of conscience itself does not provide any justification for my actions if it is your conscience.

These three criteria – ~~that~~ a decision ~~is~~ based upon moral values, ~~is the~~ subject ~~to of~~ ownership by the individual, and ~~is~~ about the individual's own conduct – are the basis for someone to claim that a decision is based upon conscience and, consequently, for a claim that decision ought to be respected by others. Any decision, to be able to claim conscience, must have these three elements. ~~Notice, I~~ however, ~~that~~ three additional elements are not required for a decision of conscience. First, a claim of conscience need not be based upon rules. There is no requirement that a decision of conscience needs to be consistent with other decisions a person makes nor does it require any coherent set of moral rules. This is consistent with the view of conscience put forward by Fovargue and Neal: [9]. ~~In their article, Fovargue and Neal~~ They argue that it is 'too onerous' for a decision to fit within a coherent set of beliefs. They also state that it is 'unclear' why it must be part of a system and they believe that it might privilege beliefs based upon a religious system over others. ~~In addition, a~~ decision of conscience can be, ~~and often probably is,~~ a 'gut decision' ~~one~~ in which an individual may feel there is something wrong without necessarily being able to articulate the reasons for why it is wrong.<sup>5</sup> Second, a ~~conscience-based~~

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<sup>3</sup> There is considerable research on the ability to choose without having options. See, e.g., the work of Fischer and Ravizza on moral responsibility [7], [8].

<sup>4</sup> I ~~have my~~ doubts ~~as to~~ whether ~~either~~ McLeod's or Baylis' criticisms are really about the conception of conscience or serve as a persuasive refutation of the dominant view of people like Childress [6] or Wicclair [26]. Nothing, ~~as far as I can tell,~~ in the writings of either Childress or Wicclair indicate they would object to the notion that the moral principles which form the foundation of a conscience claim are at least partially determined by social factors. ~~Moreover, McLeod's criticisms seem to be more about the application of conscience than its conception, and Baylis, for me anyway, seems to conflate moral reasoning generally with conscience. However, there is insufficient space to discuss either view fully in the context of this paper.~~

<sup>5</sup> Baylis, ~~in contrast,~~ argues that conscience claims need to be 'thoughtful, reflective, inner deliberations' [4], but I disagree. We often use conscience as what some refer to as a 'moral nose' [10] ~~and what I have referred to as a~~ 'gut feeling'. ~~One of the objections that~~ Indeed people, ~~people sometimes have~~ object to conscience ~~because~~ that it ~~is~~ not necessarily based upon reason. As a consequence, it need not be thoughtful at least if we ~~take thoughtful to~~ mean a

decision ~~based on conscience~~ also does not need to be predictable, since it need not be based on a coherent system of rules. If an individual cannot specify ~~a rule or set of rules~~ which governs their behaviour, there is also no requirement that she be able to tell others in advance when a claim of conscience might arise.<sup>6</sup> This does not mean, ~~of course,~~ that a “gut” feeling based on conscience is necessarily subject to the same deference that we might give a more thought-out decision of conscience. Nor does this mean we should avoid evaluating ~~and exploring~~ these ~~gut~~ decisions in order to make sure they have a sufficiently moral basis. Gut feelings need not be based upon moral reasons but might, instead, be based on other sorts of reasons such as bias or prejudice. A gut feeling based upon a non-moral basis, however, is not ~~one which we could claim as being~~ conscience-based and thus would not form part of our discussion on conscience. Gut feeling type cases which are based on moral reasons, though, ~~should be included because of the encompassing nature of conscience are conscience-based.~~ Furthermore, ~~as noted in the introduction,~~ there may be a complex set of rules and circumstances such that, while it is not possible to predict behaviour or generalise beyond an abstract level, there is a consistent application of a reasoned process by the individual in question. Someone might, ~~for example,~~ be able to articulate that they object to treatment in a particular case because it would be ‘too much’ without having been able in advance to specify what ‘too much’ might be. In other words, some cases only cause problems with our conscience when they appear and not beforehand. Consequently, I ~~would~~ endorse ~~the view taken by~~ Fovargue and Neal’s ~~view~~ that it must be possible to articulate the basis of the position in a general way without a necessary requirement ~~about being able~~ to focus on a specific set of rules which apply in a particular case. ~~Furthermore,~~ ~~any~~ reflection necessary ~~to be able to articulate the basis of the position~~ can occur after the decision although that does not eliminate the requirement, also stated by Fovargue and Neal, that the position be sincere [9].

