

‘IN GOOD CONSCIENCE’: CONSCIENCE-BASED EXEMPTIONS AND PROPER MEDICAL TREATMENT

Lack of clarity about the proper limits of conscientious refusal to participate in particular healthcare practices has given rise to fears that, in the absence of clear parameters, conscience-based exemptions may become increasingly widespread, leading to intolerable burdens on health professionals, patients, and institutions. Here, we identify three factors which clarify the proper scope of conscience-based exemptions: the liminal zone of “proper medical treatment” as their territorial extent; some criteria for genuine conscientiousness; and the fact that the exercise of a valid conscience-based exemption carries certain duties with it. These restricting factors should reassure those who worry that recognising rights of conscience at all inevitably risks rampant subjectivity and self-interest on the part of professionals. At the same time, they delineate a robust conscience zone: where a claim of conscience relates to treatment with liminal status and satisfies the criteria for conscientious character, as well as the conditions for conscientious performance, it deserves muscular legal protection.

Keywords: Conscience, Conscientious objection, Conscience-based exemptions, Proper medical treatment, Professional obligations, Professional ethics.

I. INTRODUCTION

Concerns have been raised that the phenomenon of conscientious objection is developing in the healthcare context in a ‘wild’¹ or haphazard manner, with no clear criteria by which to assess the validity of conscience-based claims, and no general agreement regarding the conditions that ought to delineate the proper exercise of conscience where a valid claim exists. Cantor uses the term ‘conscience creep’ in relation to US regulations and rules to describe what she regards as an unchecked expansion.² The fear seems to be that, if we allow private values to ‘intrude’³ improperly into the public realm of healthcare, we necessarily risk healthcare professionals (HCPs) either ‘disavowing’⁴ certain professional obligations altogether, thus abandoning their responsibilities and their patients, or ‘imposing their moral preferences’⁵ on patients instead of respecting patient autonomy. For a patient, the outcome of an encounter with a HCP who allows her private values to influence her practice unduly might range from (at best) mild inconvenience, powerlessness, and/or a sense of being judged, to (at worst) a feeling of being abused, and/or experiencing serious obstacles to accessing proper medical treatment. Here, we seek to assuage these concerns. We examine the contention that conscientious objection is ‘creeping’ unchecked within guidance on healthcare practice in England and Wales, and then suggest three natural limits to the exercise

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¹ J Shaw, J Downie, ‘Welcome to the wild, wild north: Conscientious objection policies governing Canada’s medical, nursing, pharmacy, and dental professions’ (2014) 28 *Bioethics* 33.

² J Cantor, ‘Conscientious objection gone awry – Restoring selfless professionalism in medicine’ (2009) 360 *New England Journal of Medicine* 1484, 1485.

³ R Baker, ‘Conscience and the Unconscionable’ (2009) 23 *Bioethics* ii, iii.

⁴ LF Ross, EW Clayton, ‘To the Editor’ (2007) 356 *New England Journal of Medicine* 1890.

⁵ J Morrison, M Allekotte, ‘Duty First: Towards Patient-Centered Care and Limitations on the Right to Refuse for Moral, Religious or Ethical Reasons’ (2010) 9 *Ave Maria Law Review* 141, 142.

of conscience-based exemptions which ought to reassure those who worry about increased potential for conscience creep, at least within professional guidance.

Three points require clarification. First, we adopt the ‘prevailing view of conscience in bioethics’,⁶ according to which ‘appeals to conscience can be understood as efforts to preserve or maintain moral integrity’.⁷ On this view, the faculty of conscience is fundamental to moral agency and a proper feature of all areas of human endeavour, including professional practice. Space prevents us from explaining our view of conscience in detail; we aim to do this elsewhere.⁸ Here, our focus is on how conscience should be protected. Second, and partly as a result of our commitment to a broadly positive view of conscience, we use variants of the term ‘conscience-based exemption’ (CBE) in preference to ‘conscientious objection/objector’ (CO). When referring specifically to an exemption from acting, CBE is a more accurate and neutral term than the more familiar ‘CO’. Labelling a HCP simply as an ‘objector’ ignores all her other contributions and characteristics, and obscures the fact that a HCP’s reluctance or refusal to participate in certain types of treatment will almost always be based on a positive commitment; for example, to an alternative view of the goals of healthcare. In some instances where ‘CBE’ would be grammatically-incorrect, ‘objection’/‘objector’ will be used despite the misgivings noted here. Finally, we engage here with concern about the potential for the expansion of conscientious refusals into increasing areas of healthcare, due to vague, contradictory, or overly confident professional guidelines. Empirical questions about the actual incidence of refusals, and whether they are increasing, are not posed. Thus, when we refer to ‘creep’, we are referring to the potential for

⁶ C Fitzgerald, ‘A Neglected Aspect of Conscience: Awareness of Implicit Attitudes’ (2014) 28 *Bioethics* 24, 25.

⁷ M Wicclair, ‘Conscientious objection in medicine’ (2000) 14 *Bioethics* 205, 213.

⁸ ‘Defending conscience-based exemptions in healthcare’, work in progress.

CBEs to come to feature more widely in medical practice, rather than to any upswing in the total number of conscience claims.

II. PROTECTION FOR CONSCIENCE IN ENGLAND, WALES AND SCOTLAND

Two statutory CBEs exist in the UK, in section 4 of the Abortion Act 1967 and section 38 of the Human Fertilisation and Embryology Act 1990. Section 4(1) of the 1967 Act provides that no-one is under any duty to participate, contrary to her conscience, in any treatment authorised by the Act, although the exemption does not apply where treatment ‘is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman’ (section 4(2)). Likewise, section 38 of the 1990 Act provides an exemption from having to participate in any activity governed by that Act. Secondary legislation places an important limit on the protection afforded by section 4, as those who contract with the NHS and exercise their CBE under that section, ‘[must make] prompt referral to another provider of primary medical services who does not have such conscientious objections’.⁹ Thus, GPs who wish to be exempt under section 4 must refer patients promptly to another doctor. We discuss referral in section IIIC3 below.

Rights of conscience are also protected under Article 9 of the European Convention on Human Rights (‘freedom of thought, conscience and religion’), and have been mentioned in cases which have recently been brought under Article 8 in relation to abortion.¹⁰ In the UK,

⁹ For England see National Health Service (General Medical Services Contracts) Regulations 2004 (S.I. 2004/291), Sched 2(3)(2)(e) and clause 9.3.1(e) of the NHS England Standard General Medical Services Contract; for Scotland see National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004 (S.S.I. 2004/116), Sched 3(3)(2)(e). Note that the 1967 Act does not apply to Northern Ireland.

¹⁰ See, for e.g., *RR v Poland* (2011) 53 EHRR 31; *P and S v Poland*, App. No. 57375/08 (Judgment of 30 October 2012, ECtHR); and, to a lesser extent, *Tysic v Poland* (2007) 45 EHRR 42. Our concern here is to explore the principle of CBEs, so we do not examine the European Court’s jurisprudence.

however, the only statutory protection for conscience is to be found in the 1967 and 1990 Acts; no such protection exists in relation to other contested practices, such as the provision of emergency contraception or the withdrawal of life sustaining treatment. Nevertheless, McHale has noted an ‘incremental extension of “opt-out” across health care’.¹¹ First, she cites the suggestion in the Code of Practice to the Mental Capacity Act (MCA) 2005 that although HCPs ‘must not simply abandon patients or cause their care to suffer’, they need not ‘do something that goes against their beliefs’ in the context of life-sustaining treatment.¹² Second, she notes Butler-Sloss LJ’s statement in *Re B* that where a doctor has difficulty in complying with a request to withdraw treatment from an adult with capacity, she has a ‘duty (...) to find other doctors who will do so’.¹³ McHale cautions that ‘there is a danger [to patients] in allowing “opt-out” to be seen as an entitlement gradually through guidance, without legitimacy and the boundaries of such an opt-out being subject to a thorough reconsideration’.¹⁴ Here, we examine general guidance on CBEs from key regulatory and professional bodies in England and Wales, and some of their specific guidance on medical treatments beyond those covered by the two Acts, in order to test this claim of an incremental extension of CBEs through guidance.

