CONSCIENCE AND GOOD MEDICAL PRACTICE: IS THERE A CONFLICT OF VALUES?

Sheelagh McGuinness*

Lecturer in Bioethics
Centre for Professional Ethics,
School of Law,
Keele University

Margaret Brazier**

Full Professor in Medical Law
Centre for Social Ethics and Policy,
Institute for Science, Ethics and Innovation,
University of Manchester.

Resumen El objeto de este trabajo es analizar cuál es la naturaleza y el alcance significado del derecho a la objeción de conciencia en el ámbito sanitario inglés, tal y como aparece configurado en la Ley sobre el aborto de 1967 y en la Ley sobre Embriología de 1990. Todo ello ha sido llevado bajo la perspectiva específica del conflicto que, en determinados casos, se produce entre la conciencia personal y profesional para poder así dar respuesta a algunas cuestiones que deben ser tenidos en consideración en la dialéctica propia de la objeción de conciencia.

Abstract In this paper we discuss the nature of conscientious objection and how it relates to medical practice in the U.K. We discuss the relevant pieces of legislation on the issue in the U.K. These are the Abortion Act 1967 and the Human Fertilisation and Embryology Act 1990. Although our discussion is defined to the situation in the U.K. many of the points we make are of general application. We discuss the tension between personal and professional conscience and raise many questions which must be considered in the debate on conscientious objection.

* Email: s.mcguinness@peak.keele.ac.uk

** Email: margaret.brazier@manchester.ac.uk.

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I. INTRODUCTION

> While we do not impose restrictions on doctors, we expect them to be prepared to set aside their personal beliefs where this is necessary in order to provide care in line with the principles in *Good Medical Practice.*[1]

With these words, the General Medical Council (GMC) makes it clear to British doctors that in cases of conflict, patient care trumps doctors' consciences. The GMC may assert that personal beliefs and values, and cultural and religious practices, are central to the lives of both patients and doctors, but how far are doctors in the UK today allowed the liberty to have regard to such beliefs in fulfilling their vocation?[2] In this paper, we ask whether in practice doctors' individual values are, and should be, respected in any meaningful form. When values conflict, what scope is there for conscientious objection? We will also consider the nature of conscientious objection and the distinction between how it is manifested in both private and professional life. Should we be free to act according to our conscience in our own domestic life, but when we act in a professional capacity is it

[1] See GMC *Personal Beliefs and Medical Practice* (2008)

[2] We confine our discussion to the jurisdiction of England and Wales. This is the jurisdiction where the legislation which we discuss applies.

legitimate to suggest that personal ethics be left at the door of the office or the clinic?

In the United Kingdom, express statutory provisions for conscientious objection are rare. In the medical context such a right is expressly provided for in the context of abortion[3] and fertility treatment[4]. The courts have conceded a right of conscientious objection in relation to withdrawal of life support[5] and pharmacists are allowed to refuse to sell the 'morning after pill'.[6] But the potential for conflict between what patients may seek and what doctors find compatible with conscience is much broader than such limited instances.

We explore what kinds of conflict may arise in a country such as the UK with diverse cultural and religious views among the lay and the medical community. We seek to identify why conscientious objection is a hot topic in health care but barely

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[3] Abortion Act 1967 s.4

[4] Human Fertilisation and Embryology Act 1990 s.38 and see Human Fertilisation and Embryology Authority Code of Practice, 7th ed. S.6.2.3

[5] *Ms B* v *An NHS Hospital Trust* [2002] 2 All ER 449

[6] This something which has been the subject of much discussion in the U.S. In Michigan a case was reported where not only would the pharmacist not dispense the morning after pill but they also refused to return the prescription to the patient to have filled elsewhere. See Julie Cantor and Ken Baum, 'The Limits of Conscientious Objection — May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception?' (2004) 351 *New England Journal of Medicine* 2008 – 2012. In the UK pharmacists have a general right to conscientiously object as laid out in their 'Code of Ethics for Pharmacists and Pharmacy Technicians'. See http://www.rpsgb.org/pdfs/coeppt.pdf. They say: "Ensure that if your religious or moral beliefs prevent you from providing a particular professional service, the relevant persons or authorities are informed of this and patients are referred to alternative providers for the service they require." p.8. In relation to provision of the 'morning after pill' they sate: "Pharmacists who choose not to supply EHC on the grounds of religious or moral beliefs should treat the matter sensitively and advise women on an appropriate local source of supply available within the time for EHC to be effective (i.e. within 72 hours of unprotected sex)." Taken from 'Practice Guidance on the Supply of Emergency Hormonal Contraception as a Pharmacy Medicine' http://www.rpsgb.org/pdfs/ehcguid.pdf.

debated at all in the context of other businesses and professions. Is medicine different? We use the tendentious word vocation above- should we do so? Are doctors to be considered like any other 'service provider'? Then we examine whether personal beliefs of the doctor should claim any respect at all before analysing how conscientious objection has been defined in the courts and in daily practice. Can a satisfactory definition be formulated? Where does the line lie between conscience and prejudice? We focus here on doctors, while acknowledging that dilemmas of conscience will also impact on other health care professionals. This paper analyses English law but we seek to make some more general points about this difficult dilemma in modern medicine.