Finally, ~~in addition to these two elements,~~ conscience decisions do not necessarily need to be ‘correct’. A claim of conscience, ~~like any other type of moral claim,~~ ~~may~~ be based upon faulty or insufficient information. ~~It may be based upon,~~ incorrect reasoning ~~or,~~ bias or prejudice. Since, ~~as McLeod and Baylis note,~~ there is a social aspect to the creation of our moral systems, this is as likely to affect our decisions on the basis of conscience as it is any other moral decision [16], [4]. Claims may also be inconsistent with other moral values ~~that~~ we hold. Claims of conscience, ~~then,~~ do not require a claim to rightness, objective or otherwise. All that is required is that a claim is important to the individual and guides her actions by providing moral reasons for doing or not doing a particular action.

Using this conception of conscience, the kind of individualised decisions I have in mind can fit within the general concept of conscience. They are based upon moral values. These moral values can be ~~claimed by an individual as being within their ownership~~ ~~subject to ownership by the individual.~~ They can specify that, ~~in the case at hand,~~ the decision is one for which they have

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reflective moral process must happen before the decision arises. While we can, and should, require that individuals be able to articulate after the fact why they believe their decision to be a conscience-based one, it ~~does not seem~~ ~~is not~~ necessary to require it beforehand. Fovargue and Neal have a similar claim which requires that the individual be able to ‘articulate’ their view but does not require ‘thoughtfulness’ in the way that Baylis appears to mean [9].

<sup>6</sup> I disagree with Fovargue and Neal on this point who argue for a limited ‘duty to disclose one’s position in advance provided this does not place [healthcare practitioners] at undue risk.’ [9]. ~~I do not disagree that~~ forewarning ought to be done in situations where it is possible but ~~forewarning may not be possible~~ ~~this is unlikely~~ in the ‘too far’ types of cases which are the focus of this article.



made a particular choice. Finally, these decisions are inward-facing. They are about the views, thoughts and actions of the individual in question, not about what others ought necessarily to do. A doctor can make a claim that in a particular case she will not do X without making any normative statements about what others ~~ought to~~should do in the same case.

### III. Conscience and decision-making

Whether these kinds of claims ~~fall within a general category~~are called ‘conscience’ is only part of the issue. It is also important to explore how these kinds of conscience claims interact with other reasons within the ~~doctors’~~ general decision-making process ~~in which doctors engage~~. Both Savulescu and Miola see doctors’ decisions as susceptible to being categorised. Miola specifies that doctors can engage in conscience-based decisions or in decisions based upon technical medical skill [19]. Conscience decisions may also be constrained and overruled by professional duties. Similarly, Savulescu seems to create a binary system where doctors either engage in their professional duties or make conscience-based objections to do something else [22], [23]. He further suggests that conscience-based objections can be contrasted with decisions in the best interests of the patient [22], [23]. Both Miola and Savulescu, then, argue for a system in which we determine what category a specific decision falls within and that provides at least a strong (if not entirely determinative) argument on how those decisions ought to be treated.