A. Guidance on conscience: Entitlements and obligations

Matters of conscience are discussed in guidance issued by the healthcare professions’ regulatory bodies - the General Medical Council (GMC), General Pharmaceutical Council (GPC), and Nursing and Midwifery Council (NMC), and also in guidance from the British

¹¹ J McHale, ‘Conscientious objection and the nurse: A right or a privilege?’ (2009) 18 *British Journal of Nursing* 1262, 1263.

¹² Department for Constitutional Affairs (DCA), *Mental Capacity Act 2005 Code of Practice* (TSO: London, 2007), para 9.61. Also, paras 9.62-9.63.

¹³ *Re B (Adult Refusal of Medical Treatment)* [2002] EWHC 429 (Fam), [100 viii].

¹⁴ McHale (n 11) 1263.

Medical Association (BMA) and the Royal College of General Practitioners (RCGP).¹⁵ The extent of the discussion varies, as does the consideration given to the obligations of a HCP seeking to exercise a CBE. The NMC states only that ‘the laws of the country’ must be complied with,¹⁶ and the GPC refers, without further elaboration, to ‘religious or moral beliefs [which] prevent you from providing a service’.¹⁷ The BMA indicates support for doctors who seek CBEs from withdrawing life-sustaining treatment from adults with capacity,¹⁸ claiming that this has ‘some support’ in the MCA’s Code of Practice.¹⁹ Furthermore, in its guidance on Withdrawing and Withholding Treatment, the BMA claims that the courts support the idea that doctors ought not to be compelled to act against their consciences,²⁰ citing Hedley J’s comment in Wyatt that ‘it was recognised on all sides that a doctor could not be required to act contrary to his conscience. The Court of Appeal have made it clear that a court should not require any doctor so to act.’²¹ It appears, however, that despite using the term ‘conscience’, Hedley J was referring to the HCP’s clinical judgment, and this is supported by his reference to Lord Donaldson MR in Re J, who spoke of ‘the bona fide clinical judgment of the practitioner concerned’.²² Subsequent paragraphs in Wyatt confirm that Hedley J was concerned with clinical rather than moral judgement. Indeed, he

¹⁵ General Medical Council (GMC), *Personal Beliefs and Medical Practice* (GMC: London, 2013); General Pharmaceutical Council (GPC), *Guidance on the provision of pharmacy services affected by religious and moral beliefs* (GPC: London, 2010); Nursing and Midwifery Council (NMC), ‘Conscientious objection by nurses and midwives’ <<http://www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/Regulation-in-Practice-Topics/Conscientious-objection-by-nurses-and-midwives-/>> accessed 25/7/14; British Medical Association (BMA) Ethics Department, *Medical Ethics Today: The BMA’s Handbook of Ethics and Law* (Wiley-Blackwell: Oxford, 3rd edn, 2013); Royal College of General Practitioners (RCGP), *Good Medical Practice for General Practitioners* (RCGP: London, 2008).

¹⁶ NMC, *The code: Standards of conduct, performance and ethics for nurses and midwives* (NMC: London, 2008) para. 49.

¹⁷ GPC, *Standards of conduct, ethics and performance* (GPC: London, 2012) para 3.4. Also, GPC (n 15) 1.

¹⁸ BMA (n 15) 33.

¹⁹ BMA, ‘Expressions of doctors’ beliefs’ 2 <<http://bma.org.uk/practical-support-at-work/ethics/expressions-of-doctors-beliefs/>> accessed 28 July 2014. In that document the BMA does, however, state that ‘doctors should have a *right*’ to CO in these three areas ‘where there is another doctor willing to take over the patient’s care’, 1, emphasis added. Referring to DCA (n 12) paras 9.61-9.63.

²⁰ BMA, *Withholding or Withdrawing Life-prolonging Medical Treatment* (Blackwell: London, 3rd edn, 2007), para. 16.1.

²¹ *Re Wyatt* [2005] EWHC 2293 (Fam), [32], emphasis added.

²² *Re J (A Minor) (Wardship: Medical Treatment)* [1993] Fam 15, 26-27, emphasis added.

noted that the 'professional conscience of a doctor will of course have been honed by experience of patients, exposure to the practice of colleagues, and the ethos of his work',²³ and also referred to 'professional conscience, intuition or hunch'.²⁴ Thus, we suggest that this authority supports the right of doctors not to be compelled to act against their clinical judgement, rather than any general right of conscience. Nevertheless, the BMA considers that:

there is no reason why reasonable and lawful requests by doctors to exercise a conscientious objection to other procedures should not be considered, providing individual patients are not disadvantaged and continuity of care for other patients can be maintained. In these circumstances, conscientious objection should not be seen as a 'right', but individual requests should be assessed on their merits.²⁵

The RCGP and the GMC also adopt a liberal approach to CBEs, with the RCGP assuming that wide-ranging opt-outs to 'a particular form of treatment' will be possible,²⁶ and the GMC advising that a doctor may 'choose to opt out of providing a particular procedure because of [her] personal beliefs and values',²⁷ providing that the objection is explained to patients.²⁸

In terms of objectors' obligations, nurses and midwives are advised that they must inform their employers in writing of their objection 'at the earliest date in their employment', and are cautioned that they might be called to justify their actions in court.²⁹ The GMC's and GPC's guidance states that doctors and pharmacists should inform employers, partners, colleagues,

²³ Wyatt (n 21) [35], emphasis added.

²⁴ Wyatt (n 21) [36], emphasis added.

²⁵ BMA (n 19) 6, emphasis added.

²⁶ RCGP (n 15) 15, emphasis added.

²⁷ GMC (n 15) para 8, emphasis added.

²⁸ General Medical Council (GMC), *Good Medical Practice* (GMC: London, 2013) revised April 2014, para 52.

²⁹ NMC (n 15).

and relevant authorities of their views, so that patient care is not compromised as others can deal with the services that are affected by the belief, and colleagues are not overburdened.³⁰ Pharmacists are also instructed to know where patients requesting an objected-to service may be directed to for alternative provision,³¹ and to ensure that patients are ‘properly informed’ of the reason why the service in question is not being made available.³² Both the NMC and GPC advise their members to consider their conscientious position when deciding where to work,³³ and the BMA, GMC, and GPC require doctors to explain their position to their patients, inform them of their right to see another doctor, and provide them with information to enable them to exercise that right.³⁴ In some instances, according to the BMA and GMC, doctors should even arrange an appointment for the patient with another doctor.³⁵ Furthermore, the GMC states that a doctor’s decision not to provide a particular procedure must not result in direct or indirect discrimination against, or harassment of, any patient or group of patients: so, for example, a doctor may decide not to provide any contraceptive services to patients at all, but she may not decide to provide them only to married women.³⁶ Doctors must ‘do [their] best’ to ensure that patients know of any CBE in advance,³⁷ and must not express their personal beliefs in ways ‘that exploit their [patients’] vulnerability or are likely to cause them distress’.³⁸

B. Guidance on conscience in relation to particular treatments

³⁰ GMC (n 15) para 11; GPC (n 15) para 1.3. Also, GPC (n 17) para 3.4.

³¹ GPC (n 15) para 1.2.

³² GPC (n 15) para 1.4.

³³ NMC (n 15); GPC (n 15) para 1.1.

³⁴ BMA (n 15) 33; GMC (n 28) para 52; GMC (n 15) para 12; RCGP (n 15) 15.

³⁵ BMA (n 15) 33; GMC (n 28) para 52; GMC (n 15) para 13.

³⁶ GMC (n 15) para 8.

³⁷ GMC (n 15) para 10.

³⁸ GMC (n 28) para 54.