II CONSCIENTIOUS OBJECTION IN ENGLISH LAW

The obvious starting point for any examination of conscientious objection in English law is section 4 of the Abortion Act 1967.[7] It is important to note that abortion remains prima facie a crime in England. The 1967 Act (as amended) provides a defence to a charge of procuring a miscarriage contrary to section 58 of the Offences against the Person Act 1861. Abortion is legal only when the pregnancy is terminated by a registered medical practitioner after two doctors have certified in good faith:[8]

1. that the pregnancy has not exceeded its 24th week and 'the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the

[7] This act does not extend to Northern Ireland. Abortion Act 1967 s.7(3)

[8] On the law relating to abortion generally in England and Wales see M. Brazier and E. Cave *Medicine, Patients and the Law* (4th ed) (Lexis-Nexis/Penguin, 2007) Chapter 14.

physical or mental health of the pregnant woman or any existing children of her family"; or

2. that the termination is necessary to prevent grave permanent injury to the physical or mental health of the woman; or
3. that the continuance of the pregnancy would involve risk to the life of the woman grater than if the pregnancy were terminated; or
4. that there is "a substantial risk that if the child were born it would suffer from physical or mental abnormalities as to be seriously handicapped".

Note that for the latter three grounds there is no time limit. Termination in such cases is lawful throughout the whole 40 weeks of pregnancy.

A doctor may be called on to undertake a number of tasks when a patient seeks an abortion; he or she may be asked to certify that one of the grounds within the 1967 Act is met; he or she may be asked to perform or assist in the termination of the pregnancy; or the doctor may be asked to advise the patient and refer her to another practitioner. There will be doctors and nurses who would not wish to be involved in any way in an act or advice that might lead to what they perceive as the killing of the fetus. While the desire not to be involved may sometimes be religiously motivated this will not always be the case. Sometimes the motivation will be an entirely secular view of the moral status of the fetus. Both religious and moral motivations lie within the realm of conscience and arguably within the protection afforded to freedom of thought, conscience, or religion by Article 9 of the European Convention on Human Rights. What is a more difficult case is where the desire not to be involved stems from a professionally informed belief that the fetus after a certain stage of development should not be killed. A doctor who holds a belief

like this may be prepared to assist in early abortions but not abortions that take place at a later stage of gestation. When an objection takes this form we will be asking the clinician not just to act against their personal conscience but also their professional conscience as well. This relationship between professional judgment and how it informs professional conscience will be explored throughout this paper.

Section 4 of the Act, which provides for a right of conscientious objection, states that:

> no person shall be under any duty, whether by contract or by any statutory or other legal requirement to participate in any treatment authorised by this Act to which he has a conscientious objection.[9]

That right is immediately qualified in two respects. First, in any legal proceedings the burden of proving a genuine conscientious objection falls on the doctor relying on such an objection[10]. Second, a claim of conscientious objection to abortion does not relieve any doctor or nurse of any duty to participate in treatment necessary to save the life of the woman or prevent grave permanent injury to her health[11]. However, that there even exists such a conscience clause is testament to the fact that doctors will often be faced with very difficult professional and ethical challenges which are subject to reasonable disagreement in relation to the legitimacy of what the doctor is asked to do. Section 4 thus allows any health professional to refuse to *perform* an abortion on grounds of conscience. And he

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[9] Abortion Act 1967, s.4

[10] S.4(1)

[11] S.4(2) and see *R v Bourne* [1939] 1 KB 687

or she cannot be penalised for such a refusal either by their employers in the NHS or the GMC. Nor can a patient bring a claim of negligence or breach of duty against such a doctor.

We explore later just what is meant by conscience, but deal now with the more straightforward case of a doctor or nurse who believes that the moral status of the fetus makes any abortion morally equivalent to homicide. He or she is entitled to refuse to participate in the process of ending the pregnancy such as prescribing or providing the abortion pill, any surgery to evacuate the products of conception, or setting up a prostaglandin drip to induce labour, or above all any act of feticide. Much turns in English law on just what is meant by the words 'participate in any treatment'. The House of Lords, the highest court in the United Kingdom, considered this phrase in *Janaway v Salford Area Health Authority*.[12] Mrs Janaway worked as a secretary for a health centre run by the NHS. She refused to type letters referring women for abortions, arguing that as devout Roman Catholic she had a conscientious objection to doing anything that might lead to the termination of pregnancy. The Authority dismissed her and she sued for unfair dismissal arguing that her refusal to comply with her employers' instructions was protected by section 4 of the Abortion Act. Her claim failed. In a complex judgement that we do no more than summarise here the House of Lords held that section 4 only applied 'to actually taking part in treatment'[13] that played a part in ending the pregnancy; treatment administered in the hospital or clinic[14].

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[12] [1989] AC 537

[13] Ibid at 570.

[14] It should be noted that writers in the field of Roman Catholic ethics seem to support the position taken by Mrs Janaway. These authors suggest that the level of involvement which Mrs. Janaway had in the abortion procedure was sufficient to count as complicity in an immoral act. For a summary of different issues raised by Catholic ethics and conscientious objection see Armand H. Matheny Antommaria, 'Adjudicating rights or analyzing interests: ethicists' role

The legal ruling in *Janaway* prompts a number of practical questions. We have seen that a doctor might seek to invoke conscientious objection to avoid a number of different levels of involvement with abortion. *Janaway* makes it clear that he or she can refuse to take any direct part in the actual process of medical or surgical abortion. However the doctor cannot rely on section 4 to remove him or herself entirely from any engagement with lawful termination of pregnancy. The General Medical Council instructs doctors that if they hold such an objection and so are not prepared to certify that there are lawful grounds for abortion and refer the woman to suitable hospital or clinic they must tell their patient of their objection and refer her to another doctor who will make the necessary arrangements.[15] That advice from the GMC reflects the law as stated in *Janaway*. The doctor cannot opt out of helping the patient find another doctor ready to assist her, nor can they object to providing care pre or post abortion care, or assistance if it is an emergency.[16] Mason and Laurie rightly say

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in the debate over conscience in clinical practice' (2008) 29 *Theoretical Medicine and Bioethics* 201-212 at 206-7.