Real decision-making ~~however,~~ is unlikely to work in quite this clear a way. Doctors’ decisions ~~are~~ most likely ~~to~~ involve a range of different reasons which come together to shape a final choice. ~~Indeed,~~ there are probably at least four different kinds of reasons which combine to form a decision.<sup>7</sup> The first is what Miola refers to as ‘technical medical skill’. This is also often referred to as ‘clinical judgement’, but ~~my preference is for~~ ‘technical medical skill’ is better because it ~~more clearly~~ distinguishes this type of reason from the more nebulous use of ‘clinical judgement’ which might include other types of reason which go beyond the application of ~~a~~ technical skill. Technical medical skill refers to anything which is exclusively within the purview of the medical professional. This includes matters such as whether a particular drug or treatment would be effective in a particular situation, and includes knowledge of particular risks of a drug or treatment (but not the application of that knowledge). Thus, ~~for example,~~ it would be technical medical skill to know that a surgery would provide a certain percentage risk of impotence, but the decision on how to ~~classify and~~ act on that risk would *not* be a matter of technical medical skill. Technical medical skill is part of every decision a doctor might make in relation to treatment, but is only likely to be substantially at issue in a case where a patient requests something that a doctor does not believe to be effective. Such might be the case where a patient requests a treatment that they learned about through the internet but that the doctor knows would not be useful in the particular case. ~~This kind of reason is also at issue when, for example, parents refuse to have their children vaccinated for other than medical reasons.~~

The second type of reason which ~~will~~ form part of a doctor’s decision-making process is that of professional requirements. These include two important elements – professional ethical codes and responsibilities, and legal duties. Both the codes of professional bodies like the UK’s General Medical Council and legal duties set down by statutes and the courts provide reasons for doctors to behave in particular ways. They may override both the technical medical skill of the doctor as well as other important aspects of their reasoning process. For example, Robert Smith

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<sup>7</sup> I say ‘at least’ because there are types of reason which are possible but I will exclude from this analysis. This would include things like personal preferences and biases, views toward risk-taking, etc. which might ~~have an~~ impact upon decisions.

was a surgeon who came to prominence for what many saw as an unethical treatment for amputee identity disorder.<sup>8</sup> Smith's proposed treatment was to amputate the offending limb [24]. He claimed ~~that~~ those who underwent this treatment had beneficial results with limited side-effects. ~~In particular, he~~ He claimed that this treatment was more effective than alternative treatments available to patients [24]. Despite this, he was forbidden from providing this treatment to patients who requested it, primarily because the Trust where he worked was concerned that it violated his professional duties, both ethical ~~(e.g. the duty of non-maleficence)~~ and legal [24]. Professional requirements, especially ethical codes of conduct, may sometimes look like a matter of conscience but they are different. ~~Whereas a~~ claim of conscience is an individual decision ~~which is~~ based partially upon a notion of ownership by the individual making the claim, professional requirements are not. ~~A~~ professional requirement applies *whether or not* the doctor in question actually agrees with it. A claim of conscience, ~~on the other hand~~ ~~however~~, is only applicable if the doctor in question believes it to apply.

The third aspect of a doctor's decision-making process is the best interests of the patient. This is a determination by the doctor of what, considering non-medical as well as medical factors, would actually be best for the patient under the circumstances. Both legal and ethical theories emphasise that this decision should be made from the patient's perspective rather than the doctor's [2]. It is not ~~then~~, what the doctor believes they would want under the same circumstances that the patient is in; it is what is best for *this patient* in these circumstances [2]. Legally this is covered in English law by the Mental Capacity Act 2005, [17] for patients who lack the capacity to consent for themselves and by the consent of the patient for those who are.<sup>9</sup> Ethically, this is covered by the duty of beneficence [5]. As a consequence, it might be tempting to claim merely that the best interests of the patient are covered by the professional responsibilities that a doctor has. ~~However,~~ ~~there~~ are significant benefits to seeing best interests as a distinct set of reasons. Law and ethical guidance only set the appropriate test for what a doctor ought to do in these circumstances. They do not always provide detailed guidance. Even something like the Mental Capacity Act Code of Practice [18] ~~(which is more detailed)~~ does not necessarily provide a specific answer in each circumstance. ~~Therefore~~ ~~two~~ doctors, both acting reasonably, may come to different conclusions as to what constitutes the best interests of a patient in particular circumstances.<sup>10</sup> Best interests ~~then~~, is the application of a particular legal

<sup>8</sup> Amputee identity disorder is when an individual believes that a limb that forms part of their body ~~is 'alien' and~~ does not belong to them. A person with this condition might feel, for instance, that their right arm should not be there.