The GMC, GPC, RCGP, and BMA all support an extension of CBEs beyond the two areas where conscience is already protected by statute. Evidence of a willingness to extend conscience provision beyond the existing statutory protections is also evident in some of the guidance on specific procedures and treatments, and in the Bills on assisted suicide recently presented to the UK Parliament. As noted above, the BMA has indicated that it will support doctors who seek exemption from withdrawing life-sustaining treatment from adults without capacity,³⁹ and the GMC has stated that doctors may be exempt in such a situation but must ‘first [ensure] that arrangements have been made for another doctor to take over your role’.⁴⁰ As long ago as 1997 the BMA stated that a CBE for HCPs would be necessary were assisted dying to be legalised,⁴¹ and Lord Joffe’s Assisted Dying Bills included CBE clauses.⁴² In 2005, a House of Lords Select Committee Report on one of the Bills advised that imposing a duty of referral might violate Article 9(1) of the European Convention on Human Rights.⁴³ Perhaps in the light of this advice, the CBE clause in Lord Falconer’s current Assisted Dying (HL) Bill resembles section 4 of the Abortion Act 1967, which, on its face, contains no duty to refer.⁴⁴ As we have noted, however, a duty to refer in relation to abortion is imposed on GPs and others by secondary legislation.

In relation to the provision of emergency contraception, the GPC recognises that pharmacists might wish to be exempt, and requires those who do to refer patients to non-objecting

³⁹ BMA (n 15) 33.

⁴⁰ GMC, *Treatment and care toward the end of life: Good practice in decision making* (GMC: London, 2010) para 79, emphasis added.

⁴¹ BMA, *End-of-life decisions: Views of the BMA* (BMA: London, 1997). Now see, BMA, *End-of-life decisions: Views of the BMA* (BMA: London, 2009) 5.

⁴² Clause 6(2)-(3) Patient (Assisted Dying) Bill [HL] 2003-04; clause 7(2)-(3) Assisted Dying for the Terminally II Bill 2004-05.

⁴³ House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill (2005) Recommendation 269 (viii) referring to House of Lords, House of Commons, Joint Committee on Human Rights, *Scrutiny of Bills: Fifth Progress Report*, Twelfth Report of Session 2003-04, HL Paper 93/HC 603, paras. 3.11-3.16.

⁴⁴ Clause 5 Assisted Dying [HL] Bill 2014-15. Note that the Assisted Suicide (Scotland) Bill 2013 contains no provision for CBEs.

pharmacists.⁴⁵ Similarly, the BMA states that ‘doctors with a conscientious objection to providing contraceptive advice or treatment have an ethical duty to refer their patients to another practitioner or family planning service’.⁴⁶ Insofar as this countenances objection to types of contraception other than those regarded as constituting abortion, this further extends the scope of CBEs. In contrast, according to the GPC, the NMC’s guidance Conscientious Objection (not publicly-available on the NMC website) states that a refusal to provide emergency hormonal contraception would contravene the NMC’s regulatory Code.⁴⁷ Presumably, this is because the Code requires nurses and midwives to comply with the law of the country in which they are practising,⁴⁸ and emergency contraception is lawful in England and Wales. Finally, in the first edition of Medical Ethics Today in 1993, the BMA stated that doctors could have a CBE to being involved in surrogacy arrangements, and also to advance decisions.⁴⁹ Although these statements are not repeated in the 2013 edition, they demonstrate that the BMA has been willing to extend protection for conscience beyond the legal protection offered by statute; albeit perhaps not to the same extent as the GMC.

C. Conclusion

An examination of the guidance provided by professional organisations appears to corroborate concerns about ‘conscience creep’, as some of it envisages a role for CBEs beyond the two statutorily protected areas. There is a lack of clarity about which treatments a HCP may validly seek exemption from, and also about the obligations of HCPs seeking to exercise CBEs, including whether they are obliged to inform patients in advance of the

⁴⁵ GPC (n 15) 3.

⁴⁶ BMA (n 15) 277, emphasis added.

⁴⁷ GPC, ‘Review of Standard 3.4 – religious or moral beliefs interim update’, Council meeting 12th April 2012, 04.12/C/01, para. 3.3.

⁴⁸ NMC (n 16) para 49.

⁴⁹ BMA, *Medical Ethics Today: Its Practice and Philosophy* (BMA: London, 1993) 121 and 163 respectively.

conscientious position, and/or to refer them to a non-objector who will provide the treatment. Vagueness within individual guidance documents, combined with the inconsistencies across the guidance offered by different organisations, leaves matters unclear for HCPs and patients. This leaves the door open for ‘creep’ via the *ad hoc* interpretation and extension of CBEs. While the extension of CBEs may be warranted, if it is to occur it must be systematic and clearly justified so that patients and HCPs will know where they stand.

III. THE NATURAL LIMITS OF CBEs: THREE RESTRICTING FACTORS

We recommend that three limits be applied to restrict the operation of CBEs: (i) CBEs apply only to those treatments whose status as ‘proper medical treatment’ is contested or liminal; (ii) a set of criteria can be identified which must be met before a claim can be regarded as genuinely ‘conscientious’, and which enables the rejection of ineligible claims; and (iii) where a genuinely conscientious claim exists, a number of duties arise which the genuinely conscientious HCP must fulfil. These are restricting factors, insofar as they prescribe limits for CBEs and impose certain controls on their operation, thus removing the danger of CBEs either ‘creeping’ into illicit areas or operating in a ‘wild’, uncontrolled manner.

A. *The margins of “proper medical treatment”: CBE as a liminal phenomenon*

Savulescu has notoriously declared that ‘[i]f 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'.⁵⁰ Kennedy has denied the validity of CBEs where lawful treatment is concerned, complaining that section 4 of the Abortion Act 1967 entitles 'a doctor employed and paid by the taxpayer ... to opt out of providing a service voted for and paid for by the taxpayer if he does not think it right'.⁵¹ He contrasts this with the fact that a barrister cannot refuse to represent a client on the basis that she will not represent terrorists. Those who work within the National Health Service, according to Kennedy, 'should remember the last word of the three, "service", and serve'.⁵² Critics of CBEs pose a fundamental question: to what extent, if any, is the exercise of individual conscience compatible with proper medical treatment? If a treatment is "proper", should professionals be allowed to avoid providing it? Conversely, can the existence of a CBE be taken as an indication that the status of a particular treatment as proper medical treatment is in some way liminal, or even doubtful?

The legal concept of proper medical treatment has emerged from the role of the criminal law in regulating healthcare practice. In England and Wales, the concept neutralises prima facie wrongs and protects HCPs against prosecution for assault or grievous bodily harm. In R v Brown a majority in the House of Lords held that while the valid consent of a person with capacity was necessary to render significant bodily harm lawful, it was not sufficient; the physical contact must also be justifiable in the broader public interest.⁵³ Proper medical treatment is one such justification,⁵⁴ and in Airedale NHS Trust v Bland Lord Mustill stated that 'bodily invasions in the course of proper medical treatment stand completely outside the criminal law'.⁵⁵ Other notions of proper medical treatment also emerge from the acceptance

⁵⁰ J Savulescu, 'Conscientious objection in medicine' (2006) 332 *British Medical Journal* 294, 294, emphasis added. See also Cantor (n 2) 1485.

⁵¹ I Kennedy, 'What is a medical decision?' in *Treat Me Right: Essays in Medical Law* (Clarendon Press: Oxford, 1988) 28.

⁵² Kennedy (n 51) 29.

⁵³ [1994] 1 AC 212, HL.

⁵⁴ *Brown* (n 53) 266 *per* Lord Mustill.

⁵⁵ *Airedale NHS Trust v Bland* [1993] AC 789, 891.

or rejection of particular practices by the medical profession and medical professionals ('recognized professional norms').⁵⁶ Recall, for example, the controversy in the late 1990s around Robert Smith's willingness to amputate the healthy limbs of consenting patients with capacity.⁵⁷ Similarly, debates on whether HCPs should be involved in ritual circumcision or assisted dying highlight the fact that, however long-established a practice, its characterisation and acceptance as "proper" can be continually contested.