[15] They say **"21.** Patients may ask you to perform, advise on, or refer them for a treatment or procedure which is not prohibited by law or statutory code of practice in the country where you work, but to which you have a conscientious objection7. In such cases you must tell patients of their right to see another doctor with whom they can discuss their situation and ensure that they have sufficient information to exercise that right. In deciding whether the patient has sufficient information, you must explore with the patient what information they might already have, or need.

22 In the circumstances described in paragraph 21, if the patient cannot readily make their own arrangements to see another doctor you must ensure that arrangements are made, without delay, for another doctor to take over their care. You must not obstruct patients from accessing services or leave them with nowhere to turn. Whatever your personal beliefs may be about the procedure in question, you must be respectful of the patient's dignity and views." Taken from 'Personal Beliefs and Medical Practice'

http://www.gmc-uk.org/guidance/ethical_guidance/personal_beliefs/Personal%20Beliefs.pdf.

[16] See *Barr v Matthews* (2000) 52 BMLR 217

that such a compromise is 'only marginally compatible with a strong conscience'.[17] We can see therefore that any 'right' to conscientious objection is a limited one as far as the guidelines are concerned. The welfare of the patient takes precedence over the personal beliefs of the clinician.

One crucial matter that is not clear from *Janaway* is whether doctors can rely on section 4 to refuse to sign a certificate that the grounds for a lawful abortion are met. The House of Lords left the question of whether the signing of the certificate constitutes participating in treatment open saying that at least prior to 1989 it had not appeared to be a problem in practice.[18] What is clear is that the right of objection embodied in section 4 of the Abortion Act is constrained to conduct closely related to the ending of fetal life. If the grounds for objection rest in the individual's belief concerning the moral status of the fetus, i.e. that killing the fetus is not morally different from killing us, is such restriction justifiable? Was Mrs Janaway using her position to make a political point on behalf of the anti-abortion lobby? We cannot know her motives. Consider however the fact that in writing the referral letter she played a role in a process that concluded in fetal death:

> [S]he was an essential cog in the wheel. Abortion was as repugnant to her as murder. For Mrs Janaway, however irrational others might perceive her views to be, her employers were asking her to type out a death warrant.[19]

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[17] JK Mason and GT Laurie *Mason and McCall Smith's Law and Medical Ethics* (7th ed) (Oxford University Press, 2006) at paragraph 5.103.

[18] *Janaway v Salford Area Health Authority* [1989] AC 537 at 572-3.

[19] See Brazier and Cave above at Note 6 at paragraph 14.13.

However in signing the abortion certificate required by the 1967 Act it might be argued that even the doctor is merely stating whether the grounds of the Abortion Act are met. So is there any real difference between a doctor stating that the grounds of the abortion have been met, and a doctor sanctioning the abortion-giving it his or her approval? Similarly critics of Mrs Janaway will argue that in *Janaway,* Mrs Janaway was only acting on the doctor's behalf – it was not her who was sanctioning the abortion. A host of other questions about the scope of section 4 and thus conscientious objection to abortion in English law remain unanswered. We have envisaged so far the professional whose views on fetal status derive from a belief that killing a fetus is itself a wrong and would wish to opt out of any termination of pregnancy on any ground at any stage in the pregnancy. But there may be those who would consider abortion justifiable, but only on narrower grounds than the Act provides, for example in cases of rape or where there is a significant threat to the woman's health. Or there may be those prepared to contemplate termination in the first 12 weeks of pregnancy but not thereafter. It is harder in such cases to evaluate what kinds of belief constitute conscientious objection rather than just disagreement about the way laws frame the boundaries of lawful abortion. There have been anecdotal reports of obstetricians who distinguish between certain sorts of patient, prepared to 'assist' the forty year old married mother of four but not the single teenager who the doctor judged to be irresponsible. We are clear that the latter can not be considered a conscientious objection. The doctor is not refusing treatment because he considers that by terminating that pregnancy he does an intrinsically wrongful act but because of a judgment about the patient before him. The GMC rightly makes it clear that doctors in the UK may not make decisions about patient care on the basis of judgment about the

patient's lifestyle.[20] We revisit the vexed question of the boundaries of conscience in Part VI below.

Whatever its boundaries the exercise of a right of conscientious objection in the Abortion Act attracts criticism both from those who wish to see liberal abortion laws in the UK and those who have conscientious objection to abortions. The first group alleges that the right to object in effect deprives women of their right to a lawful medical service or so delays access to abortion as to force women to undergo more traumatic later abortions[21]. 'Pro-choice' lobbies argue that section 4 should be repealed. The second group maintain that doctors who hold such conscientious objections are discriminated against in the development of their careers, especially should they wish to specialise in obstetrics and gynaecology[22]. It is beyond our expertise to assess the empirical accuracy of either claim. What we ask later is should such objections be allowed at all?

A second statutory right of conscientious objection is to be found in section 38 of the Human Fertilisation and Embryology Act 1990. That Act regulates most forms of assisted reproduction technologies (ARTs) and embryo research. Section 38 grants a right to anyone with a conscientious objection to treatments or procedures regulated by the 1990 Act not to participate in 'any

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[20] They say: "You must not refuse or delay treatment because you believe that a patient's actions have contributed to their condition. You must treat your patients with respect whatever their life choices and beliefs. You must not unfairly discriminate against them by allowing your personal views* to affect adversely your professional relationship with them or the treatment you provide or arrange. You should challenge colleagues if their behaviour does not comply with this guidance." Taken from 'Good Medical Practice' http://www.gmc-uk.org/guidance/good_medical_practice/GMC_GMP.pdf

[21] http://www.abortionrights.org.uk/content/view/180/121/

[22] See Mason and Laurie above at paragraph 5.105 and fn 229 suggesting that damage to the careers of conscientious objectors is more prevalent in nursing than medicine – they refer to Lord Denning in Royal College of Nursing of the United Kingdom -v- Department of Health and Social Security [1981] AC 800.