<sup>9</sup> There are ~~some~~ semantic difficulties in a legal analysis which includes this kind of claim of best interests. In law, best interests only apply to those who lack capacity: [17]. The best interests test, as a legal doctrine, ~~then~~, would not apply to competent patients for whom the applicable idea is consent and autonomy. However, ~~by best interests~~ in this section, I mean a more general understanding of what is best for the patient whether or not they have capacity. It would thus include both incompetent and competent patients. ~~In this sense, then, it is different from and more inclusive of the legal test. The reason I have chosen to refer to this as best interests is because the doctor is likely to use a similar thought process and metric — whether the possible treatment option is best for the welfare of the patient irrespective of whether the patient is competent or not. The way that metric is applied will sometimes be different, of course (doctors may concede to a competent patient's determination even if it is not the decision they would make in terms of an incompetent patient) but the relevant thought process is similar.~~

<sup>10</sup> Dame Elizabeth Butler-Sloss P. has argued that 'logically', the best interests test ought to only give one answer. *In Re S* [21] at 27-28. This is disputed by, among others, Holm and Edgar [11]. ~~I think e~~ ~~ven if~~ ~~Butler-Sloss is correct that~~ there is one logical best interests answer for each

and ethical test and it is worthwhile to explore those reasons rather than merely to set out the test under professional requirements. Professional requirements, ~~as I shall consider them,~~ constrain doctors in specific and predictable ways. The best interests analysis, ~~on the other hand,~~ is a more nuanced and fact-specific set of reasons. Additionally, it is worth separating out best interests and professional regulations because they have different objects. Professional regulations are about compliance with a set of rules ~~— either legal or ethical.~~ The focus, ~~then,~~ of professional regulation is on those rules. ~~On the other hand, while set up by rules, +~~ The focus of the best interests analysis is *the patient*. ~~Indeed, it~~ is possible that those two can conflict. As noted above, Robert Smith seems to believe that amputating a healthy limb of a patient with amputee identity disorder is in the best interests of that patient, even when it conflicts with the professional requirements that he might have, ~~at least as they are generally perceived~~ [24].

It is also worth distinguishing best interests from conscience. The two may look similar and courts appear to ~~be using~~ the best interests ~~test~~ analysis to disguise situations where what is really at issue is a decision of conscience. For example, in ~~the case~~ *Aintree v. James* [2], while the Court of Appeal focuses on the ‘best interests’ of David James, it seems more likely that the real problem is ~~a decision of conscience on the part of the doctors’~~ conscience [25]. *Aintree v. James*, ~~it should be noted,~~ takes place in the context of the Mental Capacity Act which sets out the applicable rules for doctors to follow. ~~Most specifically, +~~ It states that in the context of determining what to do for incompetent patients, as David James was, doctors are required to utilise the best interests test [17]. So, it is understandable why the courts talk in terms of best interests in the case instead of conscience. Nevertheless, a close look at the application of what they term best interests is actually more likely to be something based on conscience [25]. ~~A prime~~ The way to distinguish between the two is, ~~as with best interests and professional requirements,~~ the object of the reason. ~~As noted above, +~~ The focus of a best interests analysis is the patient. It is what is best for the patient to *receive*. In the context of a claim of conscience, ~~though,~~ the focus is on the doctor. It is what the doctor feels able to *provide*. It is not about what is better for the patient under the circumstances, because it might be the case that what is best for the patient is not something the doctor feels able to offer. ~~These may conflict in particular cases.~~ It may be the case that in a particular case, a doctor feels that she cannot give a patient a specific treatment even if, under a best interests analysis, it would actually be the best choice for the patient. In *Aintree v. James*, everyone appears to accept the idea that David James would have preferred to survive – no one disputed that he appeared to continue to derive pleasure from what he was able to do. What the doctors objected to was the requirement that they provide treatment which they felt would be horrible to provide. ~~In other words, +~~ Merely because it is considered ‘best’ for a patient does not mean that a doctor must do it. It is ~~entirely~~ possible that there are other conscience-based reasons why a doctor might not wish to provide that treatment.<sup>11</sup> So, even though the case was purportedly about best interests as specified by the Mental Capacity Act, the real determining factor was the doctor’s conscience.