While the meaning and scope of proper medical treatment may be unclear,⁵⁸ our focus here is on whether HCPs should be able to refuse to provide treatments which have been deemed, by some mechanism, to be proper. Where a particular practice is deemed improper, it is meaningless to talk about CBEs, because expectation is critical. As there is no expectation that HCPs will engage in, for example, trepanation or female genital mutilation, there is no need to provide for exemptions from participation in these procedures. CBEs operate as a bulwark against expectation, and in the absence of any expectation that reasonable HCPs will engage in a practice, the 'shield' of a CBE is unnecessary.⁵⁹ A CBE is also inappropriate where a practice is so uncontroversial and well-accepted by the professions that it falls well within the medical mainstream. It would seem absurd to provide for CBEs from prescribing antibiotics for acne, performing tonsillectomy, or removing atypical moles, for example. Again, as there is no expectation that any reasonable HCP would dissent from participating in these practices, protection for conscience is unnecessary and inappropriate. As Frader and Bosk argue, 'where society permits patients to obtain medical services and where no clear-cut

⁵⁶ Wicclair (n 7) 222.

⁵⁷ R.C. Smith, 'Body integrity identity disorder: A problem of perception?' in A. Alghrani, R. Bennett, S. Ost (eds.), *Bioethics, Medicine and the Criminal Law Volume 1: The Criminal Law and Bioethical Conflict: Walking the Tightrope* (CUP: Cambridge, 2013).

⁵⁸ For further discussion see, M Brazier, S Fovargue, 'Transforming wrong into right: What is "proper medical treatment"?' in S Fovargue, A Mullock (eds) *The Legitimacy of Medical Treatment: What Role for the Medical Exception?* (Routledge: London, 2015) forthcoming.

⁵⁹ On CBE as a 'shield' see, for eg., B Dickens, 'Conscientious objection: A shield or a sword?' in SAM McLean (ed) *First Do No Harm: Law, Ethics and Healthcare* (Ashgate: Aldershot, 2006).

moral consensus opposes those services, physicians who invoke CO to providing those services risk abusive exercise of their state-licensed power and authority'.⁶⁰

Where the status of a treatment or procedure is clearly within or without accepted medical practice there is no need for CBEs. CBEs belong only at the margins of proper medical treatment where the status of the treatment is contested.⁶¹ A treatment may occupy liminal status because, despite being lawful, it is 'morally controversial and contentious'.⁶² Practices which involve the ending of human life, such as abortion, IVF, and withholding or withdrawing treatment from unconscious patients or severely disabled newborns, may be liminally proper for this reason; assisted dying will be too, if it becomes lawful to provide it within the healthcare context. Wicclair has noted a lack of moral consensus among HCPs and the public regarding physician assisted suicide in England and Wales and in the US, and suggests that such 'moral controversy, disagreement, and uncertainty seem to recommend tolerance and the recognition of conscientious objection'.⁶³ A treatment may also have liminal status if it is extremely risky or experimental, or if it is more concerned with the satisfaction of preferences than with healing or treating disease (as is arguably true of certain cosmetic procedures, and assisted reproduction for same sex couples and single people). CBEs should be permitted only in liminal cases of proper medical treatment where they '[promote] the moral integrity of the medical profession as well as the individual physician'.⁶⁴

⁶⁰ J Frader, CL Bosk, 'The personal is political, the professional is not: Conscientious objection to obtaining/providing/acting on genetic information' (2009) 151C *American Journal of Medical Genetics Part C (Seminars in Medical Genetics)* 62, 65.

⁶¹ The BMA would appear to support this position: BMA (n 17) 2; as do Wicclair (n 7); K Greenawalt, 'Refusal of conscience: What are they and when should they be accommodated?' (2010) 9 *Ave Maria Law Review* 47; M Magelssen, 'When should conscientious objection be accepted?' (2012) 38 *Journal of Medical Ethics* 18.

⁶² Wicclair (n 7) 207.

⁶³ Wicclair (n 7) 206.

⁶⁴ Wicclair (n 7) 223, emphasis in original.

by recognising that ‘there are significant differences among appeals to conscience from the perspective of recognized professional norms.’⁶⁵

B. Criteria for conscientiousness

For a CBE to be valid it has been suggested that some or all of the following must be met: (i) the position held must be sincere;⁶⁶ (ii) it must fit within a coherent system of ethical belief;⁶⁷ (iii) it must be consistent with the HCP’s other beliefs and actions, particularly those in proximate areas of concern;⁶⁸ (iv) it must be key or fundamental in the sense that its violation poses a serious risk to the HCP’s moral integrity;⁶⁹ (v) reasonable alternatives must have been considered so that the exercise of a CBE is a ‘last resort’;⁷⁰ (vi) the HCP seeking the CBE must be able to ‘articulate the basis of [her] position’;⁷¹ (vii) the rationale must reflect a valid view of the ends/goals of medicine;⁷² (viii) the position must not be intolerant or disrespect the different conscientious conclusions of others;⁷³ and (ix) the objection must be to the treatment, rather than to the individual patient.⁷⁴

⁶⁵ Wicclair (n 7) 222.

⁶⁶ C Meyers, RD Woods, ‘An obligation to provide abortion services: What happens when physicians refuse?’ (1996) 22 *Journal of Medical Ethics* 115; E LaFollette, H LaFollette, ‘Private conscience, public acts’ (2007) 33 *Journal of Medical Ethics* 249; RF Card, ‘Reasonability and conscientious objection in medicine: A reply to Marsh and an elaboration of the reason-giving requirement’ (2014) 28 *Bioethics* 320.

⁶⁷ Meyers and Woods (n 66); Greenawalt (n 61).

⁶⁸ Meyers and Woods (n 66); LaFollette and LaFollette (n 66).

⁶⁹ Meyers and Woods (n 66); L Cannold, ‘Consequences for patients of health care professionals’ conscientious actions: The ban on abortions in South Australia’ (1994) 20 *Journal of Medical Ethics* 80; Magelssen (n 61). For an argument that moral integrity is the basis for CBEs see Wicclair (n 7).

⁷⁰ Meyers and Woods (n 66).

⁷¹ Meyers and Woods (n 66); TA Cavanaugh, ‘Professional conscientious objection in medicine with attention to referral’ (2010) 9 *Ave Maria Law Review* 189. Magelssen (n 61) and LaFollette and LaFollette (n 66) go further requiring that the HCP gives a plausible rationale for her position. On the need to give reasons in support of a CBE see Card (n 66), for a contrary view see J Marsh, ‘Conscientious refusals and reason-giving’ (2014) 28 *Bioethics* 313, and for ‘a middle ground position’ see L Kantymir, C McLeod, ‘Justification for conscience exemptions in health care’ (2014) 28 *Bioethics* 16.

⁷² Cavanaugh (n 71); Magelssen (n 61).

⁷³ LaFollette and LaFollette (n 66); D Sulmasy, ‘What is conscience and why is respect for it so important?’ (2008) 29 *Theoretical Medicine and Bioethics* 135; B Dickens, ‘Legal protection and limits of conscientious objection: When conscientious objection is unethical’ (2009) 28 *Medicine and Law* 337, 343.

⁷⁴ Cavanaugh (n 71); BMA (n 19).

A conscientious position is an 'ethical' position in two senses. First, it pertains to or concerns ethical matters; second, it is embraced (when genuinely-held) on the basis that it is believed to be in accordance with the requirements of ethics. Insofar as conscientious positions are 'ethical' in this second sense, it seems impossible to acknowledge as truly conscientious any position which fails to meet basic ethical requirements such as sincerity, good faith, and respect for others, including others with whom one disagrees. If this is correct, some criteria naturally flow from genuine conscientiousness; criterion (i) seems uncontroversial on this basis. Likewise criterion (viii) seems intuitively correct as '[i]t would seem unjust for a person to ask for tolerance for an intolerant belief. A moral system that tolerated intolerance would seem internally inconsistent'.⁷⁵

Someone who is committed to behaving ethically should also be willing to make a good faith attempt to articulate her position upon request. A version of criterion (vi) is justified, therefore, although the emphasis must be on the HCP's willingness to articulate and not on the plausibility of her rationale, since the latter depends on the receptiveness of the audience and not the conscientiousness of the position. Conscience is an element of moral agency; a matter of reflection, deliberation, and judgement. As such, a good faith exercise of conscience ought to include a willingness to try to externalise these processes in order to alleviate any legitimate concerns about the subjective elements of conscience, particularly fears that some HCPs may exploit CBEs by making false claims.⁷⁶ While criteria (i), (vi) and (viii) emerge from the very nature of conscientiousness, criterion (iv) emerges from the purpose of a CBE. Insofar as CBEs are justified by the need to protect integrity, they can only be justified when there is a reasonable prospect of an integrity violation. Whether there is such a thing as a 'trivial' violation of conscience, or whether all violations of conscience

⁷⁵ Sulmasy (n 73) 146.