activity governed by this Act'. So a doctor who can establish such an objection may (inter alia) refuse to assist in IVF, or the storage of gametes, or any form of manipulation or research on an embryo. The rationale for section 38 might at first sight be thought to be the same as that motivating section 4 of the Abortion Act. No-one who regards the embryo as having a moral claim to life akin to a born human can be obliged to assist in any process that may destroy embryos. But section 38 is broadly drafted. An objector may object to *any* activity within the remit of the Act. So a doctor could refuse to carry out IVF but participate in treatment involving donor insemination. He could carry out IVF but object to pre-implantation diagnosis. Section 38 seems in practice to have provoked much less controversy and debate than section 4 of the Abortion Act. We suspect that the reason for this is simple. Doctors with profound objections to embryo research and ARTs do not elect to specialise in fertility medicine. One matter has aroused concern and raises a question about the scope of section 38; may a doctor elect to refuse fertility treatment to certain kinds of patient? We agree with Kennedy and Grubb[23] that objection to the patient rather than the treatment falls outside the boundaries of conscientious objection being as they say the 'product of prejudice rather than principle'[24]. These cases are similar to the example above of the doctor who judges the 'irresponsible young girl'. In these judgements the doctor is not expressing a conscientious belief about that 'which is not for her', rather she is judging the action of another through the lens of her own personal morality. This is a point we will return to in the next section.

Outside legislation relating to reproduction, definitive examples of rights to conscientious objection in medicine in English law are hard to find. In *B v An NHS Trust*[25] Ms B had

[23] *Kennedy and Grubb: Medical Law* (3rd ed) (Butterworths, 2000) at p.1282

[24] Ibid

[25] [2002] 2 All ER 449

suffered a haemorrhage into the spinal column of her neck. She became paralysed below the neck and breathed only with the aid of a ventilator. Ms B after much reflection concluded that she did not wish to survive in such a state and asked her doctors to switch off the ventilator. Her doctors refused. They sought to convince Ms B that she could still live a fulfilling life in a rehabilitation programme outside hospital. Ms B was not persuaded and she argued that as she no longer consented to ventilation, continuing ventilation was an assault against her. The High Court once satisfied that Ms B was mentally competent to make the decision about ventilation agreed with her. The President of the Family Division, Dame Elizabeth Butler Sloss, held that continuing to ventilate Ms B against her will was unlawful and that the hospital authority must make arrangements to transfer Ms B to a unit where doctors would comply with her wishes. The point of great interest for us is that the judge refused to order the doctors caring for Ms B to act contrary to their conscience. But she did so in the knowledge that there were other doctors who would comply with Ms B's request. This provides an example of a possible limitation to the application of conscientious objection in medical practice. Does a doctor's right to conscientiously object to a certain activity end when there is no other clinician available? What would the judge have done if no doctors had agreed to switch off the ventilator? Some suggest that this is a necessary aspect of conscientious objection – the patient's interests in self-determination must be respected.[26] This self-determination is tempered by the fact that a doctor will not usually be forced to provide treatment which they believe to be medically futile, regardless of the requests and demands of their patients – cases like these highlight the very close interplay between a doctor's professional conscience and matters which would be strictly a

[26] Julian Savulescu, 'Conscientious Objection in Medicine' (2006) 332 *British Medical Journal* 294-297; Mark R Wicclair, 'Conscientious Objection in Medicine' (2000) 14 *Bioethics* 205 – 207.

matter of personal conscience.[27] Referral to another clinician highlights an important aspect of conscientious objection in medicine- the conscience of the clinician is neither the only nor the most important factor to be taken into consideration. The interests of patients must also be remembered, as must be the integrity and efficacy of the healthcare system. This highlights the difficulty in calculating the justifications necessary for effective conscientious objection.

B however shares with the provisions for objection in abortion and fertility treatment a central dependency on contested understandings of sanctity of life. Doctors objecting to switching off the ventilator like doctors objecting to taking part in abortions often do so because they perceive what they are asked to do as killing. In medical practice in the UK other possible instances of objection are emerging unrelated to decisions about life and death. Some Muslim doctors and medical students contend that their religion bars men from treating women, and women from treating men, at any rate if some form of physical contact or undress is a necessary part of treatment. They argue that only male doctors should treat men and only female doctors should treat women. Other exemptions from usual practice are sought. So for example, a female doctor may refuse to pull her sleeves up above her wrists when scrubbing up for surgery or may insist in wearing a full veil when attending patients.[28] In these cases the objection is not towards an activity which would in usual circumstances be considered 'contentious' or against core ethical values in medicine.[29] But then should we ask ourselves whether we are judging what is 'contentious' and what constitutes a 'core' value through the prism of the Judeao-Christian tradition that

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[27] R (Burke) v. GMC [2005] E.W.C.A. Civ. 1003

[28] http://www.gmc-uk.org/guidance/ethical_guidance/personal_beliefs/personal_beliefs.asp#7

[29] Mark R Wicclair, 'Conscientious Objection in Medicine' (2000) 14 *Bioethics* 205 – 207.

informs the common law? These cases will be more difficult to consider as they involve bigger general issues in healthcare. For instance, the importance of hygiene in healthcare practice is obvious. If I do not wish to wash my hands and arms prior to surgery in accordance with the protocols which dictate this type of process am I effectively objecting to taking part in surgery? If we do not allow individuals who do not wish to wash their arms appropriately to take part in surgery are we penalising them for a greater act than they are committing – do we take their refusal as a barrier to their taking part in the surgery at all? This balance will be considered further later.