Treatment decisions, ~~then,~~ are not based upon a single reason but a combination of the four aspects of decision-making noted above. Decisions about treatment are rarely just decisions of technical medical skill, or of professional regulations, or of best interests or of conscience. Instead, in decisions about treatment a doctor makes a complex judgment about what treatments are clinically available and allowed by professional regulations in the light of what is best for the

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individual, there is no guarantee that everyone would agree as to what that is.

<sup>11</sup> ~~Another case for which this appears to be is~~ a primary issue is ~~the removal of Ms B from a ventilator,~~ although there is no explicit mention of conscience in that case. *Re B (adult: refusal of treatment)* [3]. For a discussion of that case in relation to conscience, see [25].



patient and what the doctor feels individually able to provide in terms of their conscience. While in certain cases one element of this decision-making process might become the most important, all ~~are likely to will~~ have some effect upon the ultimate decision. It is, ~~therefore~~, crucial not only to understand the different types of reasons which might influence decisions by doctors, but also ~~to comprehend~~ the interaction between them. Disentangling notions of best interests and conscience might be the most difficult. Both are, ~~in some sense~~, subjective and personal rather than objectively determined by an outside element (~~e.g., medical technology, law or professional codes of conduct~~). Additionally, ~~under current law~~, doctors might ~~often~~ be forced to disguise what is actually a claim of conscience behind a claim of best interests or capacity which will further add ~~to~~ the confusion as it did in *Aintree v. James* [22]. Furthermore, as conscience is based upon moral or ethical principles, a claim based on beneficence might straddle the line between the two possibilities. A doctor might claim, ~~for example~~, that providing some particular treatment to a patient both is not in the best interests of that patient as well as violating ~~the ethical principles that ground~~ the doctor's conscience.

One effective way to determine whether a claim ~~made by a doctor~~ is one of conscience or best interests is to closely examine the language used by the doctor. If a doctor makes the claim that, under their understanding of the interests of the patient, a particular treatment ought not to be given but would be willing to change their opinion after listening to arguments from the patient ~~that a different treatment was better~~, then it is more likely to be a claim of best interests than of conscience. If ~~however~~ the doctor indicates that, even if the patient disagreed with the doctor's assessment, they still would not change their mind (and it is not ~~a matter of~~ technical medical skill), then this is more likely to be a conscience-based claim. ~~This is the case because the~~ The statement of the doctor in the latter case helps to show that the focus of the decision is more on what the doctor is willing to provide than what the patient ought to receive.

We might then conceive of a doctor's decision-making process as a result of four questions. They are:

1. Is this particular treatment option *possible or feasible*? (the technical medical skill question)
2. Is this particular treatment option *generally acceptable* in these cases? (the professional regulation question)
3. Is this particular treatment option good for *this particular patient*?<sup>12</sup> (the best interests question)
4. Can I *provide* this treatment *consistently with my own conscience*? (the conscience question)

Considering these four ~~different~~ questions involves different purposes and foci, yet all of them ~~will~~ need to be asked in any case. They might not ~~of course~~ be asked in anything more than a perfunctory way, especially in standard treatment cases, but all of them are relevant ~~and important in~~ ~~in~~ whatever final decision the doctor makes. Decisions based on such a confluence of different factors will not ~~then~~ fall into an easy category from which we can decide whether the decision as a whole is acceptable or not. ~~If~~ The decisions of doctors are complex, ~~then~~ we need to account for that complexity when we determine whether the answers they give are appropriate or not.

It is also worth highlighting that ~~while these are listed as~~ separate questions ~~above, they~~ are likely in their application. ~~So, while~~ Doctors will need to consider all four questions in some way ~~but~~ guarantee they ~~are likely to will~~ do so ~~in a way that sees these questions~~ as distinct ~~questions~~. circles then they do independent silos. Answers to one question ~~are likely to~~ influence the questions. That does not matter, ~~however~~, for the purposes of the analysis we are considering.

separable concerns, even if they are unlikely to be considered as wholly separate questions.