⁷⁶ Of particular note are the examples recounted by Meyers and Woods (n 66).

impact on integrity to some extent, is beyond the scope of this paper. Nevertheless, if the *raison d'être* of CBEs is the protection of integrity then the prospect of an integrity violation should be regarded as a criterion for the availability of a CBE.

The remaining criteria are problematic in various ways. It seems too onerous to require that the position held must fit within a coherent system of ethical belief (criterion (ii)); who can claim that her ethical beliefs are coherent, or form a 'system' at all? It is also unclear why a conscientious position must be located within a coherent system to be valid. Requiring such might privilege religious objections which occur against a consistent doctrinal framework over secular ethical objections. Arguably, there is at least a danger that a coherence requirement may cause those who cite the doctrinal position of a major world religion as the basis for their objections to benefit from an implicit presumption of coherence.

Criterion (iii), consistency with the HCP's other beliefs and actions, seems to envisage an unduly high level of scrutiny of individuals' inner lives. If the rationale is that only those who manage consistently to live up to all or most of their moral ideals ought to be able to access CBEs, then it is too demanding. Given the negative consequences that have been associated with integrity violation,⁷⁷ limiting protection in this way is prejudicial. Alternatively, if consistency is envisaged here as evidence of sincerity, then this is already covered in criterion (i), (the position held must be sincere). What if a HCP has two views which appear inconsistent but which she is satisfied she can justify? What if she opposes the destruction of embryos in IVF because she regards foetal and embryonic human life as valuable, but supports abortion in certain circumstances because she believes that, in the latter context, the

⁷⁷ Including 'guilt, shame, or loss of self-respect': AHM Antommara, 'Conscientious objection in clinical practice: Notice, informed consent, referral, and emergency treatment' (2010) 9 *Ave Maria Law Review* 81, 83; and 'anger, anxiety, guilt, sorrow, frustration, and/or helplessness': S Davis, V Schrader, MJ Belcheir, 'Influencers of ethical beliefs and the impact on moral distress and conscientious objection' (2012) 19 *Nursing Ethics* 738, 739.

interests of the woman take precedence? Or, she may oppose ‘social’ abortions but support abortion in other situations. Are these positions consistent (because she can explain them) or inconsistent (because she seems to be upholding the sanctity of life in some cases and derogating from it in others)? If she cites a religious faith as any part of the justification for her position, is her consistency to be judged in terms of how consistently she applies its doctrines in other areas of her life?

Criterion (v), requiring that the exercise of a CBE be a last resort, is difficult to understand. If a HCP judges that participation in a particular practice will damage her integrity, the only thing that will avoid the damage is avoiding participation. What other options could be explored before she concludes that she is going to have to avail herself of a CBE as a ‘last resort’? Criterion (vii), requiring that the CBE must reflect one view of the ends/goals of medicine, seems to demand that HCPs suspend their personal ethical commitments while at work. But this undermines the very value (integrity) which protecting conscience is aimed at promoting. Integrity must, by definition, abhor the kind of compartmentalisation which would deny anything other than a “medical” rationale for a healthcare refusal. Indeed, an ability to cast off or suspend one’s personal commitments is ethically suspect, and raises serious doubts about integrity and commitment. Healthcare is an inescapably moral enterprise,⁷⁸ and integrity and commitment are essential to it.⁷⁹ As such, it is those HCPs who lack these qualities who are unfit to perform their roles, and not those who permit personal commitments to inform their professional practice. As Curlin and others remark, ‘[p]atients will not be well-served by moral automatons who shape their practices, without

⁷⁸ D Weinstock, ‘Conscientious refusal and health professionals: Does religion make a difference?’ (2014) 28 *Bioethics* 8, 11.

⁷⁹ A Asch, ‘Two cheers for conscience exceptions’ (2006) 36 *Hastings Center Report* 11.

struggle or reflection, to the desires of patients and the dictates of whatever regime is currently in power'.⁸⁰

Finally, criterion (ix), which requires that the 'objection' be to the treatment and not to the patient, has some intuitive appeal. It is central to any ethical position that certain practices must incur disapproval and be rejected, but responding ethically to other people means embracing not rejecting them, and treating them with respect even where we disagree with them about fundamental ethical issues or disapprove of their actions. Therefore, a stipulation that HCPs may object to "practices but not persons" appears reasonable. Imagine, however, that a HCP seeks a CBE from participating in so-called "social abortions", although she does not disapprove of abortion where the woman's life or health is at immediate and serious risk. Is that an objection to the practice or the patient? It could surely be construed as either. A non-discrimination criterion might be workable if it could be formulated so as to refer specifically to non-discrimination on the grounds of sex, race, religion, or sexual orientation, but framed in terms of an objection to a "practice not a patient" it is too vague.

From all of the above, we suggest that at least four criteria delineate the boundaries of what can properly be called a "conscientious" position, because they are either presupposed by the very nature of conscientiousness (1-3), or are entailed by the purpose of CBEs as being to protect the integrity of HCPs (4):

1. The position must be sincere (the "sincerity criterion"),
2. The HCP seeking the CBE must be able to articulate the basis of her position (the "articulation criterion"),

⁸⁰ FA Curlin, RE Lawrence, JD Lantos, 'The authors reply' (2007) 356 *New England Journal of Medicine* 1891, 1892.

3. The position must not be intolerant and must not disrespect the conscientious position of others (the “tolerance/respect criterion”), and
4. The belief at stake must be key or fundamental so that its violation poses a serious risk to the HCP’s moral integrity (the “integrity criterion”).

C. Duties of HCPs exercising a CBE

A number of duties have been proposed as properly belonging to HCPs who seek to exercise CBEs, including duties to (i) behave with sensitivity and respect toward patients, (ii) avoid creating unnecessary burdens for patients and colleagues, (iii) treat in an emergency, (iv) disclose conscientious positions in advance, (v) articulate one’s position, (vi) provide other care, (vii) understand one’s own position, (viii) perform some alternative form of public-benefiting professional service, (ix) refer, and (x) inform patients of their treatment options. We suggest that just as a claim can only be conscientious if certain criteria are fulfilled, some duties are entailed by the conscientious character of a CBE and can be accepted relatively quickly and straightforwardly. Other proposed duties can be accepted only after some clarification and qualification, and some claimed ‘duties’ ought not to be regarded as duties at all.

1. Duties clearly entailed by the conscientious character of a CBE

The duty to behave respectfully toward others is a general (arguably the most general) ethical duty. One of us has observed, in another context, that all ethics is, ultimately, about requiring us to respond appropriately to the vulnerability of others, since ‘[i]t is vulnerability ... our own, and that of others ... that “provokes” us to become ethical beings, capable of ethical

responses ... in the absence of vulnerability, there would (could) be no ethics'.⁸¹ In the healthcare setting, where vulnerability is often heightened and relationships are asymmetric in obvious ways, the general duty of respect comes into sharp focus. With regard to CBEs, there is a risk that patients may be distressed or feel judged or criticised by the knowledge that a HCP has declined to provide the treatment they seek. Magelssen acknowledges that 'the moral criticism of the patient's intention implicit in conscientious objection may be ineradicable', but 'it may certainly be diminished in force' if HCPs communicate their views 'non-confrontationally and with sensitivity towards the vulnerable patient'.⁸² Thus, as a minimum:

the conscientious objecting professional incurs duties of sensitive, empathic counselling and explanation to any patient or their proxy who asks for a service that could be expected in her situation but that the particular professional will not perform.⁸³

The duty to behave with sensitivity and respect towards patients, duty (i), arises fairly straightforwardly from the ethical nature of a conscientious position, and overlaps with the criteria which are entailed by genuine conscientiousness; particularly the tolerance/respect criterion (criterion 3).