III WHAT IS A CONSCIENTIOUS OBJECTION?[30]

> "conscience" [is] an individual's faculty for making moral judgments together with a commitment to acting on them. For many persons, their consciences are deeply informed by their religious beliefs and commitments, but there is no necessary connection between conscience and religion since many non-religious persons are equally possessed of moral commitments and consciences[31]

In the above quotation, Brock highlights several important points we should remember in our discussion about conscience. The first of these is that we should not confine conscientious beliefs to those which are religious. Conscience is not reliant on religious faith, it is rather a feature which all of us will possess and will be informed by our moral and personal beliefs whatever their sources. So Ken Mason in discussing section 4 of the Abortion Act refers to the 'Hippocratic (or professional

[30] See Appendix A for three case studies put forward by James Childress as examples of appeals to conscience.

[31] Dan W. Brock, 'Conscientious refusal by physicians and pharmacists: who is obligated to do what, and why?' (2008) 29 *Theoretical Medicine and Bioethics* 187-200 at 188.

conscience)'[32] Defining Conscientious Objection and why we should respect it can be quite difficult. Macklem suggests:

> In some of these cases conscientious objection is married to religious conviction; in nearly all it is political, involving as it does the refusal of a person to do what the political community has called upon him or her to do. In every case it is dramatic and dissentient, principled and autonomous, a matter of following the dictates of one's own reasoning rather than the dictates of others in the discharge of one's moral obligations, and thus a matter of taking a stand against what one has been called upon to do by exempting oneself from its demands. Not me, or at least not in my name, goes the cry.[33]

This quotation is suggestive of many of the obvious aspects of conscientious objection. We usually associate conscientious objections with moments of saying no; with some level of dissent. We can not do what is asked of us – our conscience will not allow it. This highlights the important connection that conscience seems to have with 'the self'. Allowing individuals to object is allowing individuals the possibility for self expression and non-conformity. Furthermore when we consider conscientious objection we must remember that the objector is not merely choosing to act in accordance with their conscience but rather that their conscience may often constrain them – they could not act in any other way. Wicclair describes the situation as follows:

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[32] JK Mason *The Troubled Pregnancy* (Cambridge University Press, 2007) at p.29.

[33] Timothy Macklem, *Independence of Mind* (Oxford, Oxford University Press; 2006) 69.

> When a physician claims that there is an action that he or she cannot in good conscience perform, the physician is not merely stating that the action is unethical. Rather, the physician is asserting the stronger claim that his or her moral integrity is at stake, and appeals to conscience can be understood as efforts to preserve or maintain moral integrity.[34]

This all shows that conscience is a very strong concept. It constrains our action so that we act in accordance with what we believe to be right. It is therefore a very important notion to how we perceive of ourselves as authentic actors. By asking us to act against our conscience you are asking us to act in a way which undermines central aspects of our sense of selves. The sanction for breaching conscience, while internal, will still be great.

All of this is couched in terms of acting as an individual. We are making choices for ourselves. We do not expect these choices to apply to or persuade others. Indeed this is possibly not what we would want. What is for you is not necessarily for me and vice versa. Again we refer to Macklem:

> On the one hand, the practice generally known as conscientious objection is one in which the objector refuses to comply with an obligation on the ground that it would be wrong for him to do so. The objector does not claim that the obligation is illegitimate and that others should not comply with it either.[35]

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[34] Mark R Wicclair 'Conscientious Objection in Medicine' (2000) 14 *Bioethics* 213.

[35] Timothy Macklem, *Independence of Mind* (Oxford, Oxford University Press; 2006) 69.

All of this highlights the role of conscientious objectors. They are acting on their own behalf. They are speaking for themselves. The constraints of conscience as mentioned above are usually internal to the individual. The strength of the constraints will be great. Acting against conscience is to act against your self. We see how the parameters of conscience are therefore often seen as being personal.

This may be problematic when we consider conscientious objection in professional practice. In professional life, do clinicians act in their own name? Or in the name of the profession which they represent? If it is the latter then we need to tease out whether conscientious objection in professional life is really the act of a private individual. Or is it better understood as an individual upholding the integrity of their profession? Arguably, they are not acting in their own name but in the name of the profession to which they belong. If this is how we interpret conscientious objection in professional life we will need to see which ethical principles underpin the profession. How is the integrity of the profession being protected? These are points to which we will return later in the paper but for now we simply wish to highlight the importance of breaking down the components of conscientious objection in professional life. We must also take into account as mentioned above the professional aspects of conscience. 'My' professional beliefs will inform 'my' sense of professional integrity. Therefore not all acts of conscientious objection will be acts of personal expression but may also involve acts of professional expression. In these cases asking an individual to act against their professional conscience may undermine their sense of professional integrity.

Another important aspect of the claim 'it is not for me but it may be for you' is that it requires a certain level of agnosticism about the values being upheld. It requires the conscientious objector to acknowledge that others may legitimately act in ways with which they do not agree. A level of uncertainty about the

activity being objected to is necessary. In medical life we see many activities with this kind of uncertainty; the uncertain moral status of the fetus, the uncertainty of whether life is always supremely valuable or if it is sometimes best to end it. We may all be clear about our own personal beliefs on these issues. But this certainty of our own beliefs may not be enough to tell us these beliefs should apply to or convince others.

If we act in accordance with our beliefs as clinicians are we keeping these beliefs within the realms of conscientious objection? Or is there a slide into dissent? Macklem seems to suggest that professionals who object to activities that are expected of them in their professional capacity are dissenting, rather than objecting:

> Doctors offer procedures to patients that are forbidden, such as abortions in proscribed circumstances or on proscribed grounds, or refuse to provide procedures that they are expected to provide, such as contraception or IVF treatment, or abortion in officially sanctioned circumstances or on officially recognized grounds, just because they believe that the procedures in question should be (respectively) either available or unavailable to all who seek them.[36]

Macklem believes that physicians are acting beyond the sphere of 'It is not for me'. They are actively trying to subvert the system within which they operate. They are preventing others from gaining access to that to which they are entitled.