#### IV. Deciding between competing strands

Since the decision-making process ~~that~~ a doctor must go through in order to decide about a treatment option is formed ~~of by~~ at least these four questions, there needs to be a way to ~~decide between~~ prioritise ~~a~~ the answers to those questions in cases where they do not align. If, ~~for example~~, a doctor decides that a particular treatment option is feasible, best for the patient and consistent with their conscience but is not generally acceptable, then a doctor will need to determine whether, nonetheless, they still ought to do it.<sup>13</sup> We need ~~to understand~~ not only ~~to understand~~ the types of questions that ought to be asked but also how those questions interact with each other.

~~Someone taking~~ Savulescu's view ~~would is~~ presumably ~~argue~~ that only the first three questions actually matter and that the fourth should not be part of any official evaluation of the doctor's decision ~~even if the doctor actually used it to decide~~. Doing that, ~~however~~, causes more problems than it solves. First, if it forms part of the actual decision-making process but not part of the analysis of that decision, the analysis is ~~almost necessarily~~ distorted. Furthermore, excluding it from the analysis simply prevents the conscience-based reason from being subject to scrutiny. It does not stop a decision of conscience being made, just the ability to evaluate it. More importantly, ~~though~~, failing to analyse the conscience-based reasoning that forms a part of decision-making by doctors neglects the important role that conscience plays in medicine. Just because something is technically feasible, not prohibited by any current professional regulation and ~~that thing is what best for the patient wants it~~ does not ~~follow that mean~~ that thing ought to be done. Treatments like frequent plastic surgery are technically feasible and not against the law, certain individuals might want them, and they might even be 'best' for the particular patient on whichever metric we use. ~~That does not mean that doctors ought~~ Doctors still need ~~not to~~ offer them. It is the doctor's conscience which provides the most effective way, at least on an individual level, to prevent these kinds of practices because they can simply refuse to do it.<sup>14</sup>

~~What is more effective is a B~~balancing between the various reasons involved in the ultimate decision that the doctor makes ~~is more effective~~. We want a doctor to explain not only the answers to the four ~~different~~ questions outlined above but the way in which those answers influenced the overall final decision which was made. ~~Were, for example, the professional of the process that the doctor used in making a particular decision and this, in turn,~~ will provide number of additional benefits. The doctor ~~is likely to will~~ have a clearer understanding of their reasoning if they can outline the process by which they reached their conclusion. Patients will have a greater understanding of what a doctor sees as important within a particular case and how this influences the overall decision made by the doctor. Patients can then use this information to be better able to discuss potential treatment options with their doctor or seek another doctor's

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<sup>13</sup> This, for example, appears to be the reasoning of doctors and other healthcare workers involved in things like the euthanasia underground [15].

<sup>14</sup> There are, of course, macro-level options ~~like distributive justice or resource management~~ which are available to determine the best way forward in cases. ~~These include decisions made on the basis of some general theory of distributive justice or resource management.~~ However, these kinds of considerations are supposed to only apply in general and not in the context of particular patients. ~~Doctors, for example, ought not decide to let a patient die because they have a wealth of organs available even if that was a "better" decision in distributive justice or resource management terms.~~

services if necessary. Those who might need to evaluate the doctor's decision in more objective settings (~~judges, health care authorities, professional bodies~~) can do so without having to first. Finally, conscience can be discussed as a more generalised phenomenon, not simply as something which impedes an objective treatment decision but one which enhances not only the doctor's ability to do their jobs in a more honest manner, but allows for the exploration of a number of different treatment options.

