

Guest Editorial

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It is probably fair to say that academic interest in the role of conscience in healthcare (and specifically, in the phenomenon of conscientious objection (CO)) has never been more intense, as evidenced by the volume of articles (and indeed, special issues) devoted to the topic in recent years. The three of us have contributed to this burgeoning literature, writing separately and together.

This special issue of *The New Bioethics* marks the mid-point of a project devised and co-managed by us and funded by the Royal Society of Edinburgh's Research Networks scheme: the Accommodating Conscience Research Network (ACoRN). Our aim in developing this multidisciplinary network of academics from a range of disciplines, practitioners, and representatives of professional bodies, is to carve out intellectual space within which to begin exploring conscience/CO in healthcare from a broadly supportive perspective. Our sense, as participants in academic debates about conscience, is that although the literature contains many rich insights and fascinating discussions, some of the most interesting questions about conscience are being overshadowed by the loudest and most polarised disagreement over whether there is any legitimate role for CO in healthcare at all. This is despite the fact that it seems to us that most contributors adopt positions that are *hospitable* to the accommodation of CO, at least to some extent and in some circumstances.

This most fundamental issue of whether it is ever appropriate to allow CO by healthcare professionals is obviously important, and deserves the academic attention that it continues to receive. Nevertheless, it is a question on which positions appear particularly entrenched, and one that tends to eclipse a number of other important questions. If anything, given that most writers accept the legitimacy of at least some CO, and given the willingness of most legal systems to accommodate CO at least to some extent, it is arguably more urgent to attend to the 'secondary' questions: questions about why, how, and in what circumstances we ought to accommodate CO by health professionals. Accordingly, our aim in the ACoRN project is to create an intellectual environment that facilitates these enquiries by 'parking' the more fundamental question and proceeding on the premise that it is appropriate to accommodate

individual conscience in healthcare at least in some circumstances. The first phase of the Network consists of four roundtable events in which all participants (presenters and discussants) are required to sign up – even if only for the purposes of the event – to this basic premise.

The roundtables address four broad themes, which we have framed as the ‘what’, ‘why’, ‘how’ and ‘when’ of conscience in healthcare. The first roundtable, held at the University of Strathclyde in March 2018, asked: *what* are judgments of conscience, and how do they overlap with, and differ from, other types of judgment that health professionals make in the course of their roles? Roundtable two, held at Cardiff University in November 2018, asked *why* is it important to accommodate CO in healthcare – is healthcare a ‘special case’ in this regard, or do similar arguments justify the accommodation of conscience for those working in other professions? The third roundtable, held in Manchester in June 2019, considered where the responsibility for protecting and regulating CO should lie. What form should regulation/protection take? Does existing law strike the right balance between protecting and regulating conscience? What is the proper role of legislation and professional guidance, respectively, in these processes? The final roundtable, to be held in spring 2020 at the University of Strathclyde, will ask when and where we ought to accommodate CO: which areas of activity should be covered by conscience rights? What criteria should have to be satisfied before CO is permitted/protected? In particular, should there be criteria associated with ‘reasonableness’ and/or ‘genuineness’/ ‘sincerity’? What duties attach to someone exercising CO? Should conscientious objection include the right to refuse to give information about the objected intervention, and/or to refuse to direct the person seeking the intervention to someone who will provide it (known in the literature as ‘effective referral’ and regarded by some as a fair ‘compromise’)?

The articles collected in this special issue reflect the themes and basic premise of the ACoRN roundtables. The first paper, by David Oderberg, engages directly with the theme of roundtable two, asking whether medical conscience is ‘special’ and deserving of unique or particular protection, or whether the protection we afford in the healthcare context has parallels in other professional contexts. Drawing an analogy with military CO, Oderberg acknowledges that the healthcare context looms large for practical reasons, such as the universality of the need for healthcare, and the tendency of the healthcare context to raise life-and-death questions. Nevertheless, he argues, there is no *principled* distinction between

the healthcare professions and other professions, and protection for individual conscience (and CO specifically) is important in all professional contexts.

Three of the other papers – those by Gamble and Pruski, Saad, and Neal and Fovargue – take a noticeably different approach, explaining the accommodation of CO in healthcare in various ways that are not so obviously translatable into non-health contexts.

Nathan Gamble and Michal Pruski utilize the concepts of ‘medical activity’ and ‘medical acts’ to delineate the scope of CO in healthcare, arguing that while professionals can be expected to perform acts that are ‘medical’ in nature, there can be no obligation upon them to perform non-medical acts (although they may choose to do so). This aligns with a developing strand of thought in academic debates about CO (also discussed in the paper by Neal and Fovargue) according to which the territorial extent of CO can be limited according to the nature of the activity in question (termed ‘medical’ or ‘non-medical’ here). Gamble and Pruski engage with the theme of roundtable two since they propose an answer to the question of why we accommodate CO, their answer being that we do so because the activity in question is not medical in nature. Their paper also engages with the theme of the final, forthcoming roundtable, which will explore the parameters of CO in healthcare, since the upshot of their argument is that CO should be restricted to non-medical acts.

The paper by Toni Saad engages most obviously with the theme of the first roundtable, focusing as it does on the nature of conscientious judgments in healthcare and their relationship with the other types of evaluative judgement that health professionals make in the course of their professional activity. Saad makes the strong claim that conscience is *always* involved in clinical judgment, rather than the two sorts of judgment being distinct. Saad’s central claim, however, is that CO can be understood through the lens of the medical ethical principle of non-maleficence (‘first do no harm’). CO applies, he argues, when an action exists in irreconcilable conflict with that traditional moral imperative. In addressing the issue of when CO applies, Saad also touches on the content of the final, forthcoming roundtable – the ‘where’ and ‘when’ regarding conscience. Overall, his argument – like that of Gamble and Pruski – can be regarded as an ‘internal’ account of CO in healthcare, one that can apply only within the healthcare context, in contrast with Oderberg’s more general account.

The paper by Mary Neal and Sara Fovargue engages with and defends the ACoRN project’s basic premise by arguing that there is no necessary incompatibility between CO and the role of the health professional. Like Oderberg’s paper, their discussion aligns most closely

with the theme of roundtable two: *why* should we protect conscience in the healthcare context? Their answer is that, far from being inimical to good professionalism, accommodating CO is necessary in order to safeguard the integrity that is so fundamental to it. Another similarity with Oderberg's paper is that Neal and Fovargue also distinguish between principle and practice in the context of CO. However, whereas Oderberg draws the distinction in order to ask whether there is anything special about healthcare at either level, Neal and Fovargue's concern is to demonstrate that there is no necessary incompatibility with professionalism either in principle or in practice.

Christopher Cowley's paper explores the difference between 'selective' and 'universal' CO. At present in the UK, CO is accommodated in a 'universal' way, but Cowley is interested in exploring whether and how it might be possible to accommodate 'selective' objections, where a professional seeks to withdraw from participating in a practice in some but not all circumstances. His paper fits within the rubric of roundtable three insofar as it asks 'how'-type questions: how might selective CO play out in practice, how might it be articulated by the objector, how might it impact on patients, and can we provide for it, and regulate it, in a way that implements selective CO fairly and consistently? Cowley identifies this as an underexplored corner of academic debate, and calls for further attention to these questions from academics and policymakers.

The project of debating the nature of CO, and enquiring into why, how, where and when it is appropriate to accommodate it will not be resolved soon. Our hope is that the papers gathered in this issue, and the questions raised in them, offer some fresh insights and directions in the context of debates that are beginning to feel well-worn. We have no doubt that they will provoke further inquiry and research.