Of course when there is a right to conscientious objection, as with abortion and assisted reproductive technologies, a doctor

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[36] Timothy Macklem, *Independence of Mind* (Oxford, Oxford University Press; 2006) 70.

is acting in accordance with the system within which he or she works. However we should then be aware that this right to object is limited by the fact that there must be another clinician who is willing to be involved and to whom you can refer the patient. Does this mean that conscientious objection in the health service is limited to only those cases where the legislature has expressly granted such a right? Think again of the Ms. B case – were the courts wrong to suggest that the doctors could not be required to remove life sustaining treatments- treatments that the judge ruled to be an assault on Ms B? Or is it rather the case that often acts of conscientious objection, when they happen in professional life, are more like acts of defiance of the regime within which an individual finds themselves working? It is possible that the doctors' conscientious objections would not have been respected if another team could not have fulfilled Ms. B's wishes. The availability of others to carry out the action in question seems often to be an essential aspect of conscientious objection in healthcare.

Therefore we could suggest that the slide from an act of conscience to an act of dissent is tempered by the requirement that another clinician must be able to facilitate the requested treatment. And further not only must there be such a clinician available but the objector must refer their patient to them. This shows that the objector's beliefs are tempered by the expectations of their job. There is another important consideration for the ways in which we understand conscientious objection to certain medical activities – doctors will not usually be forced to treat. Therefore, even if we reduce or try to limits acts of conscientious objection the doctor will still be able to act in accordance with their clinical judgment. This allows doctors a certain sphere within which their choices are protected. Some bioethicists express concern that 'clinical judgment' may be used cynically to

obscure other value judgments.[37] However unless we wish to remove all discretion from physicians this will remain a possible avenue through which doctors can act in ways which are in accordance with their beliefs.

IV. IS MEDICINE DIFFERENT?

Any examination of conscientious objection in health care must at some point confront the challenge as to why health professionals' personal values and beliefs should be considered at all-why is there any debate about conscientious objection? The obligation of the doctor, nurse or pharmacist to her patient is to provide a reasonable service in accordance with responsible professional practice. What constitutes such a service is to be defined objectively and not limited by the subjective opinions of individual providers. So if termination of pregnancy is in the circumstances of the patient lawful and endorsed by good medical practice, no doctor or nurse should be allowed to say 'but no I can't agree with the destruction of the fetus'. If Ms B had a right to require that doctors switch off her ventilator the judge arguably should not have exempted the doctors caring for B from any obligation to concur with B's wishes. Wicclair suggest the following way in which we can understand the operation of conscientious objection:

> ... in contrast to many other professions and occupations, medicine is a `moral enterprise'. There are at least two respects in which it might be claimed that medicine is a moral enterprise: (1) Physician decision-making should be guided by a consideration of obligations to patients rather than the physician's self-

[37] John Coggon, 'Best interests, Public Interests, and the Power of the Medical Profession' (2008) 16 *Health care Analysis* 219-232, especially pp 228-229.

> interest. (2) Physician decision-making should be informed by ethical values and professional standards (e.g., standards of `professional integrity'), and physicians should not act as mere `technicians' who will perform requested services on demand.[38]

While it is beyond the scope of the paper to discuss fully the vocational nature of medical practice we believe that there is much merit in this reasoning. It seems to accurately describe the spirit in which much medical practice is undertaken.

Let us consider the question of conscience in the context of other services. The plumber and the carpenter are free to decide to whom they offer their lucrative services. A devoutly religious plumber who considers that sex outside marriage is a deadly sin will not knowingly contract with an unmarried couple living in what he considers to be 'sin'. He has no obligation to explain his choice of customers but he is constrained only by legislation banning discrimination on grounds of race, religion, and sexual orientation. However should he have embarked on fitting a new bathroom before he comes to know that the household is 'ungodly' and then abandons the task half done, he will be liable for breach of contract. And his tender conscience will not assist him in defending any claim against him. So once a doctor in general practice has accepted a woman as his patient, why should he be allowed to refuse her a service many now see as routine medical care?

The answer is likely to be that practising medicine touches on fundamental religious and personal beliefs and may require not just that the doctor stand by and observe what he considers to

[38] Mark R Wicclair 'Conscientious Objection in Medicine' (2000) 14 *Bioethics* 215.

be a deeply wrong action but that he plays an active role in attaining that wrong end. The plumber does nothing that implicates his own conscience. His conscience may be offended by the lifestyle of the couple, but he is not required to do anything himself to promote conduct contrary to his faith. The doctor may be asked to do an act that leads to the destruction of an entity he considers to share the same moral status as we do. So for the devoutly Roman Catholic doctor, he is asked to commit a sin himself and not merely tolerate sin in others. Again Macklem suggests:

> A person conscientiously objects to what the community requires of him or her because it embodies expectations that, although legitimate, are incompatible with the no less legitimate claims of the objector's conscience. A person goes further and becomes civilly disobedient if and when what the community requires is morally illegitimate.

The delicate balance between the practitioner as an individual and as a professional person is encapsulated in this conflict. Our expectations of practitioners may not just require them to do something which they disagree with but rather something which they think is forbidden. And our expectations do not allow for them to simply hold their hands up and say 'This is not for me' because what is for the patient is for the practitioner – the two are intimately intertwined.

However there will be some who contend that a doctor or nurse with conscientious objection to services now perceived as good practice should not be practising that profession. An orthodox Muslim with profound objections to the consumption of alcohol would not take on the job of bartender. If he did and then once he had the job he said that he would serve only soft drinks he would be dismissed. The conscientious objector to compulsory

military service is allowed to claim exemption from combat where he may be required to kill but she cannot say 'I will serve in this battleground X but not Y because I judge that battle Y is not ethically justifiable'. In a volunteer army, as in the UK, the conscientious objector simply does not join the military services. You cannot join the Navy for the uniform and travel and then turn round and say I will not fire a torpedo because I have an absolute belief in the sanctity of human life.