It is crucial to realise that this decision-making process need not be the same for all doctors or situations. ~~For example, Robert Smith appears to have decided that the professional regulations trump what might seem to be the answers for the other three questions in regards to amputee identity disorder [25]. By his own understanding, it was feasible to amputate the healthy limb, he considered it best for the patient and he appeared to be willing to do it. However, because the hospital deemed it unacceptable, he did not perform the amputations. We can then reasonably infer that he deemed the answer to the second question most important. On the other hand, there were a number of doctors (and other healthcare professionals) involved in the euthanasia underground detailed in Robert Magnusson's *Angels of Death* [15]. These doctors, in contrast, appear to have helped patients to die despite the fact that assisted dying was prohibited in their jurisdictions both legally and by the standard professional ethics codes. These doctors, then, presumably decided that the answer to the second question was less important than the answers to the other three. Some might prioritise professional codes of conduct like Robert Smith [25]; others might prioritise conscience like the doctors in the euthanasia underground [15].~~ It is, therefore, not the case that one of the four questions will always prevail in all situations. This balancing is not a mathematical formula but ~~instead~~ merely a guide to understanding the relative importance of the reasons which impact upon the final decision that a doctor makes. What it does provide, ~~nevertheless~~, is a method by which doctors can engage in reflection about their decision-making process. It allows them to sift through the complex reasons they might have for performing or not performing particular treatment options and explain why a decision was reached in a specific case. This process will be useful in many types of cases, but might be especially helpful in those cases which are not determined in the rule-based, predictive way that has been considered standard in conscientious objection cases in the past.

One result of this decision-making model is that it applies equally to ~~the types of~~ rule-based conscientious objection claims as well as the individualised claims of conscience which may be more difficult to assess. Even in the rule-based claims, we ~~would~~ expect doctors to engage in the type of reasoning suggested above. What is different in rule-based claims is that the fourth strand of reason – the conscience reason - trumps the other three reasons irrespective of the answer. We ~~would~~ expect doctors in these situations to have given due consideration to the feasibility and acceptability of the treatment as well as the best interests of the patient even if the conscience decision ultimately controls it. This might be one of the reasons why we object so strongly to doctors who claim a conscientious objection in cases in which the patient appears not to have been considered. Our objection in those cases is not to the conscience-based objection but to the giving of insufficient weight to the interests of the patient, ~~whatever they might be~~. decision-making is particularly appropriate when we explore cases where doctors have made a conscience-based objection to a particular treatment to a particular patient at a particular time, it is a model which can be applied across the board.

A criticism, however, might be raised to this approach on the basis of an argument recently made by Jonathan Montgomery. Montgomery argues ~~that~~ conscientious objection should cover actions associated with professional judgment and not personal values. As he states, these are issues associated with the 'moral identity of the profession, irrespective of personal views.' Montgomery's concern is that allowing personal values to dictate when a doctor is willing to

engage in a particular treatment ~~provides too much power to the doctor to make decisions based~~ creating a system which provides healthcare as a common good provided by society for its members. While I share his concerns and I think he and I probably agree more than we ~~I would~~ take issue with his understanding that professional discretion is easily separable from values. Montgomery seems to take professional judgment as something more objective than I believe it can be. Doctors are human beings and thus filter their understanding ~~of particular~~ views and values. ~~As a consequence, Consequently,~~ all professional judgments necessarily include personal values. If that is correct, ~~then it would not be~~ ~~is not~~ possible to differentiate between the professional and personal quite as easily as Montgomery suggests. Thus, conscience needs to be considered as a distinct element in part of the decision-making process.

## V. Conclusion

The purpose of this article has been to explore how we might encapsulate the decision-making of doctors so that we can better account for the conscience-based reasons which permeate medical care. ~~Some w~~ ~~riters such as Savulescu~~ argue that doctors ought not to be allowed to make decisions on the basis of conscience and instead should only abide by their professional duties. This article has claimed ~~not just that~~ conscience ought not to be side-lined in this way and ~~moreover also that~~ it is not possible to do so. All decisions that doctors make are based on a multi-faceted collection of reasons which include strands based upon technical medical skill, professional codes of conduct, and the best interests of the patient as well as the doctor's conscience. Moreover, all four strands are necessary and important parts of a doctor's reasoning process. We need not protect conscience absolutely in medical cases, but we need to understand that it has a crucial part to play in a large collection of cases. It is, ~~therefore,~~ more important to understand the connection between conscience-based reasons and the other reasons at issue in a case, than to dismiss these conscientious claims entirely.