Furthermore, the general duty of respect to others from which this first duty flows also gives rise to duty (ii), to avoid creating unnecessary burdens for patients and colleagues. In Magelssen's view, the HCP who exercises a CBE has an active duty to reduce any burden for

⁸¹ M Neal, "Not gods but animals": Human dignity and vulnerable subjecthood' (2012) 33 *Liverpool Law Review* 177,188.

⁸² Magelssen (n 61) 20.

⁸³ Asch (n 79) 11.

patients because ‘this would signal that his objection is based on a noble moral motive – the protection of his own integrity – and that he has not lost sight of his duty to promote the patient’s interests.’⁸⁴ A genuinely conscientious HCP acting out of a sense of ethical obligation can, thus, be expected not to create unnecessary burdens for patients and colleagues. An important caveat here is that not all burdens will be “unnecessary”; accommodating CBEs will inevitably entail some management consequences which necessarily burden patients and colleagues to a degree.

Regarding the duty to treat in an emergency, duty (iii), there is a broad consensus that CBEs do not extend to medical emergencies, so that in an emergency a HCP who is ordinarily exempt from providing certain treatment(s) becomes obliged to treat.⁸⁵ Going further, Magelssen insists that ‘a healthcare worker’s objection to providing potentially life-saving treatment should not be accepted’,⁸⁶ and Sulmasy accepts that ‘likely and imminent risk of actual illness or injury’ is sufficient reason to ‘compel conscience’, notwithstanding that ‘the grounds for contravening someone’s conscientious disagreement must be very strong’ and that ‘inconvenience, psychological distress, or mild symptoms would not be sufficient’.⁸⁷ CBEs should not be construed as permitting HCPs to refuse the relevant treatment where it is required in order to save a patient’s life or protect her from serious injury. A willingness to die for one’s own principles may, in some circumstances, be heroic, but when a HCP is content for her patients to die (or be seriously injured) for her principles, then her conscience has become an end-in-itself and a liability.

⁸⁴ Magelssen (n 61) 20.

⁸⁵ L Cannold (n 69) 80; T Beauchamp, J Childress, *Principles of Biomedical Ethics* (OUP: New York 3rd edn, 1993), 390; Morrison and Allekotte (n 5); Sulmasy (n 72); cf ED Pellegrino, ‘Commentary: Value neutrality, moral integrity, and the physician’ (2000) 28 *Journal of Law, Medicine & Ethics* 78. This duty is reflected in section 4(2) of the Abortion Act 1967.

⁸⁶ Magelssen (n 61) 20.

⁸⁷ Sulmasy (n 73) 146.

2. Duties accepted with qualification

Duty (iv), to disclose one's conscientious position in advance, can be conceived narrowly (as requiring disclosure to current patients only),⁸⁸ or more widely to incorporate 'one's prospective and current patients, colleagues, employers, and relevant institutions, for example hospitals and insurance companies'.⁸⁹ Requiring advance notice to patients enables them to seek an alternative doctor if they wish,⁹⁰ but it may not work 'when patients need care quickly or when no one else can take over the task of the objecting professional'.⁹¹ Where it is practicable, however, advance notice to patients decreases the possibility that a refusal will eventuate and 'disrupt the trust' between patient and HCP.⁹² Such disclosure might include a courteous explanation of 'why certain procedures are not morally acceptable' to the HCP,⁹³ but although 'a considerate and considered answer' should be given when a patient requests an explanation, '[patients] who are not interested ought not to be treated as captive audiences'.⁹⁴ Disclosure to employers 'allow[s] institutions to prepare for individual refusals ... and put a system in place to guarantee seamless delivery of care'.⁹⁵

Disclosure may not always be in the patient's best interests,⁹⁶ however, and a practice of disclosure may create risks for HCPs.⁹⁷ When an issue is as divisive as (say) abortion, publicly identifying objectors and non-objectors may leave each group vulnerable to attack from extremists on the "other side". Disclosure necessitates a balancing exercise in which the potential disadvantages of non-disclosure for patients and institutions are weighed against

⁸⁸ Proposed by, e.g., Pellegrino (n 85) 78; TD Harter, 'Toward accommodating physicians' conscientious objections: An argument for public disclosure' *Journal of Medical Ethics* 1,1: published online first 24 February 2014, doi:10.1136/medethics-2013-101731.

⁸⁹ Cavanaugh (n 71) 204.

⁹⁰ Pellegrino (n 85) 79.

⁹¹ R Dresser, 'Professionals, conformity, and conscience' (2005) 35 *Hastings Center Report* 9, 9.

⁹² Antommaria (n 77) 97.

⁹³ Pellegrino (n 85) 79.

⁹⁴ Cavanaugh (n 71) 205.

⁹⁵ Morrison and Allekotte (n 5) 183.

⁹⁶ Magelssen (n 61) 20.

⁹⁷ Harter (n 88).

the potential risks for HCPs of having a disclosure requirement. The outcome of such an exercise is likely to be different in different social contexts. In England and Wales the abortion debate, although robust, has (so far) been nonviolent, and the risks associated with disclosure are likely to be regarded as low. In the US, where HCPs have been murdered because of their roles as abortion providers, disclosure must be regarded as higher risk.⁹⁸ Thus, although a duty of disclosure is indicated by the values of honesty and respect for others, disclosure should only be required if it is judged to be achievable without posing an unacceptable risk to the physical and psychological safety of HCPs.

We have suggested that willingness to articulate one's position is an indicator of genuine conscientiousness, and is one of the criteria for the existence of a CBE. Others have gone further and suggested that there is a duty to articulate on the part of HCPs who exercise CBEs (duty (v)). This claim has been expressed in the "genuineness requirement", of which Meyers and Woods⁹⁹ are the main advocates. Objectors 'must demonstrate to outsiders (say a diverse committee) that their conscience is genuine – that is, a deep feature of their person and not a cover up for questionable biases or prejudices.'¹⁰⁰ In other words, they must prove 'that having to perform the relevant duty would cause [the HCP] unwarranted moral and psychological distress'.¹⁰¹ One problem with this is that refusals may be genuine but still unethical. If genuineness is the only requirement there is no basis on which to disallow, say, discriminatory refusals which meet that test.¹⁰² Furthermore, it is questionable whether genuineness can be "proven" at all. A good actor may be able to convince her audience

⁹⁸ George Tiller was shot and killed in 2009; see, for e.g., J Stumpe, M Davey, 'Abortion doctor shot to death in Kansas Church' *The New York Times* (New York, 31 May 2009).

⁹⁹ Meyers and Woods (n 66).

¹⁰⁰ Marsh (n 71) 313, emphasis added.

¹⁰¹ Kantymir and McLeod (n 71) 18.

¹⁰² Kantymir and McLeod (n 71) 20.

regardless of veracity, whereas someone with a genuine objection might struggle to convince due to inarticulacy, nerves, or diffidence.

Alternatively, the duty to articulate can be expressed as the “reasonableness requirement”, advocated by Card, Cavanaugh and Magelssen,¹⁰³ according to which ‘[t]he objector must be capable of giving reasons accessible to others, in contrast to asserting an entirely personal stance’.¹⁰⁴ Under this requirement, those seeking CBEs would be obliged to cite ‘good reasons ... reasons that others should accept’.¹⁰⁵ This version of the duty, it is claimed, precludes permitting exemptions grounded on baseless or discriminatory beliefs since ‘conscientious objections motivated by such beliefs could not be reasonable’.¹⁰⁶ But how is “reasonableness” to be determined? Ought HCPs’ views to be subject to a “reasonableness test”, similar to the legal test of the reasonable clinician espoused in Bolam?¹⁰⁷ If so, the HCP seeking to exercise a CBE need only point to the existence of other HCPs who agree with her, and demonstrate that their shared position is, in essence, logically defensible.¹⁰⁸ And what of metaphysical beliefs, such as that the human foetus possesses a soul? Can these ever form a ‘reasonable’ basis for a CBE?¹⁰⁹ As Marsh observes:

arguably most refusals ... are metaphysically or religiously based, meaning that they make little or no sense in the absence of certain controversial metaphysical or religious assumptions ... when we are in contexts of metaphysical disagreement and

¹⁰³ Card (n 66); Cavanaugh (n 71); Magelssen (n 61).

¹⁰⁴ Cavanaugh (n 71) 191.

¹⁰⁵ Kantymir and McLeod (n 71) 20.

¹⁰⁶ Kantymir and McLeod (n 71) 20.

¹⁰⁷ *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583.

¹⁰⁸ *Bolitho v City & Hackney Health Authority* [1997] 3 WLR 1151, HL.

¹⁰⁹ Marsh (n 71) 316.

we adopt a demanding public conception of rationality, refusals will likely never, or virtually never, be justified.¹¹⁰

Kantymir and McLeod suggest that while '[a] refusal should not have to be reasonable for the objector to receive some conscience protection ... [a]t the same time, not every refusal that is genuine warrants an exemption'.¹¹¹ They propose a middle-ground position under which HCPs seeking exemption would be required to prove either reasonableness or genuineness, and to satisfy certain criteria, namely that 'patients will still get the care they need in a respectful and timely fashion, any empirical beliefs on which the objection rests are not baseless, and the moral or religious beliefs on which it rests are not discriminatory'.¹¹²

All versions of the duty to articulate raise procedural questions. Meyers and Woods recommend that 'a review board be established to evaluate claims of moral objection to providing abortions',¹¹³ with its composition reflecting 'a diversity of racial, ethnic and religious beliefs and academic training ... it should also include [representatives from] a range of disciplines'.¹¹⁴ This process would begin relatively informally, as a discussion between the HCP and the committee, but could escalate to 'a court of competent jurisdiction' with legal representation.¹¹⁵ Although this procedure 'relies upon the adjudication of putatively normative reasons, which can be unreliable',¹¹⁶ Kantymir and McLeod propose two ways of minimising arbitrariness or capriciousness. First, guidance for review panels in the form of a 'handbook on discrimination that outlines the different ways in which sexism,

¹¹⁰ Marsh (n 71) 316, emphasis in original.

¹¹¹ Kantymir and McLeod (n 71) 23.

¹¹² Kantymir and McLeod (n 71) 21.

¹¹³ Meyers and Woods (n 66) 118. Similarly, Kantymir and McLeod (n 71).

¹¹⁴ Meyers and Woods (n 66) 119.

¹¹⁵ Meyers and Woods (n 66) 119.

¹¹⁶ Kantymir and McLeod (n 71) 22.

racism, and the like can manifest themselves’,¹¹⁷ and, secondly, an appeals process ‘so that poor decisions of review boards could be overturned’.¹¹⁸

Although we agree that ‘the attempt to justify one’s views to others in a pluralistic society shows respect for others as equal citizens’ and that ‘reason-giving in front of a critical audience can be a helpful way of uncovering unjustified biases’,¹¹⁹ we are not persuaded that a formal (and possibly adversarial) process leading to a “verdict” is desirable. In practice, the reason-giving process ought to look more like “reflecting aloud” than being “called to account”. The point is to externalise the internal process of conscience (or try to) as a mark of sincerity and a gesture of respect for the moral community, and not to force a HCP to plead her case in a ‘draft board’ process which ‘can be damaging to morale...cannot detect skilled liars, and ... may be incompetent or corrupt’.¹²⁰ Furthermore, a HCP may have a deep and genuine moral unease but lack the intellectual or verbal skills to narrate it impressively, or she may be motivated purely by religious humility or obedience. Protection for conscience should not be contingent upon an ability to convince or persuade; thus, we cautiously endorse a duty to articulate providing that the process is informal and reflective, and that the aim is mutual understanding rather than a “verdict”.

Cavanaugh maintains that ‘conscientious objector status bears exclusively on the patient’s contested request; it does not relate to the other care the physician, nurse, or pharmacist provides for the patient.’¹²¹ Duty (vi), to provide other care, requires careful enunciation. While we endorse a general duty along these lines, in practice the boundary between the contested treatment and “other care” can be fiercely contested. It is crucial, therefore, to

¹¹⁷ Kantymir and McLeod (n 71) 23.

¹¹⁸ Kantymir and McLeod (n 71) 22.

¹¹⁹ Kantymir and McLeod (n 71) 318.

¹²⁰ Dresser (n 91) 10.

¹²¹ Cavanaugh (n 71), 206, emphasis added.

uphold the duty of providing other care in a way that avoids violating the integrity of HCPs, either by effectively requiring their participation in the objectionable activity, or by forcing them into complicity (see our discussion under 3 below). Recent litigation in the UK courts concerning the interpretation of section 4 of the Abortion Act 1967 highlights how thin the boundary between contested treatments and “other care” can be.¹²² “Good conscience” may well demand that a HCP does not participate in any way in a practice held to be deeply immoral, and has been argued to cover such supposedly remote participation as ‘delegation, supervision, and support’.¹²³

Recalling the fundamental ethical duty to respond appropriately to the vulnerability of others, we suggest that a genuinely ethical position cannot entail a lack of compassion or care. Good conscience never demands that a HCP avoid feeding, toileting, comforting, listening, and other basic acts of care. Even if I regard the treatment a patient is receiving as immoral, it cannot be immoral for me to dry her tears if she is distressed, fetch her a glass of water if she is thirsty, or adjust her pillows if she is uncomfortable. It would be immoral not to do these things. Thus, the duty to provide other care, short of participation in the contested treatment, arises directly from the ethical nature of a conscientious position.

3. ‘Duties’ which ought to be rejected

Regarding duty (vii), to understand one’s own position, Pellegrino suggests that ‘moral maturity is part of integrity and requires knowing which acts destroy moral integrity and which do not’, and that ‘physicians who lay claim to moral integrity are obliged to

¹²² *Greater Glasgow Health Board v Doogan & Anor* [2014] UKSC 68, which concerns whether the ‘supervision, delegation, and support’ of staff directly involved in the abortion process constitutes the kind of ‘participation’ from which a HCP can be exempted under section 4(1) of the Abortion Act 1967. See M Neal, ‘Commentary: The scope of the conscience-based exemption in section 4(1) of the Abortion Act 1967: *Doogan and Wood v NHS Greater Glasgow and Clyde Health Board* [2013] CSIH 36’ (2014) 22 *Medical Law Review* 409 for commentary on an earlier stage of the litigation.

¹²³ *Doogan* (n 122).

comprehend their own beliefs sufficiently well to know when they can compromise and when not'.¹²⁴ We have already proposed that willingness to articulate one's position is not only a criterion for the validity of CBEs (criterion (2)), but also a duty for those who exercise them (duty (v)). These articulation requirements provide sufficient prompt to reflect, self-scrutinise, and understand one's reasons: who, knowing she may be called upon to explain her position, will not reflect upon it privately in advance? An additional duty to understand one's own position is unnecessary, and runs the risk of being interpreted as a 'duty to be sure.' An ethical position can be genuine, reasonable, and authentically conscientious, and yet lack precision around the edges. As such, a conscience claim should not be regarded as lacking in maturity or credibility simply because the individual who makes it acknowledges areas of doubt. Indeed, a cautious approach which acknowledges that we are not always certain of our moral responsibilities in hard cases might be regarded as evidence of maturity. The sincerity criterion (1) is also relevant here. It would be regrettable if individuals making claims of conscience were incentivised to downplay any doubt in order to pass a certainty test, rather than being encouraged to articulate their positions sincerely within a mutually-respectful exchange.

Meyers and Woods suggest that where a HCP has been granted a CBE from participation in a practice, she has a duty to compensate for her exemption by undertaking some other alternative 'public-benefiting' service (duty (viii)).¹²⁵ We are unpersuaded by this for two reasons. First, it has unpleasant punitive overtones. The phrase 'public service' is redolent of reparation or sentencing, and, as such, carries the implication that the HCP who exercises a CBE is guilty of a failing or offence, as opposed to being a reflective moral agent striving to preserve her integrity. Second, in practice employees who cannot or will not perform one

¹²⁴ Pellegrino (n 85) 80.

¹²⁵ Meyers and Woods (n 66) 119.

task will inevitably be redeployed to other tasks in line with their skills, seniority, and (if applicable) their contract. Such redeployment is normal activity and not an ‘alternative public-benefitting professional service’. It is difficult to imagine how any of a HCP’s duties in a national health service could avoid being ‘public-benefitting’. How would we distinguish an employee’s ordinary, everyday public-benefitting activities from her “alternative” activities? If an employee was redeployed in a way not befitting her skills in order to underline the fact that she was now engaging in her “compensatory” activities, this would be a misuse of resources and compound the sense that a punishment was being meted out. This, in turn, would issue a powerful negative message about how conscience is regarded in the healthcare context.

Duties (ix), to refer, and (x), to inform patients of their treatment options, both encounter the serious obstacle of complicity in wrongdoing. It has been claimed that ‘the status quo on conscientious objection in medicine’ is that HCPs can exercise CBEs provided they make a referral to another HCP.¹²⁶ We have noted that in England and Scotland at least, a duty of ‘prompt referral’ is imposed by secondary legislation on those who contract with the NHS. In her judgment in *Doogan*, Lady Hale reasserted the duty to refer in her *obiter* remark that:

it is a feature of conscience clauses generally within the health care profession that the conscientious objector be under an obligation to refer the case to a professional who does not share that objection. This is a necessary corollary of the professional’s duty of care towards the patient.¹²⁷

¹²⁶ Kantymir and McLeod (n 71) 17. Also, Marsh (n 71) 314; Asch (n 79) 11.

¹²⁷ *Doogan* [2014] (n 122) [40].

While it seems clear that a duty to refer does attach to the CBE in section 4, the suggestion that such a duty ‘is a feature of conscience clauses generally’ or, indeed, ‘is a necessary corollary of the professional’s duty of care’ is questionable. As Davis notes, a duty to refer ‘appears to be inconsistent with the [perceived] duty not to perform the procedure’¹²⁸ because ‘by referring one endorses the relevant act’.¹²⁹ This problem is widely acknowledged,¹³⁰ and is summed up by Del Bò’s observation that ‘[t]here is something morally unsound about stating “I do not kill people myself, but let me tell you about a guy who does”’.¹³¹ Cavanaugh argues that a HCP exercising a CBE has a duty to inform her patients that they may seek the contested treatment elsewhere, and so:

[o]ne must bring to the patient’s attention that not all medical professionals agree with one’s own view ... The patient ought to emerge having a sense both of one’s grounds for objecting and of the pluralism found in medicine regarding the controverted matter.¹³²

Two kinds of reassurance have been offered regarding complicity in this context. Antommara claims that informing a patient about options cannot amount to ‘illicit co-operation’ because co-operation requires something with which to co-operate, and ‘the patient has not formed an intention until the informed consent process is complete’.¹³³ But looking backwards from the outcome of a process, would we not wish to say that the person who had put the eventual outcome on the table as an option in the first place had “facilitated”

¹²⁸ JK Davis, ‘Conscientious refusal and a doctor’s right to quit’ (2004) 29 *Journal of Medicine and Philosophy* 75, 82.

¹²⁹ Cavanaugh (n 71) 199.

¹³⁰ See, e.g., D Hill, ‘Abortion and conscientious objection’ (2010) 16 *Journal of Evaluation in Clinical Practice* 344; KWM Wildes, ‘Conscience, referral, and physician assisted suicide’ (1993) 18 *Journal of Medicine and Philosophy* 323; Kantymir and McLeod (n 71) 17.

¹³¹ C Del Bò, ‘Conscientious objection and the morning-after pill’ (2012) 29 *Journal of Applied Philosophy* 133, 138.

¹³² Cavanaugh (n 71) 205.

¹³³ Antommara (n 77) 94.

the process, and so been complicit in it? Alternatively, Brock reasons that ‘if the physician who does the informing also recommends against it, makes clear why she believes it to be immoral, and doesn’t help the patient to obtain it, then her complicity seems relatively minimal’.¹³⁴ This attempt to minimise the role of the informer is problematic. We could deny that the physician’s role is minimal as it is a *sine qua non* in the chain of events which culminates in the immoral action, regardless of whether she counsels against the immoral choice. Or we could accept that the degree of complicity is minimal but argue that a small degree of complicity in a seriously immoral enterprise is in itself serious. Imagine that X had a small but vital role in a campaign of genocide; a role without which the genocide would likely not have occurred at all. Does the fact that X’s role was small mean her culpability is also small, notwithstanding that the wrong was serious and her role vital? Or imagine that infanticide is decriminalised and Y, who objects to it on moral grounds, informs a patient of its availability. Does Y have any moral culpability in the subsequent death of the infant? If she does, so must a HCP who informs a patient about abortion. In the context of abortion, the view that “merely informing” does not amount to serious complicity is predicated on an underlying assumption that abortion itself is not seriously wrong, which is precisely what the exempting HCP disputes.

Recall that according to the integrity criterion, (criterion (4)), a CBE arises only where performance would risk damage to the personal integrity of a HCP; only, in other words, where a HCP deems a practice to be ‘intrinsically and seriously wrong’.¹³⁵ To force a HCP into complicity with such a practice to a degree which is ‘at least significant, if not substantial’,¹³⁶ must itself be a violation of integrity.¹³⁷ Accordingly, we reject the notion

¹³⁴ DW Brock, ‘Conscientious refusal by physicians and pharmacists: Who is obligated to do what, and why?’ (2008) 29 *Theoretical Medicine and Bioethics* 187, 197.

¹³⁵ Pellegrino (n 85) 79.

¹³⁶ Brock (n 133) 198.

that any duty to inform or refer ought to attach to the exercise of a CBE, since in our view, it is logically nonsensical to ‘protect’ HCPs integrity in a way that obliges them to violate their integrity through complicity.

IV. CONCLUSION

In line with the mainstream view, we regard conscience a matter of personal integrity, and we consider legal protection for conscience as essential in order to prevent HCPs suffering serious violations of integrity in the course of their employment. CBEs must operate within certain limits, however, and much academic discussion on conscience to date has centred on what these proper limits are. McHale is correct in observing that the guidance currently offered by professional bodies can be problematic; it is often unclear and/or contradictory, and in some cases, it appears to support CBEs in contexts where the law currently recognises no such right.

Here, we have proposed three factors which ought to be recognised as placing natural limits on the operation of CBEs: (A) they apply only where the status of a practice as proper medical treatment is liminal; (B) a position is authentically conscientious only if it fulfils four criteria (sincerity, articulation, tolerance, and integrity); and (C) wherever a CBE ought to be acknowledged because (A) and (B) are satisfied, it operates with certain duties attached. Duties to behave respectfully, avoid unnecessary burdens on patients and colleagues, and treat in emergencies all attach to the exercise of a CBE because they are entailed by conscientiousness in the same way as the four criteria. Other duties are recognised in qualified form: a duty to disclose one’s position in advance provided this does not place

¹³⁷ Pellegrino (n 85) 79.

HCPs at undue risk; a duty to articulate one's position provided the articulation process emphasises reflection and respectful exchange rather than putting HCPs' deeply-held views "on trial"; and a duty to provide "other care" so long as this does not amount to complicity in the contested practice. We reject other duties proposed in the literature, however: duties to inform and refer entail a logically indefensible complicity with the objected practice; a duty to perform alternative public-benefitting service reflects a punitive attitude to CBEs and is practically unnecessary; and a duty to understand one's position amounts either to a duty to be sure, which is unreasonable, or to a duty to reflect on/explain one's position, which is already covered under the duty to articulate (duty (v)).

These three limits represent natural and defensible parameters for the operation of CBEs. Were they to be applied in practice, those who have concerns about the creeping expansion of CBEs could be reassured that the development of the law in this area would have to take place within natural limits: criteria for genuine conscientiousness would be applied before a CBE could be exercised, and the exercise of a CBE would be a dutiful, respectful undertaking, a different engagement with the patient rather than a disengagement. At the same time, proponents of conscience rights could be reassured that the crucial link between conscience and integrity was being acknowledged, that their exemption from certain activities would be free of complicity, and that rights of conscience would be available to HCPs (with accompanying duties) wherever a practice had liminal status and the criteria were met. Although our proposed framework is in no sense a compromise, therefore, it offers reassurance both to those who defend conscience rights and to those who resist them.