V. WHY CARE ABOUT DOCTORS' CONSCIENCES?

Do the justifications of conscientious objection in the private sphere translate into the public professional activities of doctors? Or are there further factors that should be taken into account? What about the scope for reasonable disagreement about some of the activities that doctors are involved in? Julian Savulescu describes that although 80% of clinical geneticists and obstetricians surveyed agreed in principle, that a woman at 13 weeks gestation should not be denied access to abortion which she sought only because the pregnancy was impeding her career, fewer than 40% would themselves be prepared to be involved in such an activity.[39] Those doctors who are not willing to be involved fall within the scope of Macklem's above account – they say this is not for them. They allow that for some this will be a reasonable choice but not a choice for them. However they face difficulties in that if there are very small numbers willing to participate then they may not be able to transfer their patient to another clinician – the claim 'not for me' is limited in these cases. When enough clinicians begin to object to certain activities is it time to coerce them to take part or to review the activity in question?

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[39] Julian Savulescu, 'Conscientious Objection in Medicine' (2006) 332 *British Medical Journal* 294-297.

We have spoken briefly about the vocational nature of medicine and also about the role of the ethics of medicine. These are core values which we would expect all doctors to act in accordance with, such as respect for life, and respect for patients. However, there is a further issue which must be acknowledged. Many of the activities to which doctors conscientiously object will be very contentious. All doctors may have respect for life but may, just like the rest of society, interpret that respect in very different ways. Treatments that provoke conscientious objection will be treatments upon which there is limited consensus in society as to their acceptability, such as late term abortions or the refusal of treatment by a patient not terminally ill, or a lone parent who is the sole carer for his young children. To suggest, as Savulescu seems to, that anyone who has anything less than standard and secular beliefs in this area be debarred from medical practice is to ignore the nature of the decisions doctors have to make. It is also to presume that an underlying religious ideology is a necessary component for the discomfort we may feel about these hard cases. We do not believe that such a belief is necessary. It seems fair to say that these are just very difficult cases to be involved in. Allowing doctors personal space in their private activities may simply be an acknowledgement of the difficulty of the choices that they face. As Wicclair suggests:

> Physician assisted suicide has its strong advocates as well as opponents, and for many it remains shrouded in moral uncertainty. Such moral controversy, disagreement, and uncertainty seem to recommend tolerance and the recognition of conscientious objection.[40]

[40] Mark R Wicclair 'Conscientious Objection in Medicine' (2000) 14 *Bioethics* 205-227 at 206.

That is not to say that difficult choices are a trump card in this issue. The doctor cannot wash her hands of an uncomfortable choice. The late term abortion which prevents the death of the mother, when there is no other clinician available, may be an example of a time when we expect clinicians to put their own most fundamental beliefs behind their patient's needs[41]. All this serves to show us is the difficulty in pinpointing how a policy on conscientious objection will operate successfully in all cases. But perhaps this is too much to hope for. As Wicclair suggests, maybe the only option that we have is to approach the matter on a case by case basis.[42]

We should be mindful of more general reasons why we consider conscientious objection to be important. It plays a role in our self expression and our ability to act as moral persons, as Brock describes:

> Deeply held and important moral judgments of conscience constitute the central bases of individuals' moral integrity; they define who, at least morally speaking, the individual is, what she stands for, what is the central moral core of her character. Maintaining her moral integrity then requires that she not violate her moral commitments and gives others reason to respect her doing so, not because those commitments must be true or justified, but because the maintenance of moral integrity is an important value, central to one's status as a moral person.[43]

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[41] See R V Bourne above at Note 11.

[42] Mark R Wicclair 'Conscientious Objection in Medicine' (2000) 14 *Bioethics* 227.

[43] Dan W. Brock, 'Conscientious refusal by physicians and pharmacists: who is obligated to do what, and why?' (2008) 29 *Theoretical Medicine and Bioethics* 189.

We see that respect for conscientious objection is reciprocal it involves a sense of doctors and patients respecting each other[44]. Of course, when a clinician states a conscientious objection to a procedure much wanted by the patient, the apparent doctor patient conflict may seem like a barrier to this reciprocity. By respecting the doctor we may infringe on the legitimate interests of the patient. Overriding the doctor's conscience tramples on her interests.

VI. A WAY FORWARD?

One way out of the dilemma of medical conscience is perceived as a move towards a more consumerist notion of healthcare delivery so that the consumer-patient is simply free to access any form of treatment that he desires. Medical care is bought just as we buy apples and oranges. This is something that we suggest is not welcome[45]. The nature of medical practice is not we believe one that should simply classify the doctor as a service provider and the patient as a consumer. And even if we did accept this model there would still be grounds for respecting doctors' conscientious beliefs.

A shopkeeper can not be prevented from selling fair-trade or ethical goods simply because his customers want the cheaper option. They can be expected to go elsewhere. A doctor can not be expected to provide every medical option that there is, either in the public or the private sphere. They may object because they think certain choices involve a waste of resources. Others may not be clinically indicated. Once there is another clinician

[44] See M Brazier "Do No Harm – Do Patients have Responsibilities Too?" (2006) 65 Cambridge Law Journal 397.

[45] See M Brazier and N Glover "Does Medical Law have a Future?" in D Hayton (ed) *Law's Futures* (Hart Publishing, Oxford; 2000) 397.

available to provide a service then we have good reason to allow the doctors not to provide it.