## References

- [1] Abortion Act 1967, section 4.
- [2] *Aintree v. James* [2013] UKSC 67.
- [3] *Re B (adult: refusal of treatment)* sub nom *Ms B v. An NHS Hospital Trust* [2002] 2 All ER 449.
- [4] Baylis, F., (2015), A Relational View of Conscience and Physician Conscientious Action, *International Journal of Feminist Approaches to Bioethics*, 8(1), 18-36.
- [5] Beauchamp, T., and Childress, J., (2013) *Principles of Biomedical Ethics* (7<sup>th</sup> Ed.), New York: OUP.
- [6] Childress, J., (1997) Conscience and Conscientious Actions in the Context of MCOs, *Kennedy Institute of Ethics Journal*, 7(4), 403-411.
- [7] Fischer, M., (2006) *My Way: Essays on Moral Responsibility*, New York: Cambridge University Press.
- [8] Fischer, J.M. and Ravizza, M., (1998) *Responsibility and Control: A Theory of Moral Responsibility*, New York: Cambridge University Press.
- [9] Fovargue, S and Neal, M., (2015) 'In Good Conscience': Conscience-Based Exemptions and

Proper Medical Treatment, *Medical Law Review* 23(2) 221-241.

[10] Glover, J. (2015) On Moral Nose. In J. Coggon, S. Chan, S. Holm, T. Kushner, From Reason to Practice in Bioethics: An Anthology Dedicated to the Works of John Harris. Manchester: Manchester University Press.

[11] Holm, S. and Edgar, A., (2008), Best Interests: A Philosophical Critique, *Health Care Analysis*, 16, 197-207.

[12] Human Fertilisation and Embryology Act 1990, section 38.

[13] Kennedy, I., (1981), *The Unmasking of Medicine*, London: George Allen and Unwin.

[14] Kennedy, I., (1988), What is a Medical Decision?. In I. Kennedy, *Treat Me Right: Essays in Medical Law and Ethics* (pp. 19-31). Oxford: Oxford University Press.

[15] Magnusson, R., (2002), *Angels of Death: Exploring the Euthanasia Underground*, New Haven, CT: Yale University Press.

[16] McLeod, C., (2012) Taking a Feminist Relational Perspective on Conscience. In J. Downie and J. Llewellyn (Eds.) *Being Relational: Reflections on Relational Theory and Health Law* (pp. 161-181). Vancouver: U of British Columbia Press.

[17] Mental Capacity Act 2005.

[18] Mental Capacity Code of Practice 2007. Available at <https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice> (accessed 14 July 2016)

[19] Miola, J., (2015), Making Decisions about Decision-Making: Conscience, Regulation and the Law, *Medical Law Review*, 23(2), 263-282.

[20] Montgomery, J., (2015) Conscientious Objection: Personal and Professional Ethics in the Public Square, *Medical Law Review*, 23(2), 200-220.

[21] *In Re S* [2001] Fam 1.

[22] Savulescu, J., (2006) Conscientious Objection in Medicine, *British Medical Journal*, 332, 294.

[23] Savulescu, J., (2007), The Proper Place of Values in the Delivery of Medicine, *American Journal of Bioethics*, 7(12), 21-22.

[24] Smith, R., (2009) Less is More: Body Integrity Identity Disorder. In S. Smith and R. Deazley (Eds.) (pp. 147-157) *The Legal, Medical and Cultural Regulation of the Body: Transformation and Transgression*, Farnham, Surrey: Ashgate Publishing.

[25] Smith, S.W., (2015) A Bridge Too Far: Individualised Claims of Conscience, *Medical Law Review*, 23(2), 283-302.

[26] Wicclair, M.R., (2010) Conscience-Based Exemptions for Medical Students, *Cambridge Quarterly for Healthcare Ethics*, 19, 38-50.