The difficulty will be when a large number of clinicians object, do not feel that certain activities are appropriate. Does this provide an example of when we should change our policies? Or force the doctors to do that which they do not believe in? Many are especially horrified by medical involvement in torture. During the Nuremburg trials the claims of Nazi doctors that they were simply following orders when they tortured and experimented on 'prisoners' were dismissed with scorn. Should we instead start to ask why it is that so many clinicians are uneasy – is it because we are recruiting from particular sections of the community? Or because of political pressure being put on clinicians? We believe that if this is the case the correct response is not to overrule rights of conscientious objection – it is rather to recruit more widely and protect doctors more appropriately from the pressures of political activists.

We should be wary of the line between protecting conscientious objection and endorsing prejudice. Macklem describes the situation as follows:

> [I]t follows that in the same way that a person's character is liable to embody virtue, the content of that person's character is as liable to embody vice as it is to embody virtue, the content of that person's conscience, vulnerable as it is to the fragility of both his or her own reasoning and the reasoning of others upon whom he or she may have relied, is as liable to entrench what is morally forbidden as it is to entrench what is morally required.[46]

[46] Timothy Macklem, *Independence of Mind* (Oxford, Oxford University Press; 2006) 90.

While we agree that doctors should be given the opportunity to object to certain practices on grounds of conscience, we do not think that such objections will always be justified. Nor should they be protected from scrutiny. The doctor cannot simply assert an objection, distaste for a medical practice that is lawful and consonant with good medical practice as defined by the profession as a whole. There will be good and bad reasons for acting in different ways and we as a society have grounds for limiting behaviour that we do not believe to be acceptable.[47] If an individual is acting from solely from objectively unjustified prejudice then we can step in; we can say that this is not something we need to respect. Consider what Savulescu has to say on the subject:

> Conscience, indeed, can be an excuse for vice or invoked to avoid doing one's duty. When that duty is a true duty, conscientious objection is wrong and immoral.[48]

But Savulescu goes beyond the idea that some allegedly conscientious objections may be premised on illegitimate beliefs to the more extreme claim that the very act of objecting when one has other duties to fulfil is illegitimate. This means that even if you have good reasons to object, reasons shared by may in society outside the medical profession, your role as a clinician strips you of the justification to act on that objection.

We feel that this more extreme claim is a step too far. To expect practitioners to leave their personal beliefs at the door of

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[47] Dan W. Brock, 'Conscientious refusal by physicians and pharmacists: who is obligated to do what, and why?' (2008) 29 *Theoretical Medicine and Bioethics* 189.

[48] Julian Savulescu, 'Conscientious Objection in Medicine' (2006) 332 *British Medical Journal* 294.

the clinic is to be unrealistic about the nature of human action. While we may try to distinguish between ourselves as private and public actors it will be impossible to do so fully. And further it may not even be something we would wish to happen. The nature of medical practice requires compassion and empathy. Personality is in some cases as important as technical skill. We suggest that a more nuanced approach than that suggested by Savulescu is possible. However this is a difficult issue and one which is likely to give rise to much more controversy.

A 'right' of conscientious objection provides clinicians in the UK with a certain amount of freedom of conscience at least in the context of procedures touching on ending life, whether in relation to abortion or withdrawing life support. However, it also raises many questions. For instance, is there is an implication that any case not specifically provided for in legislation or existing case-law is not covered by this 'right'? This leads to the further question – is conscience something that needs legislative provision? Should patients be clear about the occasions when a doctor may lawfully say to them that no he will not provide a particular treatment that offends his conscience? Is professional guidance from the GMC sufficient? Are there areas of practice unproblematic in the past that will raise issues of conscience with doctors from different cultures and different faiths? Conscientious objection and its place in clinical practice remain a vexed issue. We suggest that there are no easy answers, but rather only controversial ways through individual hard cases.

APPENDIX A

1. On June 21, 1956, Arthur Miller, the playwright, appeared before the House Committee on Un-American Activities (HUAC) which was examining the unauthorized use of passports, and he was asked who had been present at meetings with Communist writers in New York City. Here is part of the dialogue:

MR. ARENS: Can you tell us who was there when you walked into the room? MR. MILLER: Mr. Chairman, I understand the philosophy behind this question and I want you to understand mine. When I say this, I want you to understand that I am not protecting the Communists or the Communist Party. I am trying to, and I will, protect my sense of myself I could not use the name of another person and bring trouble on him. These were writers, poets, as far as I could see, and the life of a writer, despite what it sometimes seems, is pretty tough. I wouldn't make it any tougher for anybody. I ask you not to ask me that question. ... MR. JACKSON: May I say that moral scruples, however laudable, do not constitute legal reason for refusing to answer the question. . .. MR. SCHERER: We do not accept the reason you gave for refusing to answer the question, and ... if you do not answer ... you are placing yourself in contempt.

MR. MILLER: All I can say, sir, is that my conscience will not permit me to use the name of another person.

2. On December 29, 1970, Governor Winthrop Rockefeller of Arkansas commuted to life imprisonment the death sentences of the fifteen prisoners then on death row. He said, "I cannot and will not turn my back on life-long Christian teachings and beliefs, merely to let history run out its course on a fallible and failing theory of puni- tive justice." Understanding his decision as "purely personal and philosophical," he insisted that the records of the prisoners were irrelevant to it. He continued, "I am aware

that there will be reaction to my decision. However, failing to take this action while it is within my power, I could not live with myself."

3. In late December 1972, Captain Michael Heck refused to carry out orders to fly more bombing missions in Vietnam. He wrote his parents: "I've taken a very drastic step. I've refused to take part in this war any longer. I cannot in good conscience be a part of it." He also said, "I can live with prison easier than I can with taking part in the war." "I would refuse even a ground job supervising the loading of bombs or refueling aircraft. I cannot be a participant. . . a man has to answer to himself first."

Taken from: James F. Childress 'Appeals to Conscience' (1979) 89 *Ethics*, 315